Four Seasons (No 9) Limited

# Hallgarth Care Home

**Inspection report**

Hallgarth Street
Durham
DH1 3AY
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Date of inspection visit: 13 October 2015
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Is the service safe? | Good |
| Is the service responsive? | Good |

## Overall summary

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hallgarth Nursing Home on our website at www.cqc.org.uk

We carried out an unannounced comprehensive inspection of this service on 08 July 2015. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

Two breaches of legal requirements were found during that previous comprehensive inspection on 08 July 2015. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to these requirements.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that all records we reviewed such as care plans had been regularly reviewed and these provided information about people's care, treatment and support needs.

We found the provider had introduced systems to ensure the management of medicines were safe.

We also found medicines which were prescribed 'as required' (PRN) were handled and used safely.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

We found that action had been taken to improve safety.

There were clear procedures followed in practice, monitored and reviewed for medicines handling that included, dispensing, preparation, administrating and monitoring.

Good 

**Is the service responsive?**

We found that action had been taken to improve the responsiveness of the service.

People who used the service had safe and appropriate care, treatment and support plans in place that reflected their needs, preferences and diversity.

Good 

# Hallgarth Care Home

**Detailed findings**

## Background to this inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Hallgarth Care Home on 13 October 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 08 July 2015 comprehensive inspection had been made. We inspected the service against two of the five questions we ask about services: is the service safe, is the service responsive. This is because the service was not meeting some legal requirements.'

We reviewed the action plan the provider sent to us following our comprehensive inspection on 08 July 2015. We found the assurances the provider had given in the action plan in order to become compliant with the regulations had been met.

The inspection was undertaken by one adult social care inspector

Before the inspection we obtained information from a Commissioning Services Manager from Durham County Council, Safeguarding Practice Officer and Safeguarding Lead Officer of Durham County Council. No concerns were raised by these professionals.

During this inspection, we checked to see what improvements had been made since our last inspection.

We looked at people's care records, as well as records relating to the management of medicines. During our inspection we spoke with four people who used the service, the registered manager, a senior carer and the regional manager.

# Is the service safe?

## Our findings

At our last inspection on 8 July 2015 we found people's medicines were not well managed and required improvement. This was a breach of Regulation 12 (1) (g) HSCA 2008 (Regulated Activities) Regulations 2014.

We found where people were prescribed medicines to be taken on an 'as required' basis, often known as 'PRN' medicine, there was not enough detail or fully completed guidance about when they should be used, either in the Medication Administration Records (MARs) or in people's care plans. We did a stock check on 16 people's medicines. We found stock for some medicines did not tally with the records kept and hand written entries did not always have two staff signatures.

Body maps were not always used for the application of topical creams, despite this practice being stipulated in the provider's medication policy. We saw the providers medicines audit team had been visiting the service weekly to carry out what were described as detailed audits. We found these audits had failed to identify many of the discrepancies identified by CQC.

**During this focussed inspection**, we discussed all aspects of medicines with the registered manager, who demonstrated a thorough knowledge of policies and procedures and a good understanding of medicines in general.

We saw that the controlled drugs cabinet was locked and securely fastened to the wall. We saw the medicine fridge daily temperature record. All temperatures recorded were within the 2-8 degrees guidelines. We saw a copy of the latest medication audits, carried out 5 and 12 October 2015. We saw the medication records, which identified the medicine type, dose, route e.g. oral and frequency and saw they were reviewed daily and weekly and were up to date. We audited the controlled drugs prescribed for people; we found records to be accurate. Controlled Drugs were checked at the handover of each shift.

The application of prescribed local medications, such as creams, was clearly recorded on a body map, showing the area affected and the type of cream prescribed. Records were signed appropriately indicating the creams had been applied at the correct times. This meant people received appropriate application of local medications through detailed and readily accessible instructions.

We saw there was evidence of sample signatures of staff administering medicines. There was also a copy of the home's policy on administration, including homely remedies, and 'as and when required' medication protocols. These were readily available within the MAR (Medication Administration Record) folder so staff could refer to them when required. This meant the service had improved with regard the accountability of medicines administration and had ensured that relevant information to anyone administering medicines was readily available.

Each person receiving medicines had a photograph identification sheet, which also included information in relation to allergies, and preferred method of administration. Any refusal of medicines or spillage was recorded on the back of the MAR sheet. All medicines for return to the pharmacy, were disposed of in storage bins, and recorded.

We spoke with people who used the service, they told us they always received their medicines at the right times. One person told us they managed their medicines themselves. We saw records to confirm this happened.

This meant the provider had introduced clear procedures that were followed in practice, monitored and reviewed for medicines handling that included, dispensing, preparation, administrating and monitoring.

# Is the service responsive?

## Our findings

At our last inspection on 8 July2015 we found some care plans were not completed in enough detail to reflect people's care, treatment and support needs. This is a breach of Regulation 9 (1) (a) (c) HSCA 2008 (Regulated Activities) Regulations 2014.

We found people's care plans did not fully reflect people's current care, treatment and support needs. We saw the provider had moved to a new format of care planning but saw that important information about a person's nutrition had not been transferred from the old plans accurately. Another person who displayed challenging behaviour did not have enough information recorded to show staff how to manage this person's behaviour safely. This meant people's current needs were not easily accessible and this could cause confusion in the delivery of their care.

We told the provider to make immediate improvements to ensure people's care; treatments and support plans were up to date.

**During this focussed inspection,** we looked at three people's care records in detail. We saw all care records had been fully transferred onto the providers new care plan formats.

We saw a life story document held in people's care records contained information about their past and what mattered to them. Relatives had provided information about people's past and important people and events in their life, which helped staff to provide personalised care and support, particular to those people living with dementia.

We spoke with four people, they told us that they were able to express their views about their care and said that staff did listen and act on what they said. During the focused inspection we observed staff to be caring and responded to people's needs appropriately. One person told us that they did not always like to socialise and preferred their own company. They said, "I spend quite a lot of time in my room, but I never feel lonely as the staff are always popping in for a chat." This showed us that people's preferences were respected.

We saw some good examples of person centred care and of how peoples' needs were to be met by care and nursing staff. We found every area of need had descriptions of the actions staff were to take. This meant staff had the information necessary to guide their practice and meet people's needs safely. For example, the plans described specific ways of responding to people to guide and comfort them which took account of their dementia type illness and previous life experiences.

We saw care plans were evaluated and reviewed each month, or more frequently if needed.

For one person we saw very specific and detailed behavioural care plans were in place. We saw professional support had been sought and detailed guidance, interventions and behaviour charts were in place for staff to follow to keep the person and others safe. This demonstrated how staff worked in partnership with other professionals to maintain people's safety, health and wellbeing.

All three files contained a nutritional assessment called 'malnutrition universal screening tool' (MUST). We saw people's nutritional needs were regularly monitored and reviewed. The assessment included risk factors associated with low weight, obesity, and any other eating and drinking disorders. For those at risk of poor nutrition, the care plans included the person's likes and dislikes. There were also clear plans in place to fortify meals, by encouraging a high protein diet, including high calorie drinks and providing finger snacks between meals where appropriate. This demonstrated that people's nutritional needs were being met.

During this focussed inspection, we saw all information about people's care, treatment and support had been accurately transferred onto the new care plan formats.

When people used or moved between different services this was properly planned. For example, each person had a personal health profile completed called a 'Hospital Passport' that was unique to them. We saw people were involved in these decisions and their preferences and choices were recorded. This contributed to ensuring people maintained continuity of care in the way that people wanted and preferred.