Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

North Court Care Home

108 Northgate Street, Bury St Edmunds, IP33 1HS

Tel: 01284763621

Date of Inspection: 13 August 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed

Details about this location

Registered Provider	Four Seasons Homes No 4 Limited
Registered Manager	Mrs. Elspeth Anne Nicol
Overview of the service	The service provides residential and nursing care to a maximum of 65 people. Some people using the service have specific care needs as they have dementia.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether North Court Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 August 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information sent to us by commissioners of services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

This inspection was conducted to follow up enforcement action taken in April 2013. The service submitted an action plan which cited actions that would be implemented to improve how people were treated to ensure that they were treated with dignity and respect.

We found that the service had improved since our visit in April 2013. We observed some good interactions between staff and people who used the service. We observed some instances of staff kindness and caring ability to support people. We also observed that staff did not interact positively with some people using the service upstairs and that some staff talked about people in front of them and shouted over their heads. Some staff demonstrated a lack of understanding around ensuring the dignity of people living with dementia.

We noted that there had been a change in leadership within the service and the team working at the service including an area manager, peripatetic manager and new home manager were working to ensure the required improvements are made. This showed that the provider was taking concerns raised by the Commission seriously and was acting to improve the quality of the service provided.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 05 September 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not always respected.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our visit on 23 April 2013 evidence gathered on the day of the inspection showed that people's values and human rights were often not respected. We observed poor interactions between staff and people who used the service. Staff spoke over people's heads. They spoke loudly to other staff about people using the service, whilst they were present. People were often not supported in promoting their independence. We observed that four people using the service had lap belts in place whilst they were sitting in chairs without mental capacity assessments in place. People were often not supported to express their views and were often not involved in making decisions about their daily activities and care. Staff offered people using the service little and, in most cases, no choice around food and daily activities. We found that this had a major impact on people using the service and issued warning notices for the breaches and concerns identified.

This inspection was undertaken to determine whether the service had made the required improvements to ensure that people were being treated appropriately, with dignity and with respect. During our visit on 13 August 2013, we used the Short Observational Framework for this inspection (SOFI.) SOFI is a specific way of observing care to help us understand the experiences of people who may not have been able to talk with us. We completed the SOFI in one of the lounge areas downstairs and the dining area upstairs.

We observed the way that staff interacted with individuals over a one hour period and noted how people seemed to be feeling. In the downstairs lounge we observed six people being supported by three staff with their breakfast. We observed staff offering a choice of breakfast options for both food and drinks to people. We found that the three staff demonstrated a better understanding of how to communicate positively with people who were living with dementia. We observed staff engage in conversations with people whilst supporting them with their breakfast at a pace that suited them.

In the upstairs lounge we observed interactions between two staff and three people who

used the service. We saw that interactions between staff and people were positive, staff spoke with people addressing them by their preferred name and offered them a choice of breakfast and drinks and enabled them to choose what they wanted to eat and drink. When staff were interacting directly with people this was positive, however when staff were entering the dining area to collect other people's breakfasts they spoke over people's heads. Staff spoke with each other about people using the service, whilst they were present in the room. In one instance we observed two staff members have a conversation about a person who was present in the room without engaging them in the conversation. This showed a lack of respect for people's dignity and objectified people inappropriately. It also showed staffs lack of concern for people's dignity by using negative language about some residents.

Overall we found the interactions we observed between staff and people using the service to be positive and a notable improvement since our inspection of 23 April 2013 but when staff were speaking with each other in front of people the language used was negative.

We raised our concerns around our observations to the peripatetic manager and also to the new home manager and area manager during the feedback session. All provided us with assurances that they would continue to work to improve this area to ensure that they achieve compliance. They all felt that they could resolve the concerns identified.

We observed two people being supported to eat their breakfast in their rooms upstairs. We saw positive interactions between staff and people who were being supported, staff engaged them in conversation, were polite and offered people choice in relation to the pace of their breakfast regularly checking if the person was alright.

We spoke with four people who used the service. All four told us that there had been a lot of changes at the service. People told us that generally they were treated kindly by staff and with respect. One person told us, "There have been lots of changes in staff but they seem okay, a bit slow at breakfast but I am not complaining." Another person told us, "The staff are very sweet and caring, some good ones here."

During the inspection we saw that some people had gates across their bedroom doors. These were of similar style to child gates. We also saw that people had lap belts in situ whilst sat in armchairs. We found on review of these people's care plans that paperwork was in place to support and authorise their use in accordance with the Mental Capacity Act 2005. The provider may find it useful to note that alternative provisions of support to people could be considered that would enable more respect of their dignity and independence.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services** **How the regulation was not being met:** Regulation 17 1(a) and 2(a) services users were not always treated with respect and their dignity was not always maintained.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 05 September 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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