Four Seasons (No 9) Limited

Hallgarth Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 7 and 9 March 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We last inspected the service in October 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Hallgarth is a care home in central Durham providing accommodation and nursing care for up to 60 older people who require nursing and personal care. There were 58 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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 the service had risk management processes in place, protecting people against a range of risks through clear instructions to staff.

Whilst there was a consensus that staff faced a challenging workload, we found there were sufficient numbers of staff on duty in order to keep people safe. All people and relatives agreed that staff were attentive and put the needs of people first.

All staff were trained in areas such as safeguarding, health and safety, moving and handling, infection control, mental capacity, dementia awareness, dysphagia awareness and food hygiene. Nursing staff received additional training relevant to their role, such as phlebotomy (bloods) training.

We found that the management, administration, storage and disposal of medicines was safely carried out and adhered to National Institute for Health and Care Excellence [NICE] guidelines. Where we identified areas that could be improved the service responded promptly.

People who used the service, relatives and healthcare professionals agreed that the service was effective in their management of people's healthcare needs.

All people who used the service we spoke with, relatives and visiting healthcare professionals agreed staff were caring in their attitudes.

There were comprehensive pre-employment checks of staff in place and effective staff supervision and appraisal processes.

The service was clean and regular checks were in place to sustain high levels of cleanliness and suitability of premises and equipment.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The registered manager displayed a good understanding of capacity and we found related assessments had been properly completed and the provider had followed the requirements in the DoLS.

People's nutritional and hydration needs were met. We saw that menus were varied and people had choices at each meal as well as being offered alternatives if they did not want the planned options. Mealtimes we observed to be calm with staff attentive to people's needs. We saw that the service had successfully implemented a tool to manage the risk of malnutrition and people requiring specialised diets were supported.

There was a consensus of opinion that the quality of meals had deteriorated in the past six months. The registered manager agreed to review the manner by which people were offered and chose their meals. We also saw interviews for a new cook had taken place the day before our inspection.

Person-centred care plans had been established and documents to ensure people's life histories, likes and dislikes were incorporated into their care planning. Regular reviews ensured people's medical, personal and nutritional needs were met.

The service had an activities co-ordinator in place and a range of communal spaces suitable for group activities or for families to have quiet time with their relative. The activities co-ordinator had sourced a range of external activities providers and other community links to ensure people received a variety of meaningful activities and remained a part of the community.

The service had a range of quality assurance, auditing processes and policies and procedures to deal with a range of eventualities.

Staff, people who used the service, relatives and external professionals spoke positively about the approachability and professionalism of the registered manager, who demonstrated a good knowledge of the service and people's needs throughout the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	Good
Is the service effective? The service remains effective.	Good
Is the service caring? The service remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service remains well-led.	Good

Hallgarth Care Home

Detailed findings

Background to this inspection

We carried out this 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 visited the service on 7 and 9 March 2017 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. The inspection team consisted of one Adult Social Care Inspector, one specialist advisor and one expert by experience. A specialist advisor is someone who has professional experience of this type of care service. An expert by experience is a person who has relevant experience of this type of care service. The expert and specialist advisor in this case had experience in caring for older people and people living with dementia.

We spoke with ten people who used the service and seven relatives. We spoke with fourteen members of staff: the registered manager, the area manager, the administration officer, two kitchen staff, two domestic assistants, two nurses and five carers. We also spoke with three visiting healthcare professionals.

During the inspection visit we looked at five people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, quality assurance and auditing processes, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining areas of the home. We inspected the communal areas, kitchen, bathrooms, toilets and laundry.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports and a previous action plan sent to CQC by the provider. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning and safeguarding teams, as well as Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Good

Is the service safe?

Our findings

People who used the service told us they had confidence in staff and felt safe in their surroundings. One person said, "There's no bother – the staff are very kind." Another person who used the service told us, "I feel safe now that I have a key to lock my room at night." This person told us they had previously felt anxious due to another person who used the service walking into their room unannounced. They and their relatives were content with the actions undertaken by the registered manager to keep them feeling safe.

None of the healthcare professionals we spoke with had concerns about the service in relation to people's safety. One told us, "I visit at least twice a week and have never observed anything untoward." Relatives we spoke with expressed in the ability of staff to keep people safe from harm.

People who used the service, their relatives and staff we spoke with generally felt staffing levels were appropriate to provide for people's care needs. One person said, "They are all very helpful but always seem so busy," whilst some staff and a visiting healthcare professional told us there were times when staff found it difficult to complete all necessary aspects of their work. One relative told us, "I think they could do with another pair of hands but the staff do a great job under difficult circumstances." One visiting healthcare professional said, "Sometimes they might seem stretched but overall I would say the nursing and staffing levels are appropriate." During our inspection we observed people were supported promptly and call bells were answered. We reviewed staffing rotas and saw the number and skills of staff were dependent upon people's needs and that staffing levels were sufficient to meet people's care needs. The registered manager adhered to a recognised staff dependency tool when planning rotas. This meant, whilst staff were sometimes under pressure, people who used the service were not put at risk due to understaffing.

We found the service had systems in place for safely ordering, receiving, storing and disposing of medicines, including controlled drugs. Medicines records were maintained and medicines were stored safely in line with good practice. All medicines were within date and all recorded medicines fridge temperatures were within safe limits.

We sampled a range of Medicine Administration Records (MARs) and records to be generally in good order. We saw, where people required medicines 'as and when', for example paracetamol pain relief, this was supported by a specific plan to ensure staff knew when to administer these medicines. We saw these plans had not been reviewed in over a year. The registered manager ensured these plans were reviewed during our inspection to ensure they remained appropriate to people's needs. We saw body maps were in place to ensure staff administering medicines in a cream format knew how and where to apply these medicines. We saw there were a number of instances whereby the time one person's transdermal patch had been removed had not been clearly documented on the MAR. A transdermal patch is used to deliver strong painkilling medicine to a person through their skin. If the time of removal of the patch is not recorded there is a risk of them receiving an overdose of medicine. We saw however this information was documented elsewhere in the nurse's records. The registered manager addressed this with nursing staff to ensure the information was entered on the MAR.

We observed medicines being administered and saw safe practice was maintained throughout. We observed nurses communicating effectively with people and seeking consent before administering medicines. This meant people who used the service received medicines in a safe manner in line with National Institute for Health and Care Excellence [NICE] guidelines.

Staff demonstrated a good understanding of their safeguarding responsibilities following the relevant training. We saw previous incidents such as a medication error and a fall had been alerted to the local authority safeguarding team. This meant the service knew how to act on safeguarding concerns and involved other agencies to ensure people were protected.

We saw specific risks to individuals were managed through risk assessments that were regularly reviewed and updated. We found one care plan that had yet to have the relevant review section completed but we saw all relevant reviews had taken place and this information was accessible. The registered manager ensured the file was updated during our inspection.

Accidents and incidents were monitored, reported and acted on through the use of a computerised system. Staff entered the details of any accident or incident onto the computer system, which then generated a report to the registered manager, or the area manager and above, dependent on the severity of the incident. We saw these incidents were subject to managerial scrutiny. This meant the service had a structured approach to identifying and acting on specific incidents.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks had been made. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Maintenance records showed that all lifting and hoist equipment had been serviced, as had the boiler. We saw that fire extinguishers had been checked and serviced, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. Window restrictors were in place and had been regularly checked. Portable appliance testing (PAT) had taken place and the periodic electrical inspection was in date. Water temperatures were regularly tested to protect against the risk of scalding, whilst little used water outlets were regularly flushed to reduce the risk of water-borne infections. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

We saw that disciplinary and whistleblowing policies were in place but that there had been no recent instances of whistleblowing or disciplinary procedures invoked.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans [PEEPS] were in place and easily accessible. They contained details regarding people's mobility and communicative needs. This meant people could be supported to exit the building by someone who would have access to their individual mobility, communication needs in the event of an emergency.

With regard to infection control we saw that people's rooms were clean, as were all communal areas. Signage promoted the importance of hand hygiene and hand sanitiser dispensers were well positioned throughout the home. There were two domestic assistants on duty on each day of our inspection and one we spoke with confirmed they received adequate support to fulfil their role. This meant the service managed and reduced the risk of acquired infections.

Good

Is the service effective?

Our findings

The majority of people who used the service we spoke with, their relatives and external professionals agreed that staff had the relevant skills and knowledge to meet people's needs. One person who used the service said, "They help me with my meals, going out, picking clothes and trying to keep me independent." Another person told us, "They have to hoist me and I think they're experts at it." Relatives we spoke with generally agreed, whilst external professionals told us, "The seniors' knowledge of people's medical needs is generally very good. And if carers aren't sure of something they know who to ask. We never have any surprises."

We saw the service had recently recruited a new nurse, having seen some turnover in the role recently. Another member of nursing staff had been at the service for a number of years and we saw they had formed good working relationships with community nursing support as well as helping to maintain a continuity of service for people who used the service. We saw they had recently undertaken phlebotomy (blood) training, meaning they would be better able to diagnose people's needs.

Staff training more generally included dementia awareness, moving and handling, health and safety, fire awareness, infection control, food hygiene, dysphagia awareness and medicines administration. We saw staff training needs were monitored daily and that the registered manager was accountable for ensuring staff had refreshed their learning in line with the registered provider's policy. We found this system to be working effectively. One staff member told us, "There is a good culture of learning and support here," and welcomed the balance of e-learning and face-to-face sessions.

With regard to nutrition, people confirmed they were given a choice of meals at each mealtime and that staff acted on their preferences. We saw, where necessary, fluid and food intake was monitored closely and this correlated with people's care plans and nutritional needs.

There was mixed feedback regarding the quality of the food. One person told us, "It's marvellous, like a hotel," whilst the majority of people who used the service and relatives we spoke with stated the standard of food had deteriorated recently. One person who used the service told us, "The meals have gone right downhill," whilst another said, "I don't like the food much now – used to be better." We noted the service had interviewed for the position of head cook the day prior to the inspection and that the kitchen had been managed by two kitchen assistants since the previous head cook left. The registered manager and area manager agreed to review whether they could improve this aspect of the service. For example, in another of the registered provider's services, staff show people two respective plates of food at dinnertime in order to help them choose. There were a number of people who used the service living with dementia and this approach to choice at mealtimes is something the area manager agreed to look into.

One relative told us, "There are always plenty of drinks - they come in frequently offering drinks." We observed staff offering people drinks and snacks from a trolley throughout the inspection.

We observed mealtime experiences and found them to be positive, with staff interacting with people who used the service in a patient manner, and nobody left without support where they required it. The

atmosphere was relaxed, with music playing and tables set.

In the kitchen we saw information regarding specialised diets and the need for supplements clearly displayed. Anyone noted as at high risk of malnutrition via the Malnutrition Universal Screening Tool (MUST), was supported with a fortified diet. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw that staff had received Focus on Undernutrition training and demonstrated a good knowledge of people's dietary needs. Focus on Undernutrition is a nationally recognised system of ensuring people at risk of malnutrition are identified and supported through fortified diets. We saw two examples of people who had previously lost weight being supported through the use of the MUST tool to regain weight. This meant, whilst some people's enjoyment of meals could be improved, the service effectively managed risks of malnourishment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw appropriate applications had been made to the local authority and that there had been regular contact by the registered manager with the local authority DoLS team. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS.

We saw that people who had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people's needs had been reviewed appropriately with those who know them best.

We also saw people had Emergency Health Care Plans (EHCPs). An EHCP is completed by an external healthcare professional and makes communication easier in the event of a healthcare emergency. This demonstrated staff worked well with external professionals to ensure people's needs were planned and met.

We saw people were supported to maintain health through accessing external healthcare such as hospital appointments, visits from the dentist and external nursing support. We saw where advice was given from external professionals, for example the arrangements for fasting prior to a hospital visit, this was factored into care planning and delivery. One external professional we spoke with told us, "They listen and take on board the feedback we give. I think the appointment of the new nurse is a positive statement of intent." This meant the service ensured people's healthcare needs were met through effective liaison with external professionals.

With regard to the premises, signage was clear and people's rooms had en suite facilities. We saw there was an additional communal space designed in the style of a bar, with pub-style seating. One relative told us, "I think the bar area is a good idea – it's somewhere different for people to go with their loved ones." We saw there were ample bathing and toileting facilities and that these rooms were suitably equipped to meet people's physical needs.

The majority of staff we spoke with felt they received appropriate support from their line manager, including regular supervision meetings and an annual appraisal. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. Appraisals are an annual review of staff performance. We also saw the registered manager held regular team meetings and ad hoc group supervisions where there were important messages to share with all staff.

Good

Is the service caring?

Our findings

There was a consensus of opinion that staff demonstrated caring attitudes towards people who used the service and, for the most part, took an interest in people's individualities rather than merely focussing on the tasks they needed to complete. We observed one instance of staff interaction whereby this was not the case, with a member of staff focussing on the task and not talking or interacting with the person who used the service. We raised this with the registered manager, who agreed to address the issue.

One person told us, "The staff are kind and listen – two ladies take me for a bath and treat me with dignity. I can get up whenever I want." Another person who used the service told us, "They are kind. They brought a card and a box of toffees on my birthday and when they have time they sit and talk to me at my bed. Also, when they found out a family member had died they came to console the entire family and brought tea and biscuits."

Themes of dignity and personal choice were consistent when we spoke with other people who used the service, and through our observations. For example, we saw one person chose not to get up until 10:45, so staff served this person breakfast in their room. With regard to dignity, we observed staff knocking on people's doors before entering and informing people about how they were about to help them with, for example, a hoist.

Thank-you cards we saw contained further evidence of caring staff, for example, "Our [relative] was only with you for a short while at the home but thank you for all the love and care you gave them." Another read, "We appreciated the friendliness of all the staff, carers and nurses when we came to visit." All visitors we spoke with felt they received a warm welcome from staff and that this helped people who used the service feel at home.

We observed one person singing in their room and two members of staff responded to their encouragement to join in. Staff encouraged the person to take the lead and teach them the song. This demonstrated, whilst there had been an earlier example of a staff member engaging with people and overly focussing on the task rather than the person, staff generally understood and celebrated people's individualities. One staff member, who was able to describe people's preferences and life histories in detail, told us, "It's a job but the people you look after make it. They're not cardboard boxes to move around a room, they're people. I've cried in this job and I've laughed and I think that's how it should be."

We found the culture was generally one where staff wanted to take the time to build a meaningful connection with people, although on occasion the time constraints on staff limited these opportunities. The registered provider agreed to review good staff practices and how they could ensure these were shared to ensure the culture remained focussed on treating people as valued individuals.

We saw staff had recently undergone external training with Marie Curie to increase their awareness and competence when supporting people who may be nearing the end of their lives. We saw people had end of life care plans in place and a number of thank-you cards which referenced the dignity with which staff had

treated people who had previously used the service.

We saw information regarding advocacy services was available on noticeboards and in the Service User Guide, a copy of which was available in people's rooms. At the time of our inspection no one who used the service had an advocate but the registered manager displayed a sound knowledge of advocacy support available. This meant people's best interests could be supported, recognising the importance of advocacy services.

We saw people were asked about their religious beliefs when first moving to the home and that preferences were met through visiting clergy. This meant people's right to religious beliefs and freedoms were respected and enabled.

We saw people's confidential information, for example care records containing medical information, was securely stored in the nurses' offices.

Good

Is the service responsive?

Our findings

The service had a full time activities co-ordinator and they were responsible for planning and delivering a range of group and individual activities. We found they were passionate about the impact of their role on people's wellbeing and that they found a number of ways to ensure people who used the service experienced a variety of meaningful activities. For instance, they had contacted a local 'dog patting' service, who regularly visited the home with a dog that people enjoyed petting. We spoke with the volunteer and also people who used the service, all of whom confirmed they enjoyed the experience. Other volunteers assisted with a regular poetry class the activities co-ordinator organised. We found this was a popular activity and people enjoyed the class. Links had also been made with university students, who regularly visited the service to read to people and perform music recitals.

We saw people had been on outings to the beach and museums, as well as attending a local church regularly. Recent group activities included exercises, visits from musical entertainers and bingo. The activities co-ordinator spoke keenly about their focus on participation, for example when people played bingo, one person gave out the cards, one checked the scores, whilst one person gave out and collected pens. People were therefore actively included in the activities programme, whilst photo albums were used to celebrate and share previous events and outings. One relative told us, "My [relative] loves joining in and there are always plenty of things planned." We saw the activities co-ordinator had been nominated for a national award at the provider's annual awards ceremony.

The activities co-ordinator was also responsible for completing the 'My Choices' document, a comprehensive overview of people's likes, dislikes, personal history and other information. We found these had been completed with a good level of detail, meaning the service sought the relevant information to ensure care could be person centred.

One member of staff told us they did not have the time to read these documents in detail, but that they would like to. Other members of staff demonstrated a good knowledge of people's individualities.

We saw there was a pre-admission assessment in every care file we looked at. This document people's medical, dietary, religious, mobility and other needs. Each care plan we reviewed contained a photograph and a good level of information about people's needs. We saw that care plans were reviewed monthly and a range of staff evidenced a good understanding of people's needs. Care plan reviews were scheduled according to wall planners on each floor and these plans had been adhered to.

We saw where people's needs changed this was identified by staff and either care plans were changed or external support had been sought. We also saw specific information relevant to people's individual needs had been incorporated into care file documentation, for example from psychiatry services and the Speech and Language Therapy Team (SALT). This meant people's health needs were regularly assessed and consistently met.

We saw there was an iPad set up in the entrance foyer, on which any visitors could input feedback about the

service. Staff also used the same IT system to conduct surveys with people who used the service (and also to complete their own feedback about the service). We looked at sample information from this system and found, whilst the vast majority of responses were positive, there were very little additional comments, meaning there were limited opportunities for the registered manager to respond to and improve specific areas via this form of communication method. We did see there were regular resident and relative meetings in place however, whilst the majority of relatives confirmed they were encouraged to give feedback to the registered manager. They confirmed they did this in person as this was more likely to have an immediate impact. We also saw the registered provider sent annual satisfaction surveys to people who used the service and their relatives – these were being compiled at the time of our inspection. This meant the registered manager routinely involved people who used the service and their relatives in the ongoing review of service provision.

We saw the service had a complaints policy in place and the manager had acted in line with this policy when complaints had been made to ensure any underlying issues were addressed and complainants were given full explanations. Complaints had been limited since the previous CQC inspection but those we reviewed had been responded to in line with the registered provider's policy and acted upon. All people and relatives we spoke with were confident in how to make a complaint should they need to and we saw this information was also incorporated into the service user guide. This meant people were supported to raise concerns and that their complaints were handled professionally and fairly.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care. They had been at the service for two years and had a good knowledge of people's needs, likes and dislikes, as well as the day-to-day workings of the service.

All relatives we spoke with knew who the registered manager was and that they were regularly accessible and visible. They confirmed they felt able to raise queries or concerns with the registered manager. People who used the service who we spoke with similarly knew who the registered manager was and that they were approachable.

On the second day of our inspection one member of care staff called in sick. We saw the registered manager arranged another member of staff to cover but, until they arrived, took an active role in ensuring people's needs were met by helping with the breakfast service and ensuring staff worked flexibly to meet people's needs.

The registered manager had made and maintained good links with the local community, for example the university, and also health and social care professionals. We saw they had, through these latter relationships, ensured staff benefitted from opportunities to access additional training sessions. The registered manager also kept themselves abreast of developments in social care through attending training courses.

The registered manager and other staff confirmed that the area manager attended the service regularly, which they felt added another level of accountability. The registered manager told us how they had received additional support from the registered provider's quality team shortly after they began working at the service. They felt they had made improvements, particularly with regard to the consistency of care documentation, and we found external professionals shared this opinion. One told us, "They're generally good – they don't keep themselves to themselves and get involved." Another said, "There have been noticeable improvements since they took over. It's stable now and we have confidence in them. The registered manager is willing to try things we suggest, both in terms of a specific care need but also wider approaches to things."

We saw the registered manager led the quality assurance and auditing work at the service. Regular audits included care plans, medicines including controlled drugs and audits of the premises. Audits identified, for example, when medicines stock was running low, when eye drops had passed their use by date but had not been disposed of, or when people who self-medicate had not had an appropriate assessment completed. This meant quality assurance processes identified areas where practice improvement was required before they developed into potentially more serious issues.

The service user guide outlined a service that "fostered a sense of home and of belonging." We found that staff achieved this for the most part and, where there were opportunities to improve person centred care,

the registered manager was committed to this.

Staff we spoke with confirmed they were well supported by the registered manager, both through formal processes and on an ad hoc basis, should they need to raise anything. One staff member told us, "They do their best, both the manager and the people higher up. It's a difficult balancing act but they do it well."

During the inspection we asked for a variety of documents to be made accessible to us. These were promptly provided and well maintained. We found records to be clear, easily accessible and contemporaneous. Policies and procedures were regularly reviewed by the registered manager and we saw the previous CQC report displayed in a communal area. We also saw that appropriate notifications had been made securely to CQC in a timely fashion, for instance when there had been an allegation of abuse. This meant people could be assured their confidential information was treated carefully and in line with the Data Protection Act.