Four Seasons 2000 Limited

York Court

Inspection report

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Date of inspection visit: 09/06/2015
Date of publication: 05/08/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service responsive?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 and 20 January 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to safeguarding people, staffing, person centred care, receiving and acting on complaints, good governance and care and welfare.

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

York Court provides accommodation, nursing and personal care for up to 59 older people over three floors. There were 45 people using the service when we visited. On the ground floor there is a mixed nursing unit, with some people who are living with dementia. On the first floor, there is a dementia unit and on the second floor a residential unit for people who are more independent.

There was a registered manager at the service; however he was not managing the service at the time of our inspection. A deputy manager was overseeing the management of the home, with support from a peripatetic manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 our previous inspection we found that risk assessments for people were not up to date, staff were not aware of which people had Do Not Attempt Resuscitation (DNAR) orders in place, incidents of behaviour that challenged the service were not being managed appropriately, and there was a lack of meaningful activities for people.

At this inspection, we found that improvements had been made.

Risk assessments were updated every month and action taken where it was found risks had changed and people needed extra support.

Discussions had been held with people, and if appropriate, relatives, about their wishes with respect to resuscitation in the event of an emergency. A GP had reviewed and signed DNAR forms and where people did not have the capacity to consent, decisions were made in their best interests. Staff were aware of which people had DNAR's in place.

Where people displayed behaviour that challenged the service, staff made referrals to specialist behaviour management teams within the community for specialist input. Recommendations were followed.

A part time activities co-ordinator had been recruited and a staff member was allocated on each unit to take a lead on activities in the absence of the activities co-ordinator. People's care plans had been updated to reflect individual preferences.

At our previous comprehensive inspection on 19 and 20 January 2015 we also found breaches of legal requirements relating to safeguarding people, staffing, person centred care, receiving and acting on complaints, good governance. We will carry out another unannounced inspection to check on all outstanding legal breaches.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had been taken to improve the safety in this service.

Staff were aware of which people did not require resuscitation in the event of an emergency. Care plans clearly identified people who had a Do Not Attempt Resuscitation (DNAR) in place.

Risk assessments were reviewed monthly and appropriate referrals were made where people were identified at being of high risk.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Inadequate

We found that action had been taken to improve effectiveness.

Where people displayed behaviour that challenged the service, behaviour monitoring forms were in place to record these incidents and try to manage them more effectively.

We could not improve the rating for effective from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Inadequate

We found that action had been taken to improve responsiveness to the needs of people who used the service.

A part time activities co-ordinator had been recruited to support the full time co-ordinator.

Care plans had been updated to take into account people's preferences.

We could not improve the rating for responsive from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

York Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of York Court on 9 June 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 19 and 20 January 2015 had been made. The team inspected the service against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service responsive? This is because the service was not meeting some legal requirements.

The inspection was undertaken by an inspector. During our inspection we spoke with five people using the service and five relatives. We also spoke with the quality manager, a peripatetic manager, the deputy manager, seven care staff, and the activities co-ordinator. We reviewed people's care records. We made general observations on each of the floors 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 talk with us.

We reviewed records relating to the management of the service including incidents and accident records. Prior to our inspection, we attended a meeting with the local authority and the local clinical commissioning group to discuss concerns about the service. We contacted health care professionals after the inspection to gather their views.

Inadequate

Is the service safe?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that people were not kept safe from the risks of inappropriate or unsafe care. Staff who we spoke with were not aware of which people did not require resuscitation in the event of an emergency. We found that risk assessments were not kept up to date, and that they did not take account of known risks to people's safety. People's behaviour that challenged was not always managed in a way that maintained their safety and protected their rights.

At this inspection, we found that some improvements had been made.

The service had introduced a visual aid to identify people who had Do Not Attempt Resuscitation (DNAR) orders in place; this proved to be a simple but effective way for staff to identify those people with written agreements. Care plans had a red or green label stuck on them for staff to identify. In addition, during every shift handover there was verbal confirmation of which people had DNAR's in place.

Staff we spoke with confirmed that DNAR's were discussed at handover and they were aware of the label system that had been introduced. Staff on each unit were able to identify which people on their unit had DNAR's in place with confidence.

We looked at a sample of care records and saw that DNAR forms were in place where appropriate and agreed by the person's GP. Where people had the capacity to make this decision, this was recorded on the forms. If people did not have the capacity to make this decision it was made in their best interests by the GP in consultation with relatives where appropriate. One relative said, "I had a discussion with the manager about DNAR." DNAR decisions were reviewed on a regular basis by the GP.

We saw evidence that risks to people were being managed. For example, nutrition risk assessments took into consideration factors including the Malnutrition Universal Screening Tool (MUST) and weight changes. These were accompanied with a dietetic care plan. One person who was at risk of malnutrition was weighed weekly and had been referred to a dietitian. The support plan for this person was to increase certain foods, which was being done. We saw another example where a mobility risk assessment had been reviewed following a fall and actions to prevent future occurrences taken. Another person who was at risk of pressure sores was cared for appropriately when their skin had grazed. They had been given a pressure relieving mattress and were being mobilised every two hours. One relative said, "They have contacted me when [my family member] had a fall, they seem to manage them well."

Care plans were reviewed monthly and any incidents/ accidents were uploaded onto a risk management system called Datix so that trends could be analysed. We requested a printout of all the incidents that had been uploaded onto this system since the previous inspection and saw that staff had been making use of this. We cross referenced some incidents against people's care records and saw that they corresponded.

Although we found that serious concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained and to follow up any outstanding breaches of regulation.

Inadequate

Is the service effective?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that people's behaviour that challenged was not always managed in a way that maintained their safety and protected their rights.

At this inspection, we found that some improvements had been made.

Where people displayed behaviour that challenged the service, referrals were made to the Behaviour and Communication Support Service (BACSS) team, part of the community mental health team for older people. Staff who we spoke with felt that improvements had been made in this area. Some of the comments included, "I feel that things have improved", "We work well with the multi-disciplinary team from the community" and "We have involved the BACCS team, they took a lot of information about people with challenging behaviour and how we can manage them."

Staff gave us examples of people who had been referred to the BACSS team and the type of interventions that had been recommended to support people with behaviours that challenged the service. For example, one person who did not speak English as a first language had a picture translation sheet and life story created. Another person had sessions based around activities that were suitable for them. Staff provided reports for the BACSS team highlighting incidents which were then used to develop care plans for people. We saw evidence that behavioural monitoring forms had been completed for people. One staff member told us, "We write daily reports detailing how they have been behaving." A relative told us, "It has improved, they now they have a better understanding of why [my family member] shouts so much."

The BACSS team were visiting on the day of our inspection reviewing some people using the service. Although we were not able to meet with them, we contacted them after the inspection. They told us that although referrals were being made and there had been an improvement, certain units in the service were more proactive in making referrals than others. They also said that although they had a good working relationship with the service, recommendations they had made were not always passed onto the wider staff team. They said that although key workers were familiar with their recommendations, other care staff were not as familiar which may have meant people were not receiving care and support that was consistent and adequately supported them.

Although we found that serious concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained and to follow up any outstanding breaches of regulation.

Inadequate

Is the service responsive?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that people's individual needs were not being met as people were not participating in meaningful activities and their social needs were not being met.

At this inspection, we found that some improvements had been made.

The acting manager told us a part time activities coordinator had been recruited to help share the workload with the full time activities co-ordinator. They worked one day during the week and one day during the weekend. The activities co-ordinator told us that this had helped them to arrange more suitable activities for people. Staff also told us that one visible improvement had been the allocation of one care worker on each unit to take to take the lead on activities, so that unit staff were not fully dependent on the activities team to provide this input.

We observed an arts and crafts activities session that was taking place on one unit. Five people were fully engaged and enjoyed the activity. Five other people were not engaged but we did see other care staff trying to encourage them to participate. When they did not show any interest, staff respected their wishes. We also saw one person helping to lay the table after breakfast, we asked them if they liked doing it and they said "yes". We saw the activities co-ordinator checking with people in the morning, asking if they wanted anything from the shop.

Other areas of improvements included more attention given to the 'This is me' section of the care plans. This document was used to give information about people based on different aspects of their life, including their history and social interaction. Staff told us, "We updated sections that cover day and night activities, and also social wellbeing", "Each person has a journal in their room where we write how they spent their day" and "We asked families to complete life stories to help us understand people a bit better.

We got mixed feedback from people and relatives about the activities on offer. Comments included, "Very satisfied", "Activities are so-so", "I donated some stuff for bingo", "[member of care staff] does take me out" and "they did ask me if I wanted to go Brighton but I don't want to."

Our observation of activities was that more improvement was required. For example, there was a room allocated as a sensory room but it was not utilised. Some staff told us that they did not always feel confident in running activities in the absence of the activities co-ordinator. Our observation was that it would take some time for this change in working practice to take effect across the service.

Although we found that serious concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained and to follow up any outstanding breaches of regulation.