Review of compliance

Hallaton Manor Limited Hallaton Manor Limited	
Region:	East Midlands
Location address:	Hallaton Manor Cranoe Road, Hallaton Market Harborough Leicestershire LE16 8TZ
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Hallaton Manor is a care home without nursing. The provider is registered to provide the regulated activity accommodation for persons who require nursing or personal care for a maximum of 41 people.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Hallaton Manor Limited was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 13 March 2012.

What people told us

People told us they were satisfied with the care and treatment they received. some people said they were bored and unoccupied for a lot of the time.

What we found about the standards we reviewed and how well Hallaton Manor Limited was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People mostly received effective, safe and appropriate care treatment and support. Staff did not fully consider or meet peoples social and daytime activity needs. Staff had not taken appropriate action regarding nutritional risk for one person.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People were not fully protected from the risk of abuse. Staff training was not up to date and procedures to monitor the management of people's personal money were not robust.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Safe procedures for the management of people's medicines were not always followed and this put people using the service at risk.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People using the service may not have their health and welfare needs met because the provider's recruitment policy was not robust.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People may not always have their health and welfare needs met by sufficient numbers of staff.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People may not have their health and welfare needs met because not all staff had been properly trained or supervised.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One person spoken with told us they were satisfied with the care and treatment they received. This person told us that staff were kind. People told us that they had access to healthcare services and that staff would contact their GP whenever this was required. Some people told us that although there were opportunities to participate in activities, they were bored and unoccupied for a lot of the time. During our site visit, some people were getting ready to go out shopping for the day with the activities organiser. Some people seemed to be unengaged and unoccupied for a lot of the time.

Other evidence
We pathway tracked three people living at Hallaton Manor. This included looking at their care records, speaking with them and to staff about the care they needed and received.

Care records included an assessment of people's needs and a care plan telling staff what they needed to do to meet people's needs and keep them safe. Information about people's spiritual and cultural needs were included. Where possible information was available about peoples life histories and about their preferences. This information is important, particularly when people may experience communication difficulties and may not always be able to express their wishes and preferences clearly.

Care plans and risk assessments were in place for the majority of needs and identified risk. There were no care plans in place for social activities or social inclusion so it was not clear to staff what action they should take to meet people's needs in this area.

Nutritional risk assessments were in place to monitor and identify when people are at risk of malnutrition. We saw that one person had lost a significant amount of weight. Staff had not taken appropriate action such as contacting this persons GP.

People were able to make choices about the care and treatment they received. Staff worked in a flexible way in order to accommodate people's needs and preferences. A relative spoken with told us that communication was good and that staff treated people with respect.

Our judgement
People mostly received effective, safe and appropriate care treatment and support. Staff did not fully consider or meet peoples social and daytime activity needs. Staff had not taken appropriate action regarding nutritional risk for one person.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they felt safe living at Hallaton Manor.

Other evidence
Staff spoken with were aware of the correct actions to take in the event of suspected abuse. Not all staff training regarding safeguarding people from abuse was up to date. Not all staff had received training regarding the Mental Capacity Act and associated Deprivation of Liberty safeguards.

Some staff had received training regarding the use of restraint; however, the acting manager told us that restraint was never used at Hallaton Manor.

We received information of concern regarding some staff failing to maintain professional boundaries with people living at Hallaton Manor. The acting manager told us that all staff had since been spoken with about this and that staff living at the service were no longer using the communal space at the home or visiting people using the service when they were not on duty. However, staff spoken with told us they had not received any further training regarding this.

We looked at records maintained and procedures for managing people's personal money. All transactions were recorded and receipts retained. We felt that in order to minimise the risk of financial abuse and protect people using the service, the provider must put procedures in place to regularly monitor people's accounts.

Our judgement
People were not fully protected from the risk of abuse. Staff training was not up to date and procedures to monitor the management of people's personal money were not robust.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
People told us they received their medicines at the times they needed them.

Other evidence
We looked at medication administration records and storage areas. We found some discrepancies in the amount of tablets people had in stock. It appeared that people had not always been given the tablets they had been prescribed.

We looked at controlled drug administration records. Again we found some discrepancies in the amount of tablets in stock and the amounts recorded. The acting manager contacted us shortly after our site visit and told us that the discrepancies had been caused by a member of staff giving the medicine as prescribed but forgetting to record this in the register.

Staff had received training regarding the safe management of medicines.

Our judgement
Safe procedures for the management of people's medicines were not always followed and this put people using the service at risk.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are minor concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
People spoken with told us they liked the staff that looked after them.

Other evidence
We looked at the provider's recruitment policy and at three staff files.

Nearly half of the carers employed at the service had been recruited directly from abroad, but the service's recruitment policy did not contain any guidance or instruction about recruitment of people from abroad. The service had entrusted an international recruitment agency to refer people who the registered manager interviewed by telephone. There were no satisfactory safeguards in place to ensure that the person the registered manager interviewed was the person who had been referred by the agency.

We looked at three randomly selected recruitment files for people who had been recruited. Two of those files did not contain any record that the person had been interviewed.

It was difficult to see how the service's recruitment process had ensured that only people of good character and those who had the necessary qualifications, skills and experience had been recruited.

Our judgement
People using the service may not have their health and welfare needs met because the

provider's recruitment policy was not robust.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us that there were enough staff on duty to meet their needs.

Other evidence
We looked at staff duty rosters. There were at least five members of care staff on duty during the day and two at night. Some staff also worked for the providers domiciliary care agency and had to leave the home during the lunch time period to carry out a visit.

Some people living at Hallaton manager had high dependency needs and required two staff to attend to them for moving and handling and for personal care. Therefore, at night, if two members of staff were attending to a person using the service, there were no other staff members available for other people using the service.

We spoke with the acting manager about staffing requirements. The acting manager could not demonstrate that a needs analysis and risk assessment had been used as the basis for deciding staffing numbers.

Our judgement
People may not always have their health and welfare needs met by sufficient numbers of staff.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People told us that staff were competent and well trained.

Other evidence
Two carers we spoke to had been supported to build upon the social care qualifications they had. Both had achieved a level 2 National Vocational Qualification in health and social care.

The two carers had received training that helped them understand medical conditions experienced by many of the people who used the service. They had also been supported to learn as much as possible about the needs of the people they supported from reading people's care plans. Both carers demonstrated a comprehensive understanding of a person whose care plan we had looked at.

The service had a policy concerning staff supervision. This required that staff had a supervision meeting every two months and that staff received a written record of their supervision. Staff we spoke to told us that they'd had regular meetings and an annual appraisal with their line managers but that the process had been informal. The acting manager told us that the supervision process had been reviewed and that a more formal process was about to be introduced.

We looked at staff training records. Some people's training had not been refreshed or updated for some time. The acting manager told us that a new training manager had recently been employed and was in the process of reviewing training records and ensuring that staff received the training they required to meet people's needs

Our judgement
People may not have their health and welfare needs met because not all staff had been properly trained or supervised.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People mostly received effective, safe and appropriate care treatment and support. Staff did not fully consider or meet peoples social and daytime activity needs. Staff had not taken appropriate action regarding nutritional risk for one person.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People were not fully protected from the risk of abuse. Staff training was not up to date and procedures to monitor the management of people's personal money were not robust.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Safe procedures for the management of people's medicines were not always followed and this put people using the service at risk.	
Accommodation for persons who require nursing or personal care	Regulation 21	Outcome 12:

	HSCA 2008 (Regulated Activities) Regulations 2010	Requirements relating to workers
	How the regulation is not being met: People using the service may not have their health and welfare needs met because the provider's recruitment policy was not robust.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People may not always have their health and welfare needs met by sufficient numbers of staff.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People may not have their health and welfare needs met because not all staff had been properly trained or supervised.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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