HC-One Limited

Four Seasons

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Four Seasons is registered with the Care Quality Commission (CQC) to provide nursing and personal care for up to 121 people. The building is two storeys with car parking facilities and is situated in the Breightmet area of Bolton.

The home had a registered manager in place at the time of the inspection. 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 and associated regulations about how the service is run.

At our previous inspection in October 2016, we had found a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. This was as the service had failed to ensure medicines were being managed safely. You can read the report from our last inspections on our website at www.cqc.org.uk.

This focused inspection was carried out on 23 January 2017 to follow up previous concerns in relation to the safe administration of medication. Good progress was found within three units of the home; and in these areas medicines were found to be managed safely.

Since the previous inspection in October 2016, the purpose of Spring Unit had been changed to provide intermediate care. This type of care is used to provide additional short term support to people when they no longer require hospital care. People using this support may then return home, or receive an assessment for long term care and support. Additional multi-disciplinary staff were employed to provide additional onsite support such as physiotherapy and pharmacy services. On the first day of the inspection 23 people were resident on the Spring Unit.

Within this part of the home we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment; and good governance. This was as the service had failed to ensure medicines were being managed safely, which placed people at risk of harm. In addition, the governance system in place to monitor the safety and efficiency of the new scheme had been ineffective, which meant the issues we found at the time of the inspection had not been identified by the service and addressed. Appropriate records were not being adequately maintained.

Due to our concerns, we liaised with the provider, the local authority and the local clinical commissioning group (CCG). At this point, the Spring Unit closed to all new admissions to enable a full review to be undertaken and for actions to be taken to improve. We carried out a further day of inspection on 20 February 2017, at this time there were 11 people resident on the Spring Unit. We found improvements had been made to reduce the level of risk to people receiving care. Due to the lower level of risk, admissions to the unit recommenced with additional monitoring arrangements in place from the CCG. A further inspection was planned to check the effectiveness of the actions that were put in place.

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.

Progress had been made with regard to the safe administration of medicines on three out of four units. We found that people were not receiving their medication in a safe manner as prescribed on Spring Unit.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Systems were in place to monitor and assess the quality of the service. However, audits had been ineffective in ensuring people's medicines were being safely managed. Records on Spring Unit relating to people's care were not being adequately maintained.

Four Seasons

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 checked 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.

The first day of the inspection on 23 January 2017 was undertaken by an inspector, a pharmacy inspector, an inspection manager, and a regional medicines manager. The second day of the inspection on 20 February 2017 was undertaken by an inspector and a pharmacy inspector.

Since our last inspection, CQC had been liaising with the provider, Bolton Council and Bolton Clinical Commissioning Group (CCG). Before the inspection, we reviewed all of the information we held about the home in the form of statutory notifications sent to CQC including those related to safeguarding incidents, deaths and injuries.

This inspection was carried out over two days. On the first day we spoke or spent time with eight people who used the service and three people's relatives. We spoke with the registered manager, the deputy manager, the unit manager for Spring Unit, two nurses, the nursing health care assistant and four carers We also spoke to six people who were employed from external organisations.

On the second day of the inspection the home did not have a registered manager in post and a new manager had been appointed. We spoke with the one agency nurse, a senior carer, the nursing health care assistant, two relatives and three people staying at the home.

We reviewed the action taken by the provider who wrote to us following our previous inspection explaining what action the service had taken to meet legal requirements. We looked at documentation including: care files and associated documentation; Medication Administration Records (MARs); and audits and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

We visited the home on 23 January 2017 to ensure the concerns we had found at previous inspections relating to the safe administration of medication had been addressed. We found good progress within three units of the home. Since the previous inspection in October 2016, the purpose of Spring Unit had been changed to provide intermediate care. This type of care is used to provide additional short term support to people when they no longer require hospital care. People using this support may then return home, or receive an assessment for long term care and support. We found medicines were not being handled safely on this unit. We carried out a further inspection visit on 20 February 2017 to check action had been taken to lower the risk to people using the service.

At the October 2016 inspection concerns were found with people not being given their medicine, or being given too much of it. Fluid thickening powder used to thicken fluids for people with swallowing difficulties was not being managed appropriately. The fluid charts to record what a person was taking in a day were also not being recorded accurately.

On 23 January 2017, we visited three of the units, Winter, Summer and Spring. Systems were in place for ordering, receiving, administering, storing and disposing of medicines as per national guidance on the Winter and Summer Unit. The Winter and Summer Units had made improvements since the last inspection and the 'when required' (PRN) protocols and record keeping was better. Topical Medication Administration Record Sheets (MARS) were now completed and organised better. Fluid thickening powder now had more information for staff to use them and they were better organised.

On the Winter Unit, we observed one nurse sign for medicines in advance of them being administered. This is not safe practice and is not in accordance with 'The Handling of Medicines in Social Care' issued by The Royal Pharmaceutical Society of Great Britain. Issues around competency of this staff member had been identified at previous inspections. There was, however, no up to date competency assessment for this nurse, although the manager said she had been supervised. We observed three other nurses who all followed the correct administration process.

On 23 January 2017 we looked at the medicines records for six people on Spring Unit and found concerns with five of them. On 20 February 2017 we looked at the medicines records for six people and found concerns with all of them.

In January 2017 we found one person who was at a high risk of developing a clot in their leg or lung following surgery was prescribed an injection to be given every day by the nursing staff. Records showed this injection was not given for four days and this may have increased the risk of the person developing a clot.

A second person had been discharged from hospital on a fluid restricted diet. We asked the nurses and care workers who were on duty and found they did not know the person had a fluid restricted diet. We spoke to

the person who said the staff monitored their fluid consumption; however, this was not being done. Not having accurate fluid consumption recorded meant that we could not tell whether the person had had enough or too much fluid.

A third person had been identified by staff as being underweight and staff had identified a referral was needed. However, when we returned to the home four weeks later the dietician had not reviewed this person and the home had not chased it up. The home had a plan to monitor the person's weight, but they were not consistently weighing them as per plan.

A fourth person had some of their fluids administered into a stomach tube, but the volumes used by staff were different to what the person said they were having at home. Staff had not checked what the person should have been having. The same person had a high risk of developing pressure sores and they were prescribed a barrier cream by their doctor to reduce the risk of this happening. The unit did not have a record of it being applied. We spoke to the person who told us it had only been applied three times over a three-week period and that it should have been used every time they had been to the toilet.

The same person took small amounts of fluids by mouth on top of the fluids administered into their stomach. To reduce the risk of choking, their fluids were to be thickened with thickening powder. The unit did not have a record for when fluids had been thickened and therefore we could not tell when and whether fluids had been thickened to the correct consistency. We found thickening powder in the dining room on the worktop, which was left unattended.

In January 2017, two people were prescribed warfarin to reduce the risk of a clot forming. Cranberry juice, which was offered to all people at breakfast can increase warfarin levels and should not be given to people taking warfarin. We spoke to four registered nurses who were unaware of the interaction. We spoke to three carer workers in the dining room who did not know that the two people should not be given cranberry juice. There was no system in place to ensure cranberry juice was not given to people on warfarin. We checked the food charts for a person who was taking warfarin and the juice given had not been specified. It was unclear from the record whether this person had or had not been given cranberry juice.

In February 2017, we saw one person was prescribed Warfarin and no system had been put in place to ensure cranberry juice was not given to them. We were told that information was now recorded on their food and fluid charts to warn staff about the interaction but when the charts were examined there was no such information recorded.

In January 2017, we checked the medicines records for two people that were prescribed Paracetamol tablets. Doses of Paracetamol should be given at least four hours apart to prevent overdosing. One person was given their doses three and a half hours apart on one occasion that placed them at unnecessary risk. Both people were given only one tablet instead of two on the same day but care planning and medicines records did not explain why only one was given. This meant there was a risk these people would not benefit from their use.

In February 2017, one person was taking Paracetamol regularly but the times of doses were not always recorded. So it was not possible to tell if they were given their pain relief with safe intervals between doses which placed their health at risk of harm.

One person was meant to be assisted to look after their own medicines in preparation for going home. The system in place did not ensure that they could be supported safely to do this while they were in the home.

Another person was prescribed thickened fluids to prevent them from choking when drinking. No arrangements were in place to ensure they could have drinks safely when they went out of the home for a meal or went to the café within the home. The nurse on duty confirmed this and told us their relatives were not all aware of the risks of them having unthickened drinks.

One person ran out of their prescribed laxative for at least three days. If people do not have an adequate supply of medicines their health could be put at unnecessary risk of harm. The records about their laxative use were confusing because they showed that they had been given more tablets than they had in stock in the home. The records could not give evidence that they were given their laxative safely and as prescribed.

Records about the administration of other medicines were looked at for the same person and they also could not show that all their medicines had been given as prescribed or could be accounted for. The pharmacist employed to work in the home confirmed the records could not evidence that the medicines had been handled safely for that person.

The medication administration records for another person did not show they were prescribed a tablet for agitation but in January their care notes showed it was currently prescribed. This placed the person at risk of not being able to have their agitation treated effectively.

We looked at how creams were handled for five people and the records showed that approximately half the creams were not applied as prescribed. During our inspection we saw that one person had a cream applied that was no longer prescribed for them. There were also a number of unlabelled creams in the trolley which meant that if they were used for different people they were at increased risk of infection.

Three people were prescribed five different medicines to be taken 'as required' or with a choice of dose. We saw that the guidance as to how these medicines should be administered was of variable quality. There was clear guidance recorded for two medicines and for one medicine no guidance at all was recorded. The plans for the other two medicines failed to give any guidance as to which dose to select or to assess if those people needed the medication. This placed people at risk of not being given their medicines safely and consistently.

During checks on medicines done by the registered manager between the two inspections it was found that "several people" had been given a double dose, for one day only, of a tablet to help prevent influenza. The doctors were contacted and they did not think that anyone's health had been placed at risk. The investigation showed this was an error made by an agency nurse who had worked at the home for three weeks.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in place at the time of the inspection. 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 and associated regulations about how the service is run.

During the inspection on 23 January 2017 we found there to be a lack of leadership and governance on Spring Unit. The roles and responsibilities of staff were unclear. The registered manager told us they had focused on progress across the rest of the home, and that Spring Unit had been managed by a unit manager who had left the service shortly before the inspection.

Medication audits for Winter and Summer undertaken in December 2016 had identified minor issues and these were part of an action plan. Our inspection of Winter and Summer Units identified improvements in medicines handling since this last audit.

In January 2017 in comparison to the other units, we were unable to find evidence of medicines audits on Spring Unit. We saw no effective oversight from the provider or the local Clinical Commissioning Group (CCG) to ensure medicines issues were promptly addressed. The provider had some support from the local CCG, which provided a pharmacy technician and pharmacist to support medicines management. However, the CCG were unable to provide the full hours of support originally agreed.

The medication errors, poor care planning and recording found on Spring Unit had not been identified and responded to effectively through quality assurance. After the first day of the inspection, we were provided with copies of audits the registered manager had undertaken in early January 2017, but these were not acted upon. For example, a medicines audit was undertaken by the registered manager on 05 January 2017. This identified actions around medicines for six people, which were assigned to the unit manager to be completed by 09 January 2017 . However, these actions had not been completed.

A provider level audit had been undertaken on 20 January 2017 of Spring Unit, and this had identified the same concerns as we found on the 23 January 2017. We did see evidence the provider had immediately taken steps to review the management arrangements on the unit, in response to this audit. A new unit manager had been brought in to address the issues identified. However, at the time of the visit they had only been in post two days and were working with the registered manager to make improvements.

At our visit in February 2017 we saw that medicines audits were being completed but the audits were in a number of different formats, which did not provide clarity regarding the concerns found and how they were being addressed. The CCG pharmacy team also carried out audits but they were not used in conjunction with the home's internal audits. We found there was still no effective oversight from the provider or the local CCG to ensure medicines issues were promptly addressed.

In January 2017 we found people had pen profiles with a photo in their rooms. These records also contained personal care charts, and additional recording charts i.e. for food and fluids if people were on them. We sampled three of these, and all were inconsistent including several days with missing records. This meant it was not possible to determine if people had received the care they needed. An accurate contemporaneous record had not been maintained for each person using the service.

On the second day of the inspection there had been some improvement with regard to care planning and reviewing. However, there were still gaps noted in the personal care charts within people's rooms. Paper work for monitoring of falls and pressure wounds had been implemented and was completed daily.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - good governance.