Four Seasons Homes No.4 Limited

North Court Care Home

Inspection report

108 Northgate Street
Bury St Edmunds
Suffolk
IP33 1HS

Tel: 01284763621
Website: www.fshc.co.uk

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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

About the service
North Court is a care home providing both personal and nursing care to up to 65 people. The service provides support to older people, some of whom live with dementia, younger adults and adults with physical disability. At the time of our inspection there were 42 people using the service.

North Court is close to the town centre of Bury St Edmunds. The home is an ex local authority care home building. There are two floors. Downstairs is for older people living with dementia. They have access to a courtyard garden and a small café that is open from time to time. The top floor is nursing care. Each floor is separately staffed and has a nurse designated to each floor.

People's experience of using this service and what we found
People did not have appetising, well presented food to eat. The kitchens were not managed to a high standard and food hygiene put people at potential risk. Fluid charts showed that one person was receiving a low intake of fluid.

Risks to people were not effectively managed. Risk assessments were not specific to the person and meaningful. Risks relating to moving and handling were not adequately managed. We observed poor practice that placed people and staff at risk of injury. Risk assessment instructions on moving and handling were confusing. Repositioning charts had gaps in them.

The quality assurance system had not been effective in identifying the issues we found during the inspection.

The current manager has had a positive impact on North Court and is liked and respected by staff. But there have been many managers in recent times and the changes and inconsistencies have impacted upon the running of the service. There is no registered manager and the current manager was leaving for another post.

There is still high use of agency (we were told this had reduced) The figures for June compared to May show an increase in agency staff for carers and support staff, but a decrease in agency nursing staff. Agency staff are used to ensure numbers of staff are maintained, but feedback and our observations show negative impact.

Infection control processors were good. There was strong leadership in the housekeeping team and an infection control lead is in place.

Medicine management had clearly improved with learning from past errors. Audits have been effective and appear thorough. Medicines were safely managed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection The last rating for this service was good. (Published 2 November 2019)

Why we inspected
The inspection was prompted in part due to concerns received about medicines, staffing and moving and handling. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for North Court on our website at www.cqc.org.uk.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to quality monitoring and assessing risk at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

North Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors and one Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience made video calls and telephone call to people and their relatives.

Service and service type
North Court is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. North Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who live at North Court and three family members of people who live in the home. We also spoke with the manager, deputy manager and 11 staff.

We reviewed a range of records. This included care records and medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested some further records after we had visited the home so that we could conclude the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risk assessments and care plans did not always contain current information for staff to follow. For example, one person's risk assessment relating to moving and handling to guide staff about their needs and risks was conflicting. Staff were told to use both a medium and large sling. This was further compounded by the fact this person had lost 26% of their body weight.
- Staff were not always following safety procedures to ensure that risks to people were reduced. For example, one person was leaning out of bed. A staff member, when asked by inspectors to support the person, physically pushed them back into bed. This could have caused harm to the person and the staff member. The staff member was not following their training nor the care plan and risk assessment in place that stated two staff should reposition the person in bed.
- Risks relating to people with distressed behaviour were not assessed for each individual. We were aware of two people who did not have plans in place to guide staff. One person was frequently non-compliant with personal care and another person made accusations of abuse. There was insufficient assessments in place or guidance for staff.
- Records that were used and completed as part of monitoring were incomplete. For example, one person's turning chart to prevent pressure sores had frequent gaps. Another person's fluid chart to ensure they were suitably hydrated recorded a daily intake as low as 720mls. This included yogurt as a fluid because of its fluid content. This lack of monitoring and taking actions, put people at risk of pressure ulcers and dehydration.
- Due to staff vacancies there was a high usage of agency staff. Many of the agency staff had worked in the home before and knew people well. The manager was sent a staff profile for each agency member of staff. However, we identified that not all staff received an induction to North Court environment, systems and people. We requested evidence of induction for two agency staff at the time of an incident, which was not available. This could mean that staff did not have the necessary knowledge to support people in a safe way.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Safe recruitment practices for permanent staff were inconsistent. Out of the three staff recruitment records we examined, one had only one reference and one person started work before their Disclosure and Barring Service (DBS) had returned. A quicker process known as DBS adult first is a service available to organisations who can request a check of the DBS adults' barred list. This was not in place either.

● Other pre-employment checks including obtaining references and checks with the Disclosure and Barring Service were in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staffing levels were determined according to peoples assessed needs. There were enough staff numbers deployed based upon North Court's staffing dependency tool and the rosters. This included using agency staff for nurses, care staff and kitchen staff. Statistics on agency usage from May and June showed that agency nurse's requirement had reduced, but care staff and kitchen staff had increased. Recruitment was ongoing. The manager said their biggest challenge was consistency of staff and acknowledged they are redressing the balance in favour of more female staff.
● Feedback about staff numbers and their abilities was mixed. One relative said, "No there are not enough staff evenings and weekends, there is nobody senior here at weekends, but there has to be one nurse." Another relative was concerned that their female relative was supported by male carers they did not know and had requested only care support from females. This was unable to be consistently provided and had a negative impact on the person concerned. Another relative said, "The nurses are excellent."

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.
● People told us they felt safe. Comments included, "I have lived here some years, yes I feel safe."
● Staff had received safeguarding training and knew how to recognise and report any concerns about people's safety and welfare. One staff member said, "I have had safeguarding training and people are safe and I know whom to report any concerns to." The manager understood their safeguarding responsibilities.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely; Learning lessons when things go wrong
● Medicines were safely managed. The records and levels of stock tallied to show people received their medication as prescribed. Medicines were stored safely. Records relating to medicines were well kept. However, one medicine care plan review sheet was confusing and gave contradicting instructions as to whether the persons medicine was to be given covertly or not. This was further compounded by overlapping dates on two forms in use.
● We saw evidence of learning from medicines errors and changes put in place to ensure incidents were not repeated. A new agency nurse who was administering medicines was able to follow and understand the processes and people's medicines profiles as to how people took their medicines.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. People said they were given the medicines they needed.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections. Two relatives commented on how clean the rooms were kept.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was an infection prevention lead who had received training.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to receive visitors of their choice. We met and spoke with visitors on both days of our inspection visits.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's quality assurance system had not always been effective at identifying areas for improvement and ensuring action was taken in a timely manner. There had been a lack of robust oversight to ensure safe care was being provided to people. For example, poor moving and handling of people. Records were not consistently up to date and staff were not following training given.
- People told us on both days of our inspection they did not like the food they were served. We saw it was uninspiring and presented badly. Unneatened food was returned. We inspected the kitchen and found food storage was not safe. Whilst the manager was aware and stated the agency staff, responsible for the catering were not suitable, people were still being prepared food that was not safe.
- Photos of poor food storage were shown to the manager of opened undated food. For example, catering pack baked beans still in the can with no date. Meat was left out of the fridge to defrost. Freezers were full of frosted ice and needed defrosting. Dry goods such as icing sugar, flour and oats were open and at risk of being contaminated. There was a lack of fresh fruit and vegetables. When we checked the ordering of food we saw only bananas and apples were purchased.
- Whilst the manager was dealing with one unsuitable agency cook, the overall oversight of a safe kitchen and listening and acting on feedback from people was not in place.
- There was some learning from events such as medicines management, however learning from events was not sustained over time as the current manager was unaware of learning from previous events prior to their tenure. For example, when a resident went missing, they did not know what had been put in place to prevent a reoccurrence. Once we brought this to the attention of the manager they took immediate action. However, the provider did not ensure this learning was ongoing and communicated through, for instance, a learning log.
- The monitoring systems in place had not identified the issues we found regarding some care plans and risk assessments needing updating.
- The manager welcomed our inspection and accepted our feedback. We were so concerned about moving and handling within the home we asked the provider to tell us what steps they planned to take to address our concerns and mitigate the risks. We asked for a response within five working days, but nothing had been received in that timescale. CQC continue to follow this up.

The systems in place to monitor and improve the quality of the service were not always effective at identifying and sustaining areas for improvement. This was a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The current manager has had a positive impact on North Court and was liked and respected by staff. But there had been many managers in recent times and the changes and inconsistencies had impacted upon the running of the service. There was no registered manager and the current manager was leaving for another post, so we could not be assured any improvements made would be sustained.

● At our last ratings inspection of this service we found shortfalls with the care planning documentation and record keeping in the home. Improvements were needed to people's care records to inform staff on the personalised care and support required. This continues to be the case and risk assessments were not always specific to the person and meaningful.

● Our observations of an agency carer was they were supervising the people in the room rather than becoming involved, enjoying their company and interacting with them. On two separate occasions agency care staff stood over someone rushing them to eat quickly with no interaction. On one occasion the permanent care staff intervened and gave them a chair, telling them to sit down and slow down. There were no verbal interactions. Relatives said agency staff, "Sit in silence assisting my mother with her food." Personalised care was lacking.

● There was poor oversight of recruitment and not all staff were equipped for their role. One staff member who had been there a few months had yet to complete their induction booklet, saying they had been too busy doing care support.

● Feedback from complaints was used to improve the service being offered. A relative said the current manager was listening and had acted upon their care concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Not everyone felt involved in North Court. A relative said agency staff changed and communication between staff was poor. The relative said they had to repeat information several times to different staff. A different relative said, "It's terrible trying to get through to the home on the telephone. The other day, I was trying from 9.10 and I eventually got an answer at 12.45. I don't complain, we've given up."

● The service had worked with organisations including local authorities to make improvements. For example, a high number of medicines administration errors had been reported to the local authority. The manager provided an action plan to reduce the number of errors and this had been successful.

● The provider support team in the local authority had been offering support and training to North Court. This has been accepted well.

● In response to our concerns about food, people were to be surveyed for their feedback. Families had been contacted to better understand their preferences of being involved with their relative's care and support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and care plans did not always contain current information for staff to follow. Staff were not always following safety procedures to ensure that risks to people were reduced. Risks relating to people with distressed behaviour were not assessed for each individual.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system had not always been effective at identifying areas for improvement and ensuring action was taken in a timely manner.