Hawkfish Ltd

Queen Margaret's Care

Inspection report

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Date of inspection visit: 24 February 2015
Date of publication: 24/08/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 24 February 2015 and was unannounced.

Queen Margaret's Care is registered to provide residential and nursing care for up to 44 people. There is a passenger lift to assist people to the upper floors and the service is located close to local shops with an accessible garden area to the front and side of the property.

The home had a registered manager in place. 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.

Although staff had received training in the Mental Capacity Act (2005) and in Deprivation of Liberty Safeguards, (DoLS), people's mental capacity was not adequately assessed. Because of this the registered

Summary of findings

manager could not be sure that people were appropriately involved in decisions about their care. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe at the home. Risks were managed well, though the emphasis was upon protection rather than maximising freedom. Staff were trained in safeguarding and understood how to recognise and report any abuse. Staffing levels were appropriate which meant people were supported with their care and to pursue interests of their choice. People received the right medicines at the right time and medicines were handled safely.

The home had recently improved the way in which it handled the control and prevention of infection. However, there remained areas of improvement still to be made.

People told us that staff understood their individual care needs. We found that they were supported by staff who were well trained. All staff received mandatory training in addition to specific training they may need. The home had links with specialists and professional advisors and we saw evidence that the home sought their advice and acted on this.

People's nutritional needs were met and they received the health care support they required. They were enabled to make choices about their meals and snacks and their preferences around food and drink were respected.

Staff had developed positive, respectful relationships with people and were kind and caring in their approach.

People's privacy and dignity were respected and they were supported and empowered to be as independent as possible in all aspects of their lives. Staff responded people's care needs and attended to them quickly, politely and with kindness.

People were assisted to take part in activities and daily occupations which they found meaningful.

Staff responded to people in a way which placed them at the heart of care, however, care planning documentation did not always reflect this personalised approach.

People were encouraged to complain or raise concerns. The home supported them to do this and concerns were resolved quickly.

The service was lead in an open way which put people at the heart of the service. However improvements could be made to supporting nursing staff to offer the most appropriate clinical care for people. Staff were at times unsure about how planned changes would affect them and the way they were deployed. They lacked sufficient direction to ensure people always received the care they needed.

The registered manager understood the home's strengths, where improvements were needed and we saw evidence of where improvement had been made.

Systems were in place to assess and monitor the quality of the service and the focus was on continuous improvement.

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?

Requires improvement

The service was safe.

People told us that they felt safe. People had the opportunity to live a full life because of the way risk was managed. However, risk assessments did not always emphasise maximising freedom.

People were protected by the way the service managed the control and prevention of infection. However, areas for improvement were identified.

People were sure they received the right medicines at the right time because medicines were managed safely.

There were sufficient staff who were safely recruited and trained in how to safeguard people.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were trained and supported to meet people's needs. The registered manager supported them to develop professionally in an atmosphere of respect and encouragement.

People had access to healthcare services when they needed them.

People's mental capacity was not adequately assessed. This meant the registered manager could not be sure that people were supported appropriately around their capacity to make decisions about their care.

People were consulted about their meals, their nutritional needs were met and they had free access to food and drink.

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful warm and caring relationships with people, involving them in all decisions. We observed that staff had respect for people's privacy and dignity.

The dining experience could have been improved by offering people the opportunity to sit in the dining room rather than in chairs around the lounges.

Staff supported people to feel reassured. They enabled people to be as independent as possible.

Is the service responsive?

Good

The service was responsive to people's needs. People received individualised and personalised care which had been discussed and planned with them. However, care planning documentation did not always reflect this.

Summary of findings

Staff ensured people's lives were as fulfilling as possible. People's views were listened to and acted upon by staff.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The culture of the service was supportive of people who lived at the home and of staff though the registered manager accepted they could be stronger in their management style to give clear leadership at all times.

While staff understood their roles and responsibilities, lines of communication could have been improved around planned changes to the way staff were deployed.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

There was an effective quality assurance system in place and the registered manager was proactive in seeking out ways to improve. Staff were supported to improve their practice across a range of areas.

Queen Margaret's Care

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.

This inspection took place on 24 February 2015 and was carried out by one adult social care inspector and a specialist nurse advisor. An Infection Prevention and Control Nurse also accompanied us on the inspection. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered more information we needed during the inspection visit. We also reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

On the day of the inspection we spoke with six people who lived at the home, the registered manager and six members of staff. After the inspection we spoke with a health care professional.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission), bathrooms, communal areas and office accommodation. We also spent time looking at records, which included the care records for four people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix and other records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe. They told us that they felt there were sufficient staff on duty to assist them. One person told us, "The staff are always nearby if you need anything." Everyone we spoke with told us that if they ever felt unsure about their safety, staff would reassure them and deal with what was troubling them.

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. When we spoke with staff about this they were able to describe different types of abuse and what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. This gave us evidence that staff had the knowledge to protect people. appropriately.

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had an open and positive approach towards managing risk. For example, one member of staff told us, "We support people to be as independent as possible; such as, when we are helping people to move, if they are able to assist us with standing we encourage them to do this." Another member of staff told us, "If people wish to go out, for example with relatives, we do all we can to make sure they can do this safely."

Staff told us that the person's behaviour which others might find challenging was managed with a positive attitude. One member of staff told us, " If a person becomes distressed or agitated we may return later to offer personal care, or sometimes a change of staff may help. We always look at the person and try to think of why they are upset, rather than the behaviour."

However, while care plans identified a person's level of risk, risk assessments tended to be generic. These were not personalised and did not give an indication of consultation with people or their representatives. Neither did they consider people's level of independence or what support was needed to ensure independence was promoted. Risk assessments did not consider how managing risk may cause undue restrictions, or how to maximise people's freedom.

We checked recruitment practices within the home. Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received on all staff files we looked at.

Staff told us that inexperienced staff were on rota with skilled and experienced staff who could support them. We found that during the day there was always eight care workers on duty, which included at least two senior staff and the registered manager. There would be a clinical lead when this person was in post. We observed that there were enough staff to attend to people's needs and to be relaxed with them during our inspection visit.

The home had a policy and procedure on staff discipline and the registered manager explained how they had used this in the last year to ensure people received safe and appropriate care.

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines. Staff told us they were aware of this and we saw that they had up to date training so that they could handle medicines safely. The home used a Monitored Dosage System (MDS) with medicines supplied by on a 28 day cycle. (A MDS is where medicines are pre-packaged for each person). All cupboards that contained medications were kept secure with coded locks. We saw that medicines, including controlled drugs were recorded on receipt, administration and disposal. The controlled drug recording book was correctly completed and there was evidence of weekly stock checks being carried out. There were clear guidelines in the treatment room regarding re-ordering medication supplies, which stated the day that prescriptions had to be requested, when they need to be received and checked and when the drugs had to be checked in from the chemist. Recording for a chosen sample of medicines was accurate with correct coding used. There were several MAR sheets with hand written instructions for new residents, new medications or short course drugs such as antibiotics. These were not signed by two members of staff and there was no record of who had authorised changes. This meant there was the risk of error and there was no clear line of accountability for changes.

Requires improvement

Is the service safe?

There was therefore a risk that people may not receive the correct medicines. Medicines which required refrigeration were stored appropriately and we saw that medicines were dated on opening when required.

The registered manager told us that medicines were regularly reviewed. This was to ensure medicines were suitable and safe for current needs. Records of care planning reviews confirmed this. Staff were knowledgeable about individual's needs around medicines and any associated risks. For example they told us about pain relief medicines and how these were managed to make sure people received effective pain relief whenever needed.

We saw that the home regularly reviewed environmental risks and carried out regular safety audits.

The service had received a visit from a Community Infection Prevention and Control Nurse Specialist (IPC specialist) from Harrogate and District Foundation Trust in October 2014. This highlighted a number of risks to infection control. During our inspection we were accompanied by an IPC specialist who followed up on the concerns raised at their last visit. They reported separately on their findings. However, they noted that some carpets were stained and difficult to clean. Some wheelchairs were dirty. The covers on some seating were damaged which made cleaning difficult, and there was some hard surface damage to furniture and fittings. In the treatment room the sharps bin was full and a plastic pencil box was being used for the storage of used sharps; this caused a risk of sharps injury. The manager told us that this would be removed and an appropriate sharps storage container supplied by the next day. There was no separate hand wash basin in the treatment room which is recommended for effective infection control . We noted a number of free standing bottles of liquid soap and paper towels on surfaces which posed an infection control risk. However, most bins were now pedal operated and paper towel dispensers were available in some bathrooms and toilets. Cleaning schedules and records and internal auditing of mattress cleaning had been put in place. This reduced the risk of cross infection. The IPC specialist did not consider that the home required a further follow up visit to check on infection control practice.

We saw records of training in infection control which were all up to date. Clear timescales were recorded for when this needed to be updated. We asked two members of staff about infection control and they understood what good infection control practice was to ensure people were protected. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people.

We recommend that the registered manager consults best practice advice to ensure that people are protected by effective infection control practice.

We recommend that the registered manager consults best practice advice on how to consult people about how risk is managed and how to record this in a way which balances protection and freedom.

Requires improvement

Is the service effective?

Our findings

People told us that staff were skilled in caring for them. One person told us, "The staff are kind and I like the meals". We observed a morning break time, and one person told us, "They always bring me the biscuits I particularly like. They know and keep a supply." Another person told us, "There seem to be enough staff, there are always plenty around."

People told us that staff explained things clearly and that there was never any difficulty in understanding one another. We saw that staff communicated with people clearly at a pace and in a manner which helped them to respond.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests.

Care plans were 'tick box' around mental capacity , this meant that there was no narrative about a person's capacity to make decisions. There was no emphasis on the assumption of capacity, which decisions people may have capacity to make and which they may need support with, or how time of day or emotional wellbeing may affect decision making. Therefore the registered manager could not be sure that people would be supported appropriately around their capacity.

We found that the registered person had not protected people against the risk of insufficient assessment of their mental capacity. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, staff had received training in the MCA and DoLS and were able to talk about how to take people's capacity into account when involving them in decisions about their care. We saw that one person had been referred to mental health services and a review arranged, a DoLS application has been made with a view to meeting this person's needs more appropriately.

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they told us they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of people they supported and knew how their needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

In addition to mandatory training, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in dementia care and palliative care to ensure staff had the skills to offer appropriate care for people's diverse needs.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to give the care people needed.

The home had links with specialists, for example with the community mental health team, specialists in nutrition, sight and hearing. This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made when necessary, for example for the speech and language therapy team, (SALT), and specialist involvement from cardiac and neurological services.

The registered manager told us they had good links with local GPs and that they used feedback from GPs and other professionals to help them give the best care they could. Staff confirmed that they actively sought external professional's advice. Records confirmed what they told us. For example, we saw that advice from the community mental health team had been incorporated into a plan.

However, the local authority safeguarding team found that the home had not referred to a health care professional in a timely way to protect the person whose health was deteriorating. The care for this person would have been improved by better communication between staff and a faster response to changing care needs.

Care plans included information about nutritional needs. We observed that people were offered choices at lunch time and the food appeared appetising. We observed staff asking people about their preferences and bringing them

Requires improvement

Is the service effective?

drinks and snacks of their choice. Nutrition and fluid charts were used when necessary to ensure people had the food and drink they needed. We saw that advice from the SALT team around food and drink had been incorporated into a care plan, and that staff had accompanied a person to hospital so that they could support them and understand what advice the specialist was giving. Staff had highlighted if there was any weight loss and this had been evaluated. Where necessary the GP had been informed and supplements and fortified drinks prescribed. Those people who required subcutaneous fluids had this monitored, the GP was involved and records showed how the regime was adjusted to meet specific needs as they occurred.

At lunch time we noted that people were eating their meal with a bed table in front of their chairs in one of the three lounges. This was problematic, as some people had difficulty reaching their meal on the tray resulting in spillages onto their clothes, the chair and the floor. This was due to problems with posture and the difficulty of sitting close to the table. Most drinks were provided in plastic beakers and some people told us they would prefer a hot drink but had not been asked.

Good

Is the service caring?

Our findings

People told us that all the staff and the registered manager showed them concern and empathy and that staff gave them time and listened to them. For example they told us, “They will do anything I ask,” and, “The carers are very nice, they always take time to talk,” and, “They are all helpful, I love it here.”

We spent some time with people in communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff and there was kindness between them as they chatted. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. Staff gave the impression that they had time and spoke with people who were sitting so that they were on eye level with them.

When staff were assisting people with their meals they were focused upon the person, sat by their side and paced their assistance so that people were relaxed about the eating experience. However, staff were sometimes sitting on foot stools or on the arm of a chair to assist which made it difficult to assist people in a way which protected their dignity. The mealtime experience could have been improved if people had the option of using the dining room. The dining room was out of action due to a hair dresser using an adjacent room which meant that this room was on the route for people coming and going. People had their meals in various lounges. In each of the lounges the TV was on and the people were sitting around the edges of the room. This meant people did not get as much opportunity to socialise as if they had the option to sit at a dining table with others.

The way staff spoke with people demonstrated how well they understood individual needs and abilities. All were respectful in their interactions with residents and any visitors. Staff took time and care when they carried out care tasks and activities. Staff explained what they were doing and why and ensured that each person was comfortable when assisting them. We observed that staff visited people who spent most of their time in their bedrooms to ensure that they were comfortable, to offer drinks or snacks or carry out personal care activities.

Staff we spoke with told us that they really enjoyed working at Queen Margaret’s Care and had respect and affection for people, knew them very well and enjoyed the work that they were doing. One member of staff told us. “We have time to go into people’s rooms and chat with them.” Other staff also spoke about responding to each person’s need for care and kindness. One member of staff told us, “It is important to understand what is ‘normal’ for each person. If for example, they are more quiet than usual it may be that they are upset or feeling unwell.”

A health care professional told us, “I have noticed staff being kind and showing empathy.”

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. We saw plans in place for pain relief and close monitoring. Staff told us that when people neared the end of their lives a member of staff was always with them and that staffing rotas were arranged so that this could happen. When people had Do Not Attempt Resuscitation plans in place these were correctly completed with consultation recorded.

Good

Is the service responsive?

Our findings

People told us that the staff responded to their needs. For example, one person told us “I go out with one of the (staff). I only have to ask and they will arrange it.” Another person told us, "They know what help I need and they are really good at looking after me if I feel a bit down or poorly.”

Care plans had a clinical emphasis which meant that some areas of the plan were ‘tick box’. As a result, the social and personal care aspect of people’s care planning did not provide sufficient evidence that it was centred on the person. There was insufficient space in care plans for a narrative about people’s social, recreational and cultural needs with evidence of consultation with people about this. This meant that the registered manager could not always be sure that care plans reflected the personalised care which people and staff told us they were given and which we observed during the inspection visit.

Staff told us that they included people in their monthly service review and asked them how they could make things better for them. However, the recording did not always include detail of people’s involvement in their monthly review.

We observed that staff gave care in a personalised way. People we spoke with told us that they had been consulted about what was important to them regarding their care. Risk assessments were also agreed with each person when this was possible and people told us that updates were made in consultation with them when risk levels changed.

The registered manager and staff described an approach which was focused on the individual. The emphasis was upon meaningful engagement which enhanced quality of life and helped people feel worthwhile. One person enjoyed attending a day centre before admission and was supported to continue with this weekly visit . Staff told us that they carried out group and individual activities with people according to their interests. For example, one person was supported to visit a local pub, and staff accompanied people for café visits or trips to a local garden centre.

In addition to individual activities the registered manager organised group trips in the warmer months to places of interest including outings to the sea front for an ice cream. We spoke with a member of staff who told us about offering craft therapy to people. For example, people had created attractive glass candle holders and various other art works. Staff assisted people with knitting skills, played dominoes, and celebrated special days with themed events such as the recent Chinese New Year on February 19, with Chinese decorations and food. The home had a ‘music for health’ plan which emphasised the positive effects of music on people’s wellbeing. This took the form of external musicians visiting the home and internal music sessions with sing- alongs. During a recent local ‘war weekend’ the home had invited people who had dressed in World War Two costume to visit the home and to entertain the people who lived there.

Staff told us that key workers consulted with people about their preferred clothing and when they did not have a representative to assist them people had the opportunity to accompany staff on shopping trips. Staff also told us that there were regular aromatherapy sessions and that they had a regular visitor who brought a dog which people could pat.

The registered manager had put plans in place to ensure that people did not feel lonely in their rooms. Staff told us they had time to visit each person if they preferred to remain in their room most of the time.

The registered manager had organised for a person to have a page magnifier so that they were able to read clearly and staff told us about people who had a talking book service and library visits so that they could benefit from listening to and reading books.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though all told us they had never made any formal complaints. The staff told us that they encouraged people to speak up if they had any concerns and confirmed that people were confident to do so and would tell them if improvements were needed. We saw a log of complaints with actions recorded and learning points for the future.

We recommend that the registered manager consults best practice advice on creating personalised care plans and reviews.

Requires improvement

Is the service well-led?

Our findings

People we spoke with confirmed that efforts were made to hear and act on their views and that the manager was visible around the home. For example one person told us " (the manager) is always around and asks me how I am."

Staff told us that the registered manager was approachable and supportive and that they were keen to listen to them and take their comments on board. The registered manager worked with staff so that any areas of concern could be quickly resolved. Staff told us that the culture values and ethos of the home was understood by them all and that the manager was clear about the need to improve so that each person was placed at the heart of care.

Staff told us that they received a detailed handover at the start of their shift where changes in care plans were discussed. They told us they all had access to care plans and there was a plan of care activity for each day so staff were clear about their responsibilities. Staff told us this was a good system which worked well.

However, staff also told us that the manager was "nurturing and kind" and that sometimes a stronger management style might be more effective. The manager agreed that they sometimes could be stronger in their leadership to assist staff to be clearer about upholding the values of the home. Changes were planned to the way senior staff were deployed and staff told us this had caused some on-going disquiet. Staff also told us they were unsure about what management long term plans were and how the new roles were going to work on a day to day basis. This meant that staff did not always benefit from strong or directive leadership which would have enabled them to move forward in a more positive way.

Staff told us that the registered manager actively sought their views both in meetings and informally, which gave them the opportunity to exchange ideas. They told us that suggestions were appreciated and encouraged. The manager and staff spoke about looking for ways to improve the quality of life for people who lived at the home. However, staff emphasised that because there was no clearly identified clinical lead at present, the nursing staff did not feel they had the direction they needed regarding clinical care. There were plans to employ a member of staff to take on this role. Staff were clear about the current scope and responsibilities of their role, and added that they would always feel confident about asking the registered manager about anything they were not clear about.

Staff told us they felt valued and that every voice was respected. This included everyone who lived at the home, all staff, including ancillary staff, visiting health and social care professionals and visitors alike.

Notifications had been sent to the Care Quality Commission by the service as required. We saw records of the notifications kept at the home, with actions recorded to ensure people were protected and that learning was taken into account for the future.

The registered manager carried out audits on areas of quality and safety within the home and we sampled the results of a medication audit, an infection control audit, and other checks associated with a safe environment. We saw written plans where the need for improvements had been identified; for example, where there had been occasional gaps in recording for the administration of medicines. The registered manager told us that the results of audits were discussed in meetings and informally so that all staff were made aware and any shortfalls were addressed to improve the overall quality of the service. Staff told us they were kept informed, up to date and consulted.

We recommend that the provider and senior manager review how direction is provided to the staff group.

We recommend that clinical staff receive the support they require to ensure people receive the care they need.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People were not protected because the provider did not have suitable arrangements in place to assess people's capacity to make decisions with regard to their care.**