Hill Care 1 Limited

Halton View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Halton View Care Home provides accommodation for persons who require personal care. The home provides support to older people including those living with dementia and can accommodate up to 64 people. The ground floor provides accommodation for people who require general residential care, and the first floor accommodates people who are living with dementia. At the time of our inspection there were 45 people living at the home.

People's experience of using this service and what we found

Systems in place to protect people from harm and learn lessons when things went wrong were not always effectively used and therefore failed protect people from abuse or improper treatment. This exposed people living at the home to a risk of harm.

People were exposed to a risk of harm as their care needs and associated risks had not been routinely assessed, reviewed, monitored, or mitigated. Medicines were not managed safely.

Staff were not always deployed effectively to ensure people's safety or that their needs were met in a timely way.

Ineffective governance and quality assurance measures meant that people were exposed to unnecessary risk. Monitoring systems failed to identify and address shortfalls found during this and the previous inspection. This was in relation to risk and medicines management, accurate care planning and recording, governance and the oversight and deployment of staff. Furthermore, improvements were needed to cleaning regimes throughout the service.

People were supported by staff who knew them well and it was evident that positive relationships had been formed.

The newly recruited manager was aware of their role and was in the process of developing an action plan to make positive changes to the service provided for people.

We could not be assured that people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; or that the policies and systems in the service supported this practice. At the time of this inspection the newly recruited manager was carrying out a full review of Deprivation of Liberty Safeguards (DoLS) and best interest decisions that were in place for people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 11 October 2023).

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive, and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Halton View Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to medicines management, management of risk, the environment, safeguarding and management oversight. We have made a recommendation in relation to staffing.

Please see the action we have told the provider to take at the end of this report.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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 with the 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 responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Halton View Care Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and a medicines inspector.

Service and service type
Halton View Care Home 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. Halton View Care Home 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.
At the time of our inspection there was no registered manager in post. A new manager for the service had very recently commenced employment.

Notice of inspection
This inspection was unannounced on all three days.

What we did before the inspection We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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 11 people who used the service and two family members about their experience of the care provided. We also observed interactions between staff and people who used the service. We spoke with 10 members of staff, including the manager, representatives of the provider, care workers and maintenance and administration staff. We reviewed a range of records. This included people's care records and medication records. We looked at a selection of staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to operate effective systems to protect people from abuse or improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- Procedures in place to protect people and report incidents had not been adhered to and exposed people to a risk of harm.
- Information available failed to show that all incidents recorded had been appropriately referred to other agencies as required or appropriately investigated.
- Those incidents that had been reported were not always reported in a timely manner and therefore, actions to mitigate risk of harm to people were delayed.

The failure to operate effective systems to protect people from abuse or improper treatment was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider had failed to operate effective systems to identify and monitor risk and do all that is reasonably practicable to reduce the likelihood of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Safety related themes and trends following incidents were not analysed reliably or robustly and there was little evidence of learning from events or action taken to improve safety. This could result in repeat incidents occurring.

The lack of effective systems to identify and monitor risk and do all that was reasonably practicable to reduce the likelihood of harm was a breach of regulation 12 (Safe care and treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess risks relating to the health, safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Systems in place to identify, assess and monitor risk were not effective.
● Information displayed in relation to fire evacuation was incorrect. Information relating to people's personal emergency evacuation procedures was not always up to date. This was addressed by the provider during the inspection.
● People's meals were seen to be placed in front of them at the dining tables without the support or encouragement needed. This resulted in the food going cold. No checks were carried out on the temperature of food people were offered.
● Systems in place for the monitoring of people's nutritional intake were not fully completed, nor did they correlate with other records.
● Risk assessments for some people had not been reviewed or updated following changes in their needs. For example, in relation to falls.
● Systems in place for monitoring people's weight were inconsistent and not effective in identifying if additional support was required.

The failure to robustly assess risks relating to the health, safety and welfare of people was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's medicines were not always managed safely.
● At the last inspection we found that people's medicines records did not always contain allergy information. Despite audits being carried out on people's records, this had not been rectified and people continued to be at risk of receiving a medicine they were allergic to.
● At the last inspection we found that not all staff had an up-to-date check of their competency to administer medicines safely. The service could not evidence that all staff had this check in place.
● Medication administration records for topical preparations such as creams were not always completed accurately. We could not be assured that people were having creams applied as prescribed.
● Medicines to be administered at certain times were not always given at the prescribed times.
● Controlled drugs were not always managed correctly. We found that one medicine had not been stored in line with legal requirements. We also found, for one medicine, that the balance in the register did not reflect

what was held in stock.
● For one person who had medicines crushed to aid swallowing we found that staff did not have access to instructions from a healthcare professional to ensure that these medicines were administered in a safe way.

The failure to ensure the safe management of medicines was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There were shortfalls in the management of prevention and control of infection.
● Areas of the service were visibly unclean. Small kitchen areas had a build-up of food debris on equipment, floors and walls. Carpets in some areas of the service were not clean and a stair carpet was frayed posing a potential tripping hazard.
● A number of food products stored in the small kitchen areas were undated or out of date. In one small kitchen cupboard several sets of dentures were being stored in an open bowl. These were removed during the inspection.

Effective systems were not in place to identify, prevent and mitigate risks of infection control. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Aprons; gloves and hand sanitizers were available throughout the building.
● Guidance was available for staff and visitors around the service on safe infection, prevention, and control measures.

The service was following current guidelines for visiting in care homes.

Staffing and recruitment
● Staff were not always deployed consistently throughout the service.
● During mealtimes, people who needed additional support were seen to be left without encouragement and support whilst staff were assisting others elsewhere.
● People and a family member told us that there was not always sufficient staff available to meet people's needs.

We recommend the provider reviews staff planning and deployment to ensure people receive safe and effective care and support in a timely manner.

● Procedures were in place for the recruitment of staff.
● Interactions between staff delivering care and support to people were positive. Staff were gentle and supportive in their approach, and it was evident that positive relationships had been formed.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is

usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We were unable to identify whether the service was working within the principles of the MCA for all people living at Halton View and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Information available, failed to demonstrate that people's rights had been maintained in relation to the Deprivation of Liberty Safeguarding and in their best interests.
● At the time of the inspection the newly recruited manager was in the process of reviewing people's DoLS applications.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care planning documents were not personalised and failed to reflect the actual care and support delivered by staff.
- People's care planning documents were not complete, accurate or always written in a respectful manner. People were potentially at risk because staff did not have the most up to date information required to meet their needs.
- People were not consistently asked for their personal choices. For example, we saw in one area of the service people were served the full meal and not given choices as to what vegetables they would like or choice of dessert. In another area, people were asked for their choices.

We recommend the provider reviews systems and procedures in place to ensure that people have maximum choice and control in their life.

Meeting people's communication needs

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.

- Improvements were needed to ensure the service met individuals' communication needs.
- Information displayed around the service for people was not always accurate and accessible. For example, the menu on one day showed different meals from what were being served.
- People's care planning documents lacked information as to their preferred communication, sight and hearing needs.

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

- Opportunities to participate in activities and social interaction differed around the service.

People living on the ground floor told us that friendships had been formed with others and we saw people gathering in the lounge, talking, reading, doing puzzles, and playing board games. No activities or interactions were seen to take place for people living on the first floor.

- At the time of the inspection the new manager was in the process of reviewing activities available with people and also contacting local churches to support people with their faith.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure in place.

● People using the service and a family member told us that if they had any concerns or complaints they would speak directly to the staff.

End of life care and support

● The newly recruited manager understood their responsibilities in providing end of life care to people when required.

● End of life care and support would be delivered with the support of local health care professionals.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Governance and quality assurance systems in place had not been effectively used which meant people were exposed to unnecessary risk. The provider had failed to effectively assess, monitor, or mitigate identified risk relating to the health, safety and well-being of the people living at the home.
● Monitoring systems failed to identify and/or address all shortfalls found during the inspection process with risk management and mitigation, medicines management and governance. This meant opportunities to drive improvements to quality and safety were missed.
● Reporting of incidents, risks, issues, and concerns was unreliable and inconsistent. Concerns raised had not been responded to or acted on in a timely manner.
● Incidents and safeguarding concerns did not have the right level of scrutiny and oversight from the provider.
● There was no effective system in place to support and monitor staff and their deployment around the service. Senior staff tasked with the management, oversight and direction of staff were located in an office away from the areas that support was being delivered.
● Records failed to demonstrate the care and support planned for people, they had received, or been offered.
● Records were not stored safely. People's care records were seen stored in a communal lounge and a kitchen area that was accessible to all.
● Systems in place for the safe management of personal effects of people no longer living at the home were not effective. Personal effects were found stored with no means of identifying who the items belonged to.

The provider failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● The newly recruited manager was responsive during the inspection. They had already identified areas of improvement needed around the service and were in the process of planning to make positive changes to the service people received.

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
● The newly recruited manager had detailed insight and understanding of the duty of candour in their role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The newly recruited manager was spending time with people to understand their likes and preferences with a view to making positive changes to the service.
● An action plan, supported by the local authority was in place to make improvements to the service.
● Local health care professionals worked in partnership with the service to meet people's health needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The lack of effective systems to identify and monitor risk and do all that is reasonably practicable to reduce the likelihood of harm was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to robustly assess risks relating to the health, safety and welfare of people was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to identify, prevent and mitigate risks of infection control. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to operate effective systems to protect people from abuse or improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.