Four Seasons Homes No.4 Limited

Marquis Court (Tudor House) Care Home

Inspection report

Littleworth Road
Hednesford
Cannock
Staffordshire
WS12 1HY

Tel: 01543422622
Website: www.fshc.co.uk

Date of inspection visit:
15 May 2017

Date of publication:
19 June 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 February 2017 and found four breaches of the legal requirements. On 14 March 2017 we issued a warning notice to the provider in Regulation 12 HCSA (RA) Regulations 2014 Safe care and treatment. This was in relation to the management of risks to the health, safety and wellbeing of service users. We told the provider to take action before the 24 April 2017. After the warning notice was issued, the provider wrote to us to tell us what action they were taking.

We undertook this focused inspection on 15 May 2017 to check that they had followed their plan and taken the relevant action needed to meet the requirements of the warning notice. This report only covers our findings in relation to those requirements set out in the warning notices. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marquis Court Tudor House on our website at www.cqc.org.uk

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

At the focused inspection on 15 May 2017, we found that the required improvements had been made to the way risks were managed. Where risks to people's health and safety had been identified, plans were in place to guide staff on the actions they should take to minimise these risks. We saw staff followed the guidance to protect people from avoidable harm.

The provider had increased staffing levels and we saw that people received timely support. However, further action was needed to demonstrate that the provider had acted on all the concerns raised at the last inspection to demonstrate there were sufficient, suitably trained staff available at all times. This meant there was a continued breach of the legal requirements.

People were safe because the provider followed recruitment procedures to ensure staff were suitable to work in a caring environment. Staff understood their responsibilities to protect people from the risk of abuse. Systems were in place to audit medicines to ensure any errors could be identified and rectified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had taken action to ensure that risks to people's health and wellbeing were managed safely. Staffing levels had been increased on the nursing unit. However, improvements were still needed to ensure there were enough, suitably trained staff available at all times. People received their medicines as needed and suitable checks were in place to ensure shortfalls could be identified and rectified. Staff understood their responsibilities to protect people from the risk of abuse.

Marquis Court (Tudor House) 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 undertook an unannounced, focused inspection at Marquis Court Tudor House on 15 May 2017. This inspection was carried out to check that the provider had made the required improvements to meet the legal requirements set out in the warning notice, issued following our comprehensive inspection on 22 February 2017. We inspected the service against one of the five questions we ask about the service: is the service safe? This was because the service was not meeting some legal requirements within this area.

The inspection was carried out by one inspector. Before the inspection we checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

We spoke with seven people who lived at the home, four care staff, a nurse, a member of the provider's pharmacy team and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met. Some of the people living at the home were unable to speak with us about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. We observed how staff interacted with people, and the support they provided in the lounges and dining areas.

We looked at the care records for five people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 22 February 2017, we found that risks associated with people's care were not always managed in a safe way. People were not always supported in line with their risk assessments to reduce the risk of harm to them. This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the management of risks associated with people's care. We told the provider that improvements must be in place by 24 April 2017.

At this inspection on 15 May 2017 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of Regulation 12 described above.

We saw that where risks to people's health and safety had been identified, risk management plans were in place and staff followed these to ensure people received their care as planned. For example, we saw staff repositioned people to prevent them developing sore skin due to pressure damage. We observed staff checking times and discussing when people needed to be moved and improvements had been made to the recording of these changes. We saw information was shared at handover to ensure staff coming onto shift were aware of the time for the next repositioning. Staff could tell us about people's individual needs and how to manage any associated risks. For example staff told us how they supported people who were at risk of choking and we saw people were provided with meals and drinks in accordance with their documented requirements. At lunchtime, we saw staff followed the guidance in people's risk management plans and sat with people who were at risk and provided encouragement to ensure people maintained a healthy weight.

Staff had received further training in the management of risks associated with people's skin integrity and the risk of choking and the registered manager showed us they had conducted flash supervision sessions to check their understanding in this area. Risk assessments were reviewed when people's needs changed, for example when people lost weight or they had difficulty swallowing. We saw that referrals had been made to relevant professionals and recommendations that had been suggested had been followed. For example, one person's care plan had been updated to record that they should have a pureed meal and at lunchtime we saw they received the correct meal. We saw the registered manager kept an action log which detailed people's risks which included dates of reviews and referrals made and progress was monitored with senior staff during the registered manager's daily walkabout at the home. This showed us the provider had taken action to ensure people were protected from the risk of avoidable harm.

At the last inspection, we found there were insufficient staff to meet people's needs at all times. People told us they had to wait for support with their care needs and the lack of suitably trained staff to administer medicines on the residential unit meant people's medicines were sometimes delayed. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider sent us an action plan which stated the regulation would be met by 10 May 2017. At this inspection we found some improvements had been made but further action was still needed. On the nursing unit, staffing levels had been increased and an additional member of staff was rostered on between the hours of 7am and 1pm. The

manager told us this had only been in place for two weeks and they usually had to use agency staff. On the day of our inspection, an agency member of staff had not arrived for their shift but we saw the registered manager arranged for a member of the permanent staff to come in to cover. We saw staff had time to sit with people and did not observe people waiting for support. Staff told us things had improved on the nursing floor. One said, "It's much better and today we've had time to do some activities with people". On the residential unit, people had mixed views about staffing levels. One person told us, "Staff come quickly if I press my buzzer, I don't usually have to wait" but another said, "We definitely need more staff, especially so that people can use the bathroom when they need to". Staff told us staffing levels had not changed since our last inspection and they usually managed to meet people's needs. One told us, "We usually assist people who need the support of two staff first and people who only need one member of staff have to wait until after breakfast. It's not usually an issue as its' [Name of person and Name of person] who like to get up a bit later. If we had another member of staff, they could get to people more quickly". We spent time observing the communal areas and saw that staff had finished bringing people into the lounge by 10am. Staff were attentive and people did not wait for support when they asked for assistance. Call bells were answered within a few minutes and where people required the support of two staff to mobilise using equipment, they did not have to wait long for a second member of staff to become available. Staff supported people to take part in activities, such as playing musical instruments or using the karaoke machine.

The registered manager told us they had reviewed staffing numbers by reassessing people's dependency levels. They had also worked with a manager from another or the provider's homes to look at the deployment of staff and their daily routine over the period of a week. This had identified the need for an increase in staffing on the nursing unit in the morning which we saw had been actioned. However, the registered manager told us that this work had focussed on the nursing unit and there had been little analysis of the deployment of staff on the residential unit. They told us the recruitment process was ongoing for an additional member of staff trained to administer medicines on the residential unit and they would be appointed when references and character checks had been completed satisfactorily. This showed us that the provider followed safe recruitment procedures. In the interim, arrangements had been made for the night nurse to administer medicines that needed to be given in the early morning, to ensure people had their medicines when needed. The registered manager told us they sat in on handover or reviewed handover documentation and increased staffing levels if people's needs changed. Whilst we have seen some improvements as a result of increased staffing levels, the provider has not acted on all the concerns we raised about staffing levels on the residential unit. As a result it is too early to assure ourselves that there were enough, suitably recruited staff to meet people's needs at all times. We will follow this up again at our next comprehensive inspection.

This is a continued breach of Regulation 18 of the Health and Social Care Act (HSCA) Regulated Activities) 2014.

We saw that people received their medicines when needed. Staff were trained to administer medicines and we saw they spent time with people and checked to ensure they had taken them before leaving them. The provider carried out audits of medicine administration records to check people received their medicines as prescribed. We saw their April 2017 audit had identified some concerns with the monitoring of stock balances and use of the correct recording codes on the MAR, for example when people had been unable to take their medicines. We saw there was an action plan in place to address these issues and a member of the provider's pharmacy team was at the home to provide additional training and support. They told us some of the errors had been attributed to agency nursing staff and training was being provided to ensure they were familiar with the provider's policies and procedures. They told us, "We use regular agency staff and involve them in training with permanent staff, which helps them feel part of the team". We saw that work

was ongoing to ensure protocols to describe the use of medicines prescribed on a 'when required' basis were in place where needed. This showed us the registered manager was acting on concerns raised at the last inspection.

People told us they felt safe living at the home. One person said, "I'm safe here, I'd speak up if I wasn't". Staff understood their responsibilities to protect people from the risk of abuse and knew what actions to take if they had any concerns. Staff told us they would report any concerns to the nurse or manager and were confident their concerns would be taken seriously. The registered manager understood their responsibility to report concerns to the local safeguarding team for investigation. Our records confirmed that concerns were reported to us which meant we could check that appropriate action had been taken.