Four Seasons Homes No.4 Limited

North Court Care Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 July 2016 and rated it as Requires Improvement. The service had previously been rated as Requires Improvement following an inspection on 13 April 2016. Prior to that inspection the service had been in Special Measures and rated Inadequate.

We were made aware of some concerns in December 2016 which related to the safety of the service and which was linked to a possible impact on people's health. The local authority placed an embargo on new admissions to the service and we carried out this focussed inspection on 24 and 25 January to assess the safety of the service. This report only covers our findings in relation to people's safety and welfare. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for North Court Care Home on our website at www.cqc.org.uk

This inspection took place on 24 and 25 January. The inspection visit on 24 January was unannounced but the provider was aware we would be returning the following day to complete our inspection.

The service provides accommodation and nursing care for up to 65 people, some of whom are living with dementia. At the time of our inspection 42 people were resident.

A registered manager was 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.

This report specifically focuses on the key area of Safe with regard to keeping people safe from abuse, the management of risks to people's health and safety, staffing levels, the skills and expertise of staff and the management of medicines.

Staff had received training related to keeping people safe. General risks to people's health and safety such as fire and legionella bacteria had been assessed and action taken to minimise them. Fire systems and most equipment, such as moving and handling equipment, were checked to ensure they was safe to use but some medical equipment was found not to be fit for use at the time of our inspection.

The service was not managing risk well and staff's poor recording and lack of skills placed people at risk of harm. There were particular concerns related to the management of pressure care, moving and handling, eating and drinking, catheter care and falls. Staff understanding and knowledge was not always clear and records throughout the service, although plentiful, did not provide sufficient guidance for staff and did not accurately record care given. This made it difficult to assess if people had received the care they needed to keep them safe. Given that we found incidences of people who had lost weight and people with pressure sores developing we concluded that care was not always being delivered as required. New nursing staff had

also identified some of the issues we were concerned about and had already begun to address these which gave us some reassurance.

Medicines were mostly well managed and people received their medicines within an appropriate timeframe. However, medicines delivered via a patch were not applied in line with manufacturer's recommendations. This placed people at potential risk of harm. Some records related to medicines administration were not in place or were not accurately completed. The provider had not followed their own policy for determining whether covert administration of medicines was appropriate.

There were systems in place which were designed to protect people from the risk of abuse. Staff had received training in keeping people safe from abuse and suspected safeguarding concerns had been referred to the local authority adult protection team to investigate. Concerns raised during this inspection were not promptly referred.

Staffing levels enabled people to have their needs met most of the time but sometimes the service was stretched and basic recording tasks were not always completed. This placed people at risk as information did not provide an accurate picture of people's needs. Staffing levels were assessed according to a recognised dependency tool but it was not clear how people's particular needs with regard to deteriorating health conditions and increasing needs influenced staffing levels.

We found several breaches of regulation during this 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?

Inadequate

The service was not safe. People were at risk of harm.

Medicines were mostly administered safely although some medicines were not administered according to the manufacturer's recommendations. Records relating to medicines required some improvement.

There were systems in place designed to protect people from the risk of abuse. Potential safeguarding issues identified at this inspection were not promptly referred to the local authority.

Staffing levels were assessed but it was not clear how they catered for people's deteriorating health conditions and increased needs.

Risks relating to pressure care, moving and handling, falls, catheter care and eating and drinking were not well managed in all cases and placed people at risk.

Records were not accurate and did not ensure people who used the service were fully protected from unsafe care and treatment.

North Court 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.

The inspection took place on 24 and 25 January 2017 and was unannounced.

On 24 January the inspection team consisted of two inspectors, one of whom was a member of the CQC medicines team. The inspection visit on 25 January was carried out by one inspector and a specialist adviser who had expertise in nursing care including wound management, pressure care and catheter management.

Before we carried out our inspection we reviewed the information we held about the service. This included the information of concern we had received regarding the safety of the service and notifications the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with five people who used the service, three relatives, two members of the domestic staff, the head chef, four care staff, one senior care worker, three nurses, the deputy manager, the registered manager and the regional manager. We spoke with a member of the resident experience team who has a regional role with Four Seasons to train staff and monitor the quality of the service.

We observed staff providing care and support and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us easily.

We also spoke with staff from the local authority adult protection team and those from the clinical commissioning group (CCG) and from the local authority contracts team who have responsibility for placing people at the service.

We reviewed 15 care plans, 19 medication records, two staff records and other records relating to the safety

of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. One person who used the service told us, "They look after me very well. They are very good". A relative commented, "I am happy enough…. I pop in every day and I have no concerns". We saw that relatives and friends visited the service throughout the day and nobody raised any particular safety concerns with us.

Risks to people's health and welfare had been assessed and risk assessments provided information for staff. However information was not always comprehensive and did not always provide staff with clear guidelines about how to manage and monitor risks.

There were risk assessments and audits in place related the overall safety of the service and action taken to minimise the risk of fire, scalding and the growth of legionella bacteria was clearly documented. Equipment such as hoists and slings were regularly checked and serviced to ensure they were safe to use. All the slings we viewed were fit for purpose with no signs of wear and tear. There were good procedures in place to reduce the risk and spread of infection and domestic staff demonstrated a good knowledge of these.

Some equipment had not been checked to ensure it was safe to use. A suction machine had a missing connection (which had been ordered) and two suction catheters were out of date. A syringe driver (used to deliver medicines via a cannula) had an out of date extension set and the second syringe driver could not be located (although it was found in the days following our inspection). Regular equipment checks were not in place. For example the suction machine, which had a weekly check chart in place, had not been checked since 17 December 2016.

One person's nasal cannula, which was connected to their oxygen concentrator machine, was not clean and was found lying on a carpeted floor. This placed the person at a higher risk of a chest infection as the cannula could become contaminated by the carpet. There was no record related to the cleaning of this machine or the replacement of the cannula. These issues had also been noted at our last inspection in June 2016.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12 (1) (2) (e) and (f).

We viewed risk assessments related to people's eating and drinking, moving and handling needs, the provision of bedrails, choking, having a fall and taking medicines. Risks related to pressure care were not well managed in all cases. Equipment such as airflow mattresses and cushions were available for people at risk of developing a pressure sore. Repositioning charts were in place but they had not been consistently completed. For example, the care plan for one person at high risk of developing a pressure sore stated they should be given a change of position every four hours. We saw that records indicated that there were times when they were left for over five hours and one occasion when there was no record between 8.38pm and 8.26am the following morning. This person had two pressure areas developing which nursing staff were treating. Position changes were being recorded in three different places which made it difficult to track the care given and would have made it difficult for staff to get an accurate picture. Even when we looked in all three places we could not find records to support the fact that this person was being correctly repositioned.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 (1) (2) (c).

We had similar concerns with the repositioning of five other people. Staff were unclear as to whether one person had a repositioning chart in place. One member of staff told us they did not need a chart while four other staff members told us they were aware the person had a chart in place but it could not be found. The person's care plan stated they should be repositioned 'three hourly'. A nurse ultimately told us that the person did not require repositioning, merely checking throughout the night. This did not give us assurance that staff were always clear about people's needs.
Another assessment stated that a person needed to be repositioned every 'three or four hours'. This was not specific and was not happening in practice. When we asked the staff member on duty they were unable to tell us when the person had last had a change of position and were not sure about how often the person needed to be repositioned saying they thought it was, "Every few hours".

In addition to this concern we found that airflow mattresses were not at the correct setting for some people. For example one person who weighed 42.2kg was on a mattress set up for a person of 100+kg. We noted four other people whose mattress settings were for weights which were at least double the person's actual weight. This meant that their mattresses would have been too firm and would have placed them at an increased rather than reduced risk of developing further pressure areas. One of the people already had a grade three pressure sore. Throughout the day people were observed to be sitting on their slings which further increased the risk to their skin's integrity and would have reduced their comfort. We did note, however, that this was not the case on the second day of our inspection.

We were concerned that the management of one person's catheter was placing them at risk. The person had been given an indwelling catheter as they suffered from chronic urinary retention. This catheter had been recently removed. Staff told us it had been removed on the advice of a GP but there was no documentation to verify this or explain the reasons why it required removing other than one entry that stated that the catheter had bypassed. We noted that the person had been fitted with the incorrect sized catheter which could have increased the risk of it blocking.
Nursing staff had removed the catheter but had subsequently failed to accurately record the person's fluid intake and output. Records relating to fluids were incomplete and not being monitored by nurses, although the care plan stated that they were 'monitoring closely'. Fluid records for the day the catheter was removed stated that the person had a good urine output (although this was not measured) at 7.30pm and 3.00am. The following day a similar 'good output' was recorded at 3.10pm and 6.45pm. There were no further records. Fluid intake was not well documented and from the monitoring we saw it was impossible to establish if the person's urinary function was healthy. This placed them at risk of chronic urinary retention which could lead to a higher risk of infection and possible kidney stone formation.

Where people were at risk of not having their bowels open frequently enough and therefore needed this to be monitored, we saw that their bowel movements were documented in their daily notes. This made it difficult for staff to have a clear overview of when a person was at risk of becoming chronically constipated which could lead to serious health complications and might require additional medicines. We noted, for example, that one person had only one recorded bowel movement in the previous week.

People's risk of falling was not well monitored in all cases. For example we saw that one person, who was at high risk of falling, had three falls during December. These were documented on the incorrect paperwork and the monthly review for this person stated that they had not had any falls in December. This inaccurate recording meant that we were not assured that staff had a clear picture of this person's risk of falling and whether it was increasing or decreasing.

This was a further breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 (1) (2) (c).

We also noted that this person had bed rails fitted but we observed the person being half in and half out of their bed with their feet on the floor for several minutes. Their bed rails were not in use. This constituted a falls risk for this person. Where bedrails were fitted for other people we found that there was not always a corresponding risk assessment in place identifying the possible risks such as the person climbing over them or trapping their head or limbs. However there was good overall monitoring of bedrails with hourly checks being well documented throughout the night.

We also observed some poor moving and handling practice by staff supporting this person when two staff members grabbed them by their armpits and another held their feet in order to move them further up in their armchair. This placed the person at risk of sustaining an injury to their shoulders. Two further incidents of poor moving and handling were witnessed and we informed the manager who confirmed they would take the appropriate action to address this with staff and provide refresher training. Staff from the Resident Experience team also witnessed one episode and offered advice to staff but we remained concerned that trained staff had thought that such poor moving and handling was acceptable.
Risks related to people's eating and drinking were not always well monitored. People who were at risk of not eating or drinking enough had been identified and food and fluid charts put in place. A nutrition assistant role had been created to promote and record people's eating and drinking and this worked very well during the daytime when people were gathered in the main lounge. The nutrition assistant was diligent in their promotion of food and fluids and we saw that they were well recorded for these people. However this person only worked office hours and recording outside of these times and monitoring of fluids, was not so good.

We saw that there were numerous records documenting that people had not reached their fluid target, often for several days, no action was evident and overall monitoring was not in place. For example one person's daily fluid target was set at 1750mls. We saw that this person had only achieved this target on one day in the previous week, with one day only documenting a total of 500mls being drunk. It was not clear what action had been taken as a result of these low fluid intakes. Being dehydrated places people at a greater risk of acquiring a urinary tract infection.

Another care plan showed that a person's high risk of choking had been assessed as soon as they had moved in. The assessment had been reviewed two months later and it was documented that a referral should be made to a speech and language therapist (SALT) for further guidance but this had not been done. The exact risks for this person had not been documented and we saw that they were on a soft diet but had eaten chicken casserole on the day of our inspection. The chef told us that the chicken was very soft. We were not assured that the information held in the care plan made the risks clear to staff or documented how to reduce them.

We also overheard a care worker handing over a concern to a more senior staff member about one person's difficulty swallowing. The senior staff member said they would refer to a SALT but no record was made of this concern and the referral had not been made by the time of our second visit. The handover for this person stated, 'no issues/repositioning done/good intake' which did not reflect the concerns that the staff member raised.

Although people were referred to a SALT or dietician when they had sustained a significant weight loss we found that advice was not always followed. This meant their risk of further weight loss was not reduced. For example one person had lost 6.6kg since seeing the SALT in November 2016. The advice given was for a fortified diet, snacks and daily milk shakes or cream shots three times a day. Recent food charts showed that this advice was not followed. For example in the week beginning the 18 January 2017 they only had a record of receiving three milkshakes or cream shots on two out of seven days. This may have been poor recording,

however given their reducing weight it was possible that this person was being placed at risk as staff were not providing the required additional snacks and drinks.

The overall poor management and monitoring of risk was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 (1) (2) (b).

We saw that nurses and senior staff had received training in the administration of medicines and this was refreshed every two years. However records confirming that staff had been observed to ensure they were competent to administer medicines were not provided and did not appear on the overall training tracker.

Medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely. The controlled drugs we checked had been correctly recorded and the quantities in stock were in accordance with the records, however staff did not make regular checks on the stocks so they would not be able to identify and investigate discrepancies promptly.

The medicines administration records we looked at included allergy information and a photograph of the person to make sure they were correctly identified. We saw that since our last inspection the provider had introduced guidance for staff on the different ways that each person preferred to take their medicines. The charts were signed to show that medicines were administered regularly. Separate record charts for creams had recently been introduced, although they had not always been signed to confirm that the cream had been applied and some creams did not have accompanying charts. The provider told us that staff were being trained in the use of the new charts. We also found that some creams had been opened but the date they were opened was not recorded. This meant that we could not be assured that they were safe and effective to use.

On the ground floor protocols were used to manage medicines to be taken when needed, for example for pain relief, and we saw that they included details that would help staff who did not know the person well to decide whether the medicine was needed. However on the nursing floor there were no protocols in place so we could not be sure that people were given 'as required' medicines consistently and as intended by the prescriber.

Staff told us that one person was given their medicine covertly, hidden in food or drink, to make sure they took it regularly. However there was no information about this on the medicine chart and not all staff we spoke with were aware that this person was given their medicine in this way. We saw that the person's GP had agreed to this but there was no record of a full assessment involving the person's family, and there was no advice from a pharmacist about whether the medicines were suitable to be mixed with food. The provider's medicines policy for determining whether covert administration is necessary was comprehensive but they had not followed it in this case. The right people had not been involved in making the decision to ensure it was in the person's best interests according to the requirements of the Mental Capacity Act 2005 and staff administering the medicines did not have the right instructions in place to make sure the person received their medicine safely.

Some people had their medicine in the form of a skin patch, and charts were used to record where and when these were applied. However staff did not always follow the manufacturer's instructions about how long to leave before re-applying a patch to the same site. One person had a patch which should not be reapplied to the same site for 14 days but staff were not aware of this and were only leaving four days before re-using the same site. This can cause skin irritation and can mean that the medicine is absorbed into the bloodstream too quickly, with a risk of overdose.

Although controlled drugs were audited and stocks tallied with records we found that audits of other medicines which were only occasionally used did not take place. This meant that we could not be assured that any discrepancies would be identified promptly.

We looked at records relating to the recruitment of new staff. An effective recruitment procedure was in place. Recruitment records showed that staff had followed an application process, been interviewed, had their identity checked and had their suitability to work with this client group checked with the Disclosure and Barring Service (DBS). Robust checks of people's references had been carried out by the provider.

People told us that staff usually attended to them promptly when they used their call bell, although some commented on having to wait if they were short staffed. We saw that call bells were placed within reach for people to use. One person told us, "They come quickly. It's very seldom you're left waiting for them to finish with someone else". Another person commented, "They do their job. They look after me well. Sometimes it's short staffed and you wait a bit you know". For those people who were not able to use a call bell there was not always a procedure in place for checking that they were alright. However we did find that often people's doors were left open so staff could do a quick visual check as they moved around the service.

Staff received training, such as basic life support and fire safety, related to keeping people safe, although we did note that staff had not received training in using the specific equipment required to evacuate people in an emergency. The service had over 200 hours a week vacant. This was covered by permanent and Four Seasons bank staff during the day and supplemented by agency staff at night. The same agency care and nursing staff were used as much as possible to ensure consistent care. Records confirmed that the same agency staff were often on duty. A new nursing staff member gave us some reassurance as they had already identified some of the concerns we raised at this inspection and had plans to address them.

Before the inspection we had been alerted to the fact that staffing levels had been low during the Christmas period. Staffing levels were determined using a nationally recognised dependency tool and the manager and staff told us that this equated to one staff member to each five people who used the service, with a nurse or senior staff member on each floor. It was not clear to us how this equation of one staff member to five people took into account people's fluctuating needs and deteriorating health conditions.

We reviewed rotas for the last eight weeks, which included the Christmas period, and found that they were very disorganised which made it difficult to be assured that the correct staffing had been in place each day. For example one afternoon/evening shift appeared to have only five staff on duty according to the rota, although the manager assured us that the number was actually 10. We were provided with the electronic log ins for staff on that particular day which actually recorded 11 members of staff. Although numbers of staff appeared to be consistent with the service's own assessment of safe staffing levels on the days we sampled, we could not be assured that records were fit for purpose as the manager was not able to accurately identify to us the number of staff on any one day.

The rotas contained names of two staff who did not appear on the service's training tracker which logged all staff training. We asked the manager to confirm training had been put in place for these two people. Although this was confirmed, we were not provided with evidence to support this. Therefore we could not be assured that all staff had received all the training they needed to carry out their roles safely.

Poor recording related to staffing constituted a further breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 (1) (2) (c).

Staffing was clearly stretched at times although most staff told us they found the levels were manageable.

Over lunchtime we observed one staff member trying to support two people in neighbouring bedrooms to eat their meals. One person did not usually require support but if they were sleepy a senior member of staff said they needed to be monitored to make sure they did not fall asleep with food in their mouth and choke. This risk was not well managed as the staff member was not able to be in both bedrooms at the same time.

We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the signs of abuse and take appropriate action. Staff had received training in safeguarding people from abuse and most were able to tell us what they would do if they suspected or witnessed any of the different forms of abuse. One member of staff was not entirely clear and we fed this back to the manager at the end of our inspection for them to address with that staff member. Information about how to make a safeguarding referral to the local authority was clearly displayed for staff. We saw that the service made referrals to the local authority safeguarding team if they had concerns and co-operated with their safeguarding investigations. However concerns raised at this inspection related to catheter care and moving and handling were not promptly referred.

We noted an entry in one person's daily notes which stated that they had 'bruising at times most likely due to involuntary movements'. It was not documented why the bruising was judged to have been the result of involuntary movement rather than being considered a possible safeguarding matter. We were therefore not assured that any new bruising found on this person would be thoroughly investigated.