Wall Hill Care Home Limited

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Inspection report

Broad Street
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Date of inspection visit:
14 November 2023

Date of publication:
21 December 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wall Hill Care Home is a residential care home providing regulated activity to up to 35 people. The service provides support to people living with dementia and physical disabilities. At the time of our inspection there were 27 people using the service.

Wall Hill Care Home accommodates people in one adapted building across 2 floors. There are 2 communal lounges and a dining room that people can access.

People's experience of using this service and what we found
People were not always safeguarded from abuse and avoidable harm. Where safeguarding concerns were identified, they had not always been escalated to the local authority as legally required. Medicines were not always administered safely. For example, 1 person had received an overdose, but it had not been identified by quality checks. The provider did not always learn lessons when things went wrong.

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. However, the policies and systems in the service did not always support this practice as they failed to identify where Deprivation of Liberty Safeguards (DoLS) authorisations were not up to date. The provider addressed this immediately following the inspection and DoLS authorisations have now all been applied for.

The registered manager was not always clear about their role and responsibilities. For example, the provider did not always submit statutory notifications to CQC in line with their regulatory requirements. Audits were not always effective in checking the quality of the service. For example, checks did not identify where statutory notifications and safeguarding referrals had not been submitted. Quality checks of medicines did not always identify medicines errors or where stock counts were high. Systems were not in place to analyse accidents and incidents to enable the provider to identify trends. Staff were given the opportunity to provide feedback through surveys and team meetings, but their feedback was not always acted on quickly. The nominated individual had identified training opportunities, but further delegation was needed to ensure sufficient daily oversight of the home.

People told us they felt safe. Staff knew the types of abuse and understood how to share safeguarding concerns. Controlled drugs were stored and administered safely. Risk assessments were in place to guide staff how to meet people's needs safely and mitigate risk to them. Staff were knowledgeable about how to manage people's risks. People were supported by a sufficient number of staff to meet their needs safely and did not have to wait for their care. The home was clean and staff wore Personal Protective Equipment (PPE) in line with current guidance.

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

Rating at last inspection
The last rating for this service was good (published 24 June 2022).

Why we inspected
The inspection was prompted in part due to concerns received about risk management and the governance of the service. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe and well-led only. 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 good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe 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 medicines, safeguarding and the governance of the home at this inspection.

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

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Wall Hill Care Home Limited

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 team consisted of 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Wall Hill 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. Wall Hill 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with 7 people who lived at the home, 1 relative and a friend. We spoke with 5 staff including the deputy manager, care staff and kitchen staff. We also spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at 6 people's care records and 5 people's medicine administration records (MARs). We also viewed 5 staff files and documentation related to the governance of the service.

The provider sent us further documentation we had requested following the site visit including training records and evidence of actions they had taken since the inspection.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from abuse and avoidable harm.
- Safeguarding concerns were not always shared with the local authority when needed. Staff completed accident and incident forms and behaviour logs but where concerns had been identified, they were not always escalated by senior staff. For example, where 1 person had thrown a cup at another person, no safeguarding referral had been made.
- Where 1 person had made allegations of theft, the provider had informally investigated it and spoken with the person's social worker regarding the allegation but had failed to submit a safeguarding referral.
- The provider submitted retrospective safeguarding referrals once we raised this on inspection.

Systems had not been established to ensure people were safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite these concerns, people told us they felt safe. One person said, "I feel safe as houses here."
- Staff knew the types of abuse and understood how and when to share safeguarding concerns with management. One staff member told us, "If I did see abuse, I would report it to the senior. If nothing resolves, I would report it to more senior staff, then I would follow the whistleblowing policy."

Using medicines safely

- People were supported to receive their medicines in a way that was not always safe.
- One person's medication administration record (MAR) showed a 'when required' medicine was prescribed to be administered no more than twice a day, but 3 tablets in 1 day had been administered. This error had not been identified and no action had been taken to reduce the risk of reoccurrence. The provider contacted the pharmacy following the inspection who advised this would not have placed the person at risk of harm.
- Medicines were not always stored safely. During the inspection, we observed the medicines trolley unlocked whilst a staff member administered medicines in a different room. This meant people may have been able to access medicines and placed them at risk of harm. We checked the medicines trolley a number of times throughout the day and it was secure on all other occasions.
- Protocols were in place to guide staff when to administer 'when required' medicines. However, some lacked detail and staff did not always record the reason why the medicines had been administered.

Systems had not been established to ensure people's medicines were stored and administered safely. This

placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Controlled drugs were stored and administered safely. They were stored in a locked cabinet in a locked room and 2 staff members signed for the administration of these medicines in line with current guidance.
● Temperature checks were undertaken to ensure medicines were stored at a temperature that did not affect their efficacy.

Learning lessons when things go wrong
● The provider did not always learn lessons when things had gone wrong. For example, the provider had failed to ensure all statutory notifications were submitted despite this being raised as a concern at the last inspection.

Assessing risk, safety monitoring and management
● The provider assessed risks to ensure people were safe. Staff took action to mitigate any identified risks.
● Risk assessments were in place to guide staff how to meet people's needs safely and mitigate risk to them. Where one person had a clinical need, risk assessments clearly documented symptoms to look for and what action staff should take if they had concerns.
● Staff were knowledgeable about how to manage people's risks. Where people had dietary needs, staff told us how to mitigate risk to them. One staff member told us, "Where people have diabetes, we have to watch how much sugar we're putting into their meals and desserts, we use sweetener as an alternative."
● Personal emergency evacuation plans were in place which guided staff how to support people in the event of an emergency.

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 found the service was working within the principles of the MCA. Legal authorisations to deprive a person of their liberty were in place but we found some had expired. We discussed this with the provider who immediately applied to the local authority for extensions and showed us evidence this had been done.

Staffing and recruitment
● People were supported by a sufficient number of staff to meet their needs safely. One person told us, "The staff come quickly [when I press my call bell]. They're just so good. I feel confident in their care."
● People told us they did not usually have to wait for their care and staff told us they responded to people according to their needs and wishes. One staff member told us, "We are alright with response times. People like to get up at different times in the morning, so we go to the people who like to get up early first."
● During the inspection, we observed staff available to support people and people did not have to wait long for their needs to be met.
● People were supported by staff who were safely recruited. People were required to have Disclosure and Barring Service (DBS) checks prior to starting their employment and underwent a period of induction before

they supported people on their own. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Staff told us they were required to complete an induction prior to supporting people on their own. One staff member told us, "I completed my induction, did fire checks and was introduced to the residents. I had safeguarding and medication training and training from the staff on how to use the equipment."

Preventing and controlling infection

● People were protected from the risk of infection as staff were following safe infection prevention and control practices.

● The home was clean and there was evidence of regular cleaning being undertaken.

● Staff wore Personal Protective Equipment (PPE) in line with current guidance.

Visiting in care homes

● People were able to receive visitors without restrictions in line with best practice guidance.

Requires Improvement

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. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager was not always clear about their role. We identified several occasions where safeguarding referrals to the local authority and statutory notifications to the CQC should have been submitted but they had not been. This failure to report and act where allegations of abuse had been identified placed people at risk of ongoing harm.
- Audits were undertaken but these were not always effective in checking the quality of the service. For example, they did not identify where safeguarding referrals and CQC notifications had not been submitted.
- Systems were not in place to ensure accidents, incidents and safeguarding concerns were analysed to identify trends and take action where needed to reduce the risk of reoccurrence.
- Where actions had been identified in audits, it was not always clear whether action had been taken to address the identified concerns as this was not often recorded.
- When things went wrong, sufficient action was not always taken to investigate and identify the cause and whether any action was necessary to reduce the risk of reoccurrence.
- Medicines audits did not identify where there was a surplus of medicines in stock. This meant medicines were not returned and stock counts were high increasing the risk of errors with stock counts.
- Quality checks of medicines also failed to identify where errors were made and where improvement was needed to 'when required' protocols.

Systems had not been established 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 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The nominated individual had identified training opportunities to upskill staff. However, there was some reluctance to delegate tasks to the registered manager and senior staff to ensure daily oversight of the home. We discussed this with the nominated individual who assured us action would be taken to address this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were asked to complete surveys for the provider to gather feedback regarding the

home. Whilst the feedback provided was largely positive, where some suggestions had been made for improvement, we did not find any evidence to indicate this had been actioned.
● Staff were invited to meetings where they were able to share any concerns they may have. Staff told us they felt comfortable raising issues, but they were not always addressed quickly. One staff member told us, "We had a staff meeting not too long ago. There were a lot of points that came up that haven't really been acted on."
● The provider was involved with the local community. For example, children from a local school visited to read with people living at the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us there had been some staffing issues at the home, but the atmosphere had improved.
● Staff told us the management team were supportive and approachable. One staff member told us, "The managers are very approachable." Another staff member told us, "The management are very supportive, they've supported me since day 1."
● People told us they felt included by staff which was important to them. One person told us, "You use your own voice. It makes all the difference, in your own words and get them to listen which is important when you're here to be looked after."

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 registered manager and nominated individual were open and transparent throughout the inspection and were honest where things had gone wrong.
● The provider communicated with relatives when things went wrong at the home. For example, where 1 person had experienced a fall that required hospital admission, their relative was contacted immediately. The relative told us, "They contact me in good time if anything happens."

Working in partnership with others
● Professionals who worked with the provider gave positive feedback regarding the provider's engagement.
● The provider had worked positively alongside other professionals to improve outcomes for people. For example, we saw evidence of referrals to Speech and Language Therapists (SALT) and occupational therapists, and the provider had involved the GP in decision making where needed.

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 Systems had not been established to ensure people's medicines were stored and administered safely. This placed people at risk of harm.

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 Systems had not been established to ensure people were safeguarded from abuse. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.