Review of compliance

Park Lane Health Care (Moorgate) Limited Moorgate Lodge	
Region:	Yorkshire & Humberside
Location address:	Nightingale Close Moorgate Rotherham South Yorkshire S60 2AB
Type of service:	Care home service with nursing
Date of Publication:	April 2012
Overview of the service:	Moorgate Lodge is a care home for older people providing personal and nursing care. The service is divided into three units on three floors accessed by a lift. The service can accommodate up to 56 people.

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

Our current overall judgement

Moorgate Lodge 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 01 - Respecting and involving people who use services
Outcome 08 - Cleanliness and infection control
Outcome 13 - Staffing
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 19 March 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People told us they were happy living at Moorgate Lodge and most staff were caring and looked after people well. They told us they were given choices and were respected
We were also told that the activity coordinators were very good and provided many activities, however one person told us they had not been out in the community for many months and that they had asked staff to take them, but it had still not been arranged. Since our visit the manager has informed us the person had been offered transport to go out, but declined to go.

People we spoke with on York unit told us that it was difficult to locate staff when they were sat in the lounge. They often did not see staff for over an hour and there was no call system accessible to alert staff that assistance was required. Relatives also told us that when they visited they could be in the lounge for an hour or more and not see a member of staff.

What we found about the standards we reviewed and how well Moorgate Lodge was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

It was not clear if people understood the care and treatment available to them. People's independence was not always promoted and people were not always given choices or had their views listened to.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The appropriate standards of cleanliness and hygiene were not always maintained, the cleaning schedules did not clearly detail whose responsibility it was to clean specific areas.

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

Information we were given told us staff were not always available to meet people's needs. However the manager has provided an action plan telling us how staff are utilised to ensure people's needs are met.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People did not always have an accurate record including appropriate information and documentation in relation to their care and treatment.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People told us they were happy living at Moorgate Lodge and most staff were caring and looked after people well. They told us they were given choices and were respected

We were also told that the activity coordinators were very good and provided many activities, however one person told us they had not been out in the community for many months and that they had asked staff to take them, but it had still not been arranged. The manager has informed us since our visit that transport had been arranged, but the person declined.

Other evidence
We had received a number of concerns about this service and as a result it was decided to carry out this responsive review. The concerns were regarding people's needs not being met. We therefore decided during our visit to spend a period of time sitting with a group of people while lunch was served. We observed people on Chester unit and were able to observe people's experiences of living in the home and their interactions with each other and the staff. We call this the 'Short Observational Framework for Inspection (SOFI).

The meal we observed was a rushed experience, people were not always given a

choice, assistance was not always offered or given when required. One person was struggling to eat their food with their cutlery and started to pick it up with heir hands, no member of staff offered assistance. The staff were in a hurry to get the meal served and finished. Many people stayed in their rooms for the meal and staff were busy plating up meals for those people and did not give time to people in the dining room. The staff told us that the bain marie was not large enough to hold all the food so in order that food did not go cold they served as quickly as possible.

Interactions we observed between people and staff were not always inclusive or appropriate. Staff did not always explain to people what they were doing, what was happening or what was being organised.

One person sat at the table in a wheelchair, which was their choice, however due to the position of the foot plates, was unable to get close to the table. The person had to lean forward to reach the table and found it difficult to eat their meal. The staff did not try to facilitate a different table or seating position to make it easier and a pleasant experience for the person to eat their meal.

We discussed this with the manager and provider who was at the service and we were assured that the meal times would be reviewed to make it a pleasant experience for people.

Staff members who spoke with us were knowledgeable about the needs of each person they looked after. They had a good understanding of the care given on a daily basis. However some staff seemed rushed when giving care.

On Lincoln unit we observed one person being hoisted and staff carried this out safely and there were positive interactions to reassure the person. Staff on Lincoln unit were also observed giving people time to express their views.

We looked at care plans for three people who used the service; these were not clear to follow and did not detail people's capacity to understand the care and treatment given. (See outcome 21).

In the care plans we looked at there was no documented evidence that the person had contributed to the development of their care needs or had recorded their preference not to contribute.

Meetings were held with people, their relatives and friends, people told us they attended the meeting and they were very good.

Our judgement
It was not clear if people understood the care and treatment available to them. People's independence was not always promoted and people were not always given choices or had their views listened to.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not speak with people regarding this outcome.

Other evidence
The concerns we had received also raised issues regarding cleanliness of the service. We looked around the premises to determine cleanliness and management of infection control.

During this visit we identified that the premises were mostly maintained to an appropriate standard of cleanliness, however some areas required attention. The store cupboards were overflowing and many items were stored in communal areas. Toiletries and pads were stored in bathrooms these should be stored in people's bedrooms. An assisted bath we looked at was dirty.

When we spent time on Chester unit at lunch time, we observed the kitchen area was in a poor state of repair and unable to be effectively cleaned. The work tops were badly damaged, the cupboard doors were also damaged and the seal around the sink was encrusted in debris and filth. The fridge and freezers were encrusted in ice and required defrosting. The fridges were also littered with food debris causing risk of cross contamination.

We observed the domestic staff working in lounges, bathrooms and bedrooms and they cleaned thoroughly and effectively. We spoke to the manager regarding the areas we had identified and asked who was responsible for cleaning these areas. We were told it was the cleaners, however the cleaner told us these areas were not on their cleaning schedule. The manger told us this would be addressed and staff informed at the team

meeting.

Our judgement
The appropriate standards of cleanliness and hygiene were not always maintained, the cleaning schedules did not clearly detail whose responsibility it was to clean specific areas.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People we spoke with on York unit told us that it was difficult to locate staff when they were sat in the lounge. They often did not see staff for over an hour and there was no call system to alert staff assistance was required. Relatives also told us that when they visited they could be in the lounge for an hour or more and not see a member of staff.

Other evidence
We did not look at this outcome in full, however while at the service we were given information and observed a number of issues.

We spent time on York unit talking to people and their relatives and visitors. We were told there was no call system available in the lounge, a hand bell had been given to people but was not always heard. People told us on occasions they did not see staff for over an hour when they were sat in the lounge. Relatives also told us when they visited they did not always see staff in the lounge. We have been informed by the provider that two call alarms will be fitted on 3 April 2012.

One visitor told us that one person often wanted the toilet and staff were not around, on one occasion when they were visiting, the person could not wait any longer for staff and had an accident, the visitor told us it was very distressing for the person and everyone else in the lounge.

While we were talking with people one person called for staff as they required taking to the toilet, we rang the hand bell and waited ten minutes, no staff arrived. The inspector

went to look for staff on the unit there were no staff available. It was identified two care staff were in one room and one care staff with another person, the qualified nurse was on the upstairs unit. There were no staff present in the communal areas.

We discussed this with the manager and the provider, who agreed to look at dependency and the care staff required to meet people's needs. It was suggested the activity coordinators may be utilised to provide activities when care staff were unavailable to be able to observe people in communal areas for safety.

The manager has completed the dependency tool and provided us with the actions they are taking to ensure communal areas are observed by staff to ensure people's safety.

Our judgement
Information we were given told us staff were not always available to meet people's needs. However the manager has provided an action plan telling us how staff are utilised to ensure people's needs are met.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak directly with people regarding this outcome.

Other evidence
We looked at three plans of care and other records of care, including food and fluid charts, moving and handling records and visiting professional records. We found that the care plans detailed most needs and abilities of individuals, likes and dislikes. However were very difficult to follow or find relevant information to be able to meet people's needs.

One plan we looked at gave details that the person had developed a pressure ulcer, however there was no details of what dressings were to be used or how often it required redressing. It was written in care plan, 'under the care of the tissue viability nurse'. This was not detailed to ensure the person's needs could be met.

Each care plan we looked at had communication as a care need. The plans did not detail if people were able to communicate verbally or non verbally. They did not detail people's capacity to understand what they were asked or requested.

Some care plans identified a care need but the actions did not relate to the need, for example one persons care need was personal hygiene. The actions told us about poor mobility and low motivation, it did not detail how to maintain the person's personal

hygiene. It also did not give information on the person's capacity to understand the need to maintain their personal hygiene.

Food and fluid charts and moving and handling charts we looked at were not always completed. They also did not give accurate amounts of food eaten, it was written, 'ate half' or 'ate all' but no quantities recorded.

We looked at falls and body mapping these were completed and gave clear details of improvement and actions taken to maintain safety.

The manager told us the new plans of care in place still needed improving, they had achieved a standard that was acceptable, but staff would continue to be trained in care planning and at each review the plans would continue to be improved.

The manager also informed us that she wanted to improve the care plans and include more information on people's capacity to understand care needs and make decisions. They were also going to include evidence of involvement of people in the development of their care plan.

Our judgement
People did not always have an accurate record including appropriate information and documentation in relation to their care and treatment.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: It was not clear if people understood the care and treatment available to them. People's independence was not always promoted and people were not always given choices or had their views listened to.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: It was not clear if people understood the care and treatment available to them. People's independence was not always promoted and people were not always given choices or had their views listened to.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: It was not clear if people understood the care and treatment available to them. People's independence was not always promoted and people were not always given choices or had	

	their views listened to.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The appropriate standards of cleanliness and hygiene were not always maintained, the cleaning schedules did not clearly detail whose responsibility it was to clean specific areas.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People did not always have an accurate record including appropriate information and documentation in relation to their care and treatment.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People did not always have an accurate record including appropriate information and documentation in relation to their care and treatment.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People did not always have an accurate record including appropriate information and documentation in relation to their care and treatment.	

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 14 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

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