Review of compliance

Four Seasons (No 9) Limited Hallgarth Care Home	
Region:	North East
Location address:	Hallgarth Street Durham Co Durham DH1 3AY
Type of service:	Care home service with nursing
Date of Publication:	August 2012
Overview of the service:	Hallgarth Care Home provides accommodation and personal care for up to sixty-four older people, some with general nursing care needs. The service is registered with the Care Quality Commission (CQC) for the regulated activity of accommodation for persons who require nursing or personal care; treatment of disease, disorder or injury; and diagnostic and screening procedures.

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

Our current overall judgement

Hallgarth Care Home was not meeting one or more essential standards. Action is 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People who were able to speak with us told us the staff involved them in decisions about the home. One person told us, "I know what is going on. The girls tell us about everything going on here". One person we spoke with told us the staff often discussed her care plans with her and told us she staff involve her in her care.

People told us they were happy at Hallgarth Care Home and that staff supported them well with their healthcare needs. People we spoke with told us they received regular medical care from their GP and from other healthcare professionals such as dentists, opticians, chiropodists and dieticians when required. One person told us, "They get the doctor for me when I am poorly". Another person told us, "I had the doctor in when I was taken bad with my chest".

Other comments from people who used the service included:
"Staff are kind and helpful."
"They listen to what you had to say, but sometimes they are so busy they don't have time to sit and talk to us."
"I moved here because I like it better than my previous place."

What we found about the standards we reviewed and how well Hallgarth Care Home 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

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

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

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. However, the provider may wish to review the staffing levels in the light of staff comments.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard.

The provider had effective system to regularly assess and monitor the quality of the service that people received.

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

The provider was not meeting this standard.

People were not protected from unsafe and inappropriate care and treatment because records relating to their care did not always reflect the actual care that people received.

We judged that this had a minor impact on people using the service and action was needed for this essential standard.

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We spoke with the people who live at Hallgarth Care Home about their experiences. Some of the people told us about the time when they were looking to go into a care home. Two people told us they had the opportunity to visit the home and to look round before making their decision. Another person told us, "I met with the social worker and she arranged for me to come and see the place for myself". Care and assessment records showed people were supported to make informed choices about coming to live at Hallgarth Care Home.

People who were able to speak with us told us the staff involved them in decisions about the home. One person told us, "I know what is going on. The girls tell us about everything going on here".

One person we spoke with told us the staff often discussed her care plans with her and told us staff involve her in her care.

Other comments from people who used the service included:
"Staff are kind and helpful."
"They listen to what you had to say, but sometimes they are so busy they don't have

time to sit and talk to us."
"I moved here because I like it better than my previous place."

Other evidence
We spoke with the manager and asked her about the arrangements for admitting people to Hallgarth Care Home. She told us that before admission, people's needs were assessed to make sure the home had the resources to look after them. We looked at the care files for six out of 53 people to see how they were supported to make decisions for themselves. From the records, we found the views of people were sought when they were planning to come and live at the home. The records also showed that where people were able to, they were involved in the planning of their care and their views were reflected in their care plans. For those who were not able to contribute to the care plans due to memory problems, relatives were consulted about them and other decisions relating to the care and welfare.

We spoke with staff and they told us how they tried to involve people in their own care by supporting them to be as independent as possible, and also respecting their dignity and privacy. One staff member told us, "I know staff knock on people's doors before going in. You wouldn't like someone to walk into your room with alerting you, would you?" During our tour of the premises, we saw a number of occasions where staff knocked on people's door before entering their room.

The manager told us that in putting together the individual care plans for the people who used the service, the staff took into account people's social history and previous lifestyle choices. She told us that this was even more important for people who had memory problems. We saw examples of care plans which made mention of people's previous lifestyle. For example, in one of the care plans that we looked at, there was information for staff about the person being independent and preferring to wash and dress independently.

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke with the people who used the service, their relatives and staff about healthcare, and how people were supported to maintain their health. We saw hospital outpatient appointments for people and also letters relating to medical investigations.

People told us they were happy at Hallgarth Care Home and that staff supported them well with their healthcare needs. People we spoke with told us they received regular medical care from their GP and from other healthcare professionals such as dentists, opticians, chiropodists and dieticians when required. One person told us, "They get the doctor for me when I am poorly". Another person told us, "I had the doctor in when I was taken bad with my chest".

Relatives told us they felt the staff provided "good" care for the people who used the service. Relatives told us the staff always kept them informed about their relatives' health. One relative told us, "They always let me know when mom is not well". Another relative told us, " … could hardly walk when she came here but now she is able to walk. She looks really well and I am happy with the care she is getting here".

We observed staff interacting with people who used services. They were respectful in their interactions with people. We saw that staff had a good understanding of the needs of the people they care for.

Other evidence

We looked at people's care plans and other records relating to their healthcare needs. We looked at the care files for six out of 53 people to see how they were supported to maintain their health. We found that people who used the service had their medical and social care needs identified and care plans were put in place to meet their needs. In one person's assessment, it was identified that there was risk to the person when they moving or walking. The care plans identified what the person could do independently and what they would need support from staff with. For example, the care plan stated that the person could move up and down bed, sit up in bed, get in and out of bed independently with no support, but needed assistance with the help of one carer in bathing or showering.

We saw another care plan which described the person's medical condition and there was guidance for staff on how best to support the person to avoid the risk of choking. We also saw details of care to be provided for people who were confined to bed. There were care plans for regular positional changes while in bed to avoid the risk of people developing pressure sores. There was also care plans to ensure people received regular intake of fluid to avoid dehydration. Staff told us they regularly carried out these tasks and recorded these to ensure the people received the care that was planned for them. We saw the records that were completed by the staff in people's bedrooms.

We found the care plans were regularly reviewed and they reflected people's current care needs. These included care plans relating to risk of choking, managing pressure area, maintaining adequate diet and fluid intake, risks of falls and personal hygiene.

We saw hospital outpatient appointments for people and also letters relating to medical investigations. We saw appointments with dentist, chiropodist, optician and other health related activities. We also found that people who used the service had access to a keyworker or a named nurse. A keyworker or named nurse took responsibility for coordinating people's care, for example, by making sure that their care plan was always up to date and accurate. This ensured that people were looked after in line with their agreed care plans.

Our judgement
The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

We spoke with the people who used the service about safeguarding matters. They all told us that they felt safe being at Hallgarth Care Home and had no concerns or worries about their safety or treatment. People told us they felt safe and the staff supported them well. One relative told us, "I have had no need to be concerned about …'s care. The staff always address any concerns I have".

One person who used the service told us, "You couldn't be in better hands. I have no concerns and I don't know of anyone who has". All the relatives we spoke with told us they would know what to do if they had any concerns.

We observed staff interacting with people who used the services. They were respectful in their interactions with people. We saw they had a good understanding of the needs of the people in their care and treated people with respect and dignity.

Other evidence
A copy of the provider's written policy on safeguarding vulnerable people was available in the office. We also saw a copy of the Durham City Council safeguarding procedures. This meant staff had ready access to the written policies and guidance as reference in the event of needing to raise a safeguarding alert or needing to update their knowledge on safeguarding.

The manager told us all staff members had completed training in safeguarding

vulnerable adults. The staff training records confirmed this. This meant staff were better equipped to protect people from harm or potential harm. Staff we spoke with were familiar with the procedures for raising concerns about the welfare of people in their care. Staff confirmed they had received training in safeguarding people and would know what to do if they suspected any abuse or potential abuse.

One staff member told us "Yes I know what I would do, I would report it" and another told us "We are here to care and protect people. If I saw anything I am not happy about I shall immediately report it to the manager".

We spoke with the manager about safeguarding matters and she demonstrated to us that she was aware of her responsibility to respond to any allegations of abuse or potential abuse. She provided us with records of safeguarding referrals to the local authority, safeguarding investigations and one "Best Interest" referral made under the mental health act. This is where decisions had to be made on behalf of people with dementia or mental health problems if they could not make those decisions themselves. The records relating to safeguarding matters showed that the provider worked closely with other agencies such as the local authority, local NHS Trust and the Care Quality Commission in ensuring that people welfare was safeguarded.

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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
We spoke with people who use the service about the staffing levels in the home and to see if they felt there was sufficient staff on duty to meet their needs. People told us there was always plenty of staff about". One person told us, "I think there is enough staff on but at times you wait a little while before staff answer the nurse call".

Other evidence
We looked at the staff duty rotas for the previous two weeks to see what the staffing arrangements were to support the people who used the service. On the day of the visit there was the following staff on duty. The Manager who was not included in the care hours as she was extra to the care staff. One nurse to support care staff to look after the people who were receiving nursing care. One senior care assistant was responsible for overseeing the care of the people who were not receiving nursing care. There were eight care staff, one administration officer, one chef, one kitchen assistant, one laundry assistant and three domestic staff. We were told that the activities coordinator was on their day off.

There were 27 people living on the ground floor residential care unit, and 26 people on the ground floor nursing care unit. The manager told us she was not always included in the numbers of staff on duty and the current staffing arrangements reflected the care needs of the people in the home.

Staff members we spoke with also told us they felt, in general, the number of staff on duty was sufficient to meet the needs of people living Hallgarth Care Home Home.

However, a number of care staff told us that they often found themselves having to "rush" in getting people ready for their breakfast. Staff told us they felt an extra staff on the first floor unit in the morning to get people ready for breakfast would enable the staff to get people ready without what they referred to as, "Pressure to get people ready for breakfast". One staff member said, "You feel like you are rushing people on order to get them ready". Another staff member said, "It is a physical impossibility to get everyone up and ready for breakfast. It is not right for people to be rushed". We spoke with the manager about the views expressed by the staff and she told us she would discuss this with her line manager.

The provider may wish to consider the views expressed by the staff regarding extra staffing on the first floor unit when reviewing the staffing levels in the home.

Our observation on the day of the inspection visit was peoples' care needs were being met and people were comfortable and cared for appropriately.

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. However, the provider may wish to review the staffing levels in the light of staff comments.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not ask the people who used the service any specific questions relating to outcome area.

Other evidence

We discussed with the manager the systems that were in place for the regular monitoring of the service. She described the quality assurance system that was in place to monitor and assess the quality of the service they provided. This was known as home audit process (HAP). These included manager's daily, weekly and monthly audits covering areas such as medication, dining experience, kitchen, health and safety and care plans.

We looked at the provider's monthly visit reports for February, March, April and July 2012. These were quality audits carried out by the regional manager on behalf of the provider. In the March 2012 report, the regional manager commented in their audit report that wet wipes were to be provided at meal times as these were not always available to people who may have problems with spillage of food during meal times. The manager told us that this was immediately implemented. The April 2012 provider's audit report commented that personal development plans should be put in place for all staff. We looked at staff files and found that discussions had taken place between the manager and the staff about personal development. One of the files we looked at showed that the staff member had indicated their future training needs.

The manager provided us with minutes of meetings that were used to monitor the service and to pass information on to staff for continued improvement of the service. These included clinical governance meetings, senior staff meetings, staff meetings and catering staff meetings. These showed areas of discussions and recommendations on how improvements could be achieved. For example, the catering meeting in April 2012 discussed the recommendations from an environmental health officer's inspection of the kitchen that was carried out in March 2012. Subsequent records showed that the recommendations had been addressed and systems had been put in place to maintain the hygiene standards in the kitchen.

We looked at other records, including maintenance records, to make sure health and safety measures were in place. We looked at the file that contained all the servicing records relating to fire safety, servicing of electrical appliances, examination of slings for mobile hoists, maintenance of wheelchairs, gas servicing, electrical installation and lift servicing. We found all the servicing was up to date thus ensuring the safety of the people who used the service by maintaining safe environment.

Our judgement

The provider was meeting this standard.

The provider had effective system to regularly assess and monitor the quality of the service that people received.

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

The provider is non-compliant with Outcome 21: Records. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard.

Other evidence

We looked at the way records were maintained and stored in the main office and other parts of the home to make sure records were kept securely and could be located promptly when required. We found in the reception area there was a file on the desk containing details of care records which could potentially be accessed by anyone entering the building, thus compromising confidentiality principles.

We looked at how records at the home were managed. Some of the records were found to be accurate. For example, there were records that showed fire drills had been carried out at appropriate intervals and that regular checks had been made of electrical equipment and of the gas boiler. We found that other records such as written policies, safeguarding minutes and care records were securely kept in the main office on the ground floor, and the two nurse offices on the two floors, thus protecting personal information relating to peoples care.

The manager told us that staff meetings had been held. We saw there were records of staff meetings, which showed us that staff had the opportunity to meet as a group to discuss care and professional issues. The staff we spoke with confirmed that they had

attended staff meetings, although some staff told us they had not attended staff meeting for several months.

We examined the details of the care records relating to people who were confined to bed. We found that the care plans were regularly updated and reflected the current care needs of the people who used the service. When we looked at positional change and fluid intake charts we found that these had not been completed correctly and the information on the charts did not reflect what the care staff told us. For example, staff told us that people were turned hourly in bed as indicated on their care plan. However, the charts had gaps which implied that the staff had not followed the care plan. We also looked at the fluid balance charts and we found that these also had gaps. For instance, one chart that we examined showed that on 07/08/2012 the person had 350 millilitres (mls) of fluid in 24 hours. In another example, 08/08/2012 the person had 320 mls of fluid in 24 hours. The manager told us that these amounts fell far short of the amount of fluid people should be getting daily.

We spoke with staff who were responsible for carrying out the tasks and for maintaining the records to show accountability. All the staff we spoke with assured us that people who required regular turning in bed and also regular fluid intake had received the care. They told us that because of the "busyiness" on the first floor they were not always prompt in completing the necessary chart to support the care they had provided in this case.

Our judgement
The provider was not meeting this standard.

People were not protected from unsafe and inappropriate care and treatment because records relating to their care did not always reflect the actual care that people received. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider was not meeting this standard. People were not protected from unsafe and inappropriate care and treatment because records relating to their care did not always reflect the actual care that people received. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider was not meeting this standard. People were not protected from unsafe and inappropriate care and treatment because records relating to their care did not always reflect the actual care that people received. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated	Outcome 21: Records

	Activities) Regulations 2010	
	How the regulation is not being met: The provider was not meeting this standard. People were not protected from unsafe and inappropriate care and treatment because records relating to their care did not always reflect the actual care that people received. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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