Aries Healthcare Group Ltd

Haydock House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Haydock House is a residential care home providing regulated activity of personal care for up to 16 people. The service provides support to people over the age of 18 with mental health needs. Accommodation is provided over two floors of the building. At the time of our inspection there were 11 people using the service.

People's experience of using this service and what we found
People's safety was not always appropriately managed. Identified risks to people were not always considered or planned for. Medicines were not always managed appropriately. Staff supporting people were not always familiar with their individual needs and there was a lack of guidance and support available of how to support people safely. Safeguarding concerns, incidents and accidents were not always appropriately recorded or reported to other agencies.

People's needs were not always assessed in full and information supplied by other agencies was not always considered in planning people's care and support needs. People were not always supported by staff who had the relevant skills; communication; training and experience to meet their needs.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Information available to staff was limited and failed to give sufficient guidance on how to engage with people and promote community presence.

People's care and support was not planned in a person-centred way which promoted their choice, control or preferences. People's care plans failed to show that their current and long-term aspirations had been considered or planned for. There was no evidence to show that people were encouraged to widen their social circles within local communities or to pursue and develop hobbies and interests.

Records were not always fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed. The providers audits and checks in place had failed to identify areas of improvements, and take the actions needed identified during this inspection. No effective systems were in place to ensure that people were supported by staff who had the skills to meet the needs of people.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support: People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: Care was not person-centred or promoted people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff failed to ensure people using services lead confident, inclusive and empowered lives.

Following the inspection the provider took action to address the most serious concerns identified during the visits.

Rating at last inspection
This service was registered with us on 15 November 2022 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service and other information of concern raised by another agency.

The overall rating for the service is inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe; effective; caring; responsive and well-led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to risk management; medicines; staffing; training; person centred care; management and oversight at this inspection. We have made recommendations in relation to the oversight of the Mental Capacity Act and the services environment.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led section findings below.	**Inadequate**

Haydock House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspections and a medicines inspector.

Service and service type
Haydock House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Haydock House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

During the time of our inspection a manager became registered with CQC.

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since its registration. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service about their experience of the care provided. We spoke with 7 members of staff including care staff, the registered manager and 2 members of the senior management team including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included people's care and medicines records. A variety of records relating to the management of the service, including monitoring and reviewing information, were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
- Medicines were not always managed safely across the service.
- Staff who managed medicines did not always have appropriate training or had their competencies checked. We could not be assured that staff were able to manage and administer medicines safely.
- Medicines administration records (MARs) were not always completed and for 5 people we found gaps in their charts. When people were unable to take their medicines due to being asleep or away from the service, staff did not always ensure that medicines were offered at another time. This means we could not be assured that people received their medicines as prescribed.
- For one person who looked after their own medicine there was no risk assessment available to show that they were safe to do so, or that the service checked that the person was taking their medicine as prescribed.

The provider failed to ensure safe management of medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were stored securely within the service.
- Staff recorded the time of administration of medicines prescribed to people to be given when required.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- Systems to protect people from the risk of abuse were not safe.
- Safeguarding concerns and incidents recorded by the service had not been reported to the appropriate agencies.
- Records of some incidents were not fully completed or showed the actions taken to mitigate the risk of further occurrence. In addition, there was no evidence incidents had been reviewed by a member of the management team. Our review of accident and incident records showed a theme of times incidents had occurred. The provider had failed to identify these themes and take appropriate action to prevent further occurrences.
- Records showed on occasions restraint had been applied to manage situations. We were unable to establish if staff were appropriately trained in the safe use of this practice.
- Procedures were not in place to inform people or guide staff when emergency access to bedrooms would be required. In addition, no clear procedure was in place for the management of bedroom keys to ensure that staff were able to enter people's bedrooms in the event of an emergency.

The provider failed to operate systems and processes to safely manage, monitor and record safeguarding concerns. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Systems in place to identify, assess and monitor risk were not safe.
● The provider failed to review and monitor equipment in use. For example, the fire risk assessment was not up to date and there were no records available to show the required safety checks were carried out on the passenger lift.
● Safety monitoring and management of the environment was not effective or in some areas, taking place. For example, hot water temperatures were not monitored on a regular basis. When checked during the inspection, hot water temperatures were above those required to minimise the risk of scalding. Equipment that posed a risk for some people was readily accessible to all around the building. We identified a number of areas of flooring which posed a potential trip hazard.
● A number of first floor windows were not fitted with safety restrictors, not all wardrobes had been secured to a wall and two fire doors required attention to ensure they would operate appropriately in the event of fire. There was a broken windowpane in an unlocked room which posed a risk to all.
● Risk assessments were not always completed in full and failed to demonstrate that all areas of the person's needs and wishes had been considered when assessing people's care and support. Records were incomplete or information was missing in the risk assessments.

Systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The management of staff and recruitment was not always safe.
● Staff rotas failed to identify the names of all staff on duty or what support they were delivering to whom. Three people were in receipt of one-to-one support from a staff member, however rotas failed to identify these staff and the times they were providing this support.
● No specific staffing tool was in use to determine the number of staff required to support people safely. The information available did not provide details of the actual numbers of staff available to safely meet people's needs.

Systems were not in place for the safe deployment of staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were happy with the staff that supported them.
● Recruitment procedures were in place, however, records failed to demonstrate that all of these procedures were followed. For example, there were documents required for all staff and these were missing. This had already been identified by the management team and a full audit of staff recruitment files was taking place.

Preventing and controlling infection
● Procedures were in place for the safe management of preventing and controlling infection within the service.
● Personal protective equipment (PPE) was available around the service.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs and wishes were not always assessed in full.
- There was a lack of guidance recorded in assessments and care plans to guide staff on how to effectively meet people's needs and choices.
- Assessment information provided by other agencies involved in people's care and support was not always considered when developing their care plans.

Effective systems were not in place for the assessment and ongoing review of people's needs. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- People were not always supported by staff who had the relevant skills; communication; training and experience to meet their needs.
- Information about staff training and knowledge was not always available. For example, detailed profiles for agency staff were not always available to evidence they had the required experience, training and skills for the role. In addition, there was little information to show the level and appropriateness of training made available to all staff.

Effective systems were not in place to ensure people's care was delivered by appropriately trained, skilled and experienced staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● We found the service was generally working within the principles of the MCA. However, associated documentation was difficult to locate and at times gave conflicting information.

We recommend the provider consider and implements current guidance and best practice for the implementation of the MCA.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet.
● People told us that they had enough to eat and the food available was good. Comments included, "The food is lovely" and, "Three square meals a day, that's enough for anyone."
● People were seen to speak with the cook and order a meal of their choice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to live healthier lives, access healthcare services and support
● People had access to the healthcare support they required. Associated health care professionals visited the service on a regular basis to provide treatment to people.
● People's care plans for monitoring their physical health stated monthly checks were to take place. However, records showed that these checks had not taken place.

Adapting service, design, decoration to meet people's needs
● Communal living was not always planned or promoted effectively for people. For example, a large lounge remained empty during both days of the inspection. People told us this was not utilised. The heating had been switched off in this room. In addition, a designated relaxation room was being utilised as an office, preventing people from the opportunity to access the facility.
● Areas of general maintenance were needed around the building. For example, high visibility tape used on stairs had peeled away and was in need of replacing. Other areas of maintenance had been reported in the safe section of this report.

We recommend the provider consider and implements current guidance and best practice for maintenance around the building and considers best use of the space available to support people using the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- The principles of equality, diversity and human rights were not considered in the planning of people's care.
- Information available to staff was limited and failed to give clear guidance to staff of how to engage with people around specific aspects of their care and support needs. This was reflected in observations of some staff carrying out tasked based support. For example, staff providing specific support were seen to follow people around the building with no interaction.
- A key worker system was in place. However, this system was not effective. There was no evidence that people were supported to explore opportunities for increasing their community presence or have support to self-manage aspects of the life. There was no guidance or procedures in place to support staff in carrying out the role of key worker.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always maintained.
- People's personal information was not always stored appropriately. For example, personal documents relating to one person were found in an unused bedroom which was accessible to all.
- People's records were not always written in a respectful manner. For example, a record for one person stated, "Was at fault and acted unbelievably."

The provider failed to ensure people's autonomy, dignity and respect were maintained. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us that they liked the staff that supported them. We observed positive interactions between people and staff that showed positive relationships had been formed.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care and support was not planned in a person-centred way that promoted their choice, control or preferences.
- Information about people's care and choices was not consistently recorded and some information was out of date or not completed. There was a lack of information to guide staff on how to provide people with the care and support they needed. Records did not always show people had received the care and support they required consistently.
- Staff did not always have access to effective, person-centred care plans for the people.
- People did not always have access to information that met their needs. For example, menus were not available.
- People's care plans failed to show that their current and long-term aspirations had been considered or planned for. This put people at risk from lack of opportunity to make lifestyle decision for the present and future.
- There was no evidence to show that people were encouraged to widen their social circles within local communities or to pursue and develop hobbies and interests. This put people at risk of social isolation.

Systems were not in place to ensure people's needs were assessed and planned for in a person-centred way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People told us they knew who to speak to if they had a complaint about the service they received.
- It was not clear that people using the service had access to other agencies to discuss their concerns outside of the service.
- The provider stated that no formal complaints had been received about the service.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People did not receive person-centred care and support with good outcomes.
- Records relating to people were not always fit for purpose and put people at serious risk of not receiving safe and effective care and support to meet their needs. For example, some records lacked detail, were incomplete, or were not up to date.
- Systems in place failed to identify and mitigate risks to people by not identifying clear patterns of incidents occurring within the service.
- Audits and checks had not been completed routinely and therefore failed to identify areas of improvements identified during this inspection.
- The registered provider had not evidenced that statutory guidance such as "Right Support, Right Care and Right Culture" had been considered in the services practice or person-centred care planning.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not demonstrate oversight to ensure people received high quality care in a safe environment.
- The provider had not submitted notifications to CQC of all events that they were legally obligated to do.
- People's care plans and risk assessments were developed by staff without them having the necessary support and guidance on how to develop person-centred care plans and minimise risk.

The registered provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training was available and mitigate risks to people. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A new manager had been employed at the service for 8 weeks and during this inspection was registered with CQC.

Continuous learning and improving care; Working in partnership with others

- During the inspection a new member of the senior management team was engaged to drive

improvements within the service and build positive relationships with other agencies.
- The provider engaged an external advisor to monitor the service provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems were not in place to ensure people's needs were assessed and planned for in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Effective systems were not in place to ensure people's autonomy, dignity and respect were maintained. This placed people at risk of harm.