Margaret Court Limited

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Inspection report

Main Street
Tiddington
Stratford Upon Avon
Warwickshire
CV37 7AY

Date of inspection visit:
25 July 2018
26 July 2018

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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**

Summary of findings

Overall summary

An announced inspection visit took place on 26 July 2018 and we announced our return on 27 July 2018.

Margaret Court is registered to provide personal care to older people. Care and support was provided to people at prearranged times in a specialist 'extra care' housing service. Margaret Court consists of 44 apartments and six bungalows. People living at Margaret Court share on site facilities such as a lift, lounge, library, dining room, laundry and a garden.

Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. At Margaret Court, each person exclusively owns their own home and the building is designed to enable and facilitate the delivery of care and housing related support to people now, or in the future. The provider is based at Margaret Court and provides emergency support to everyone living there. Planned day to day personal care can be provided by staff based at this site or from other agencies who provide personal care and support packages. Not everyone living in extra care housing receives regulated personal care.

People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection only looked at people's personal care service provided by Margaret Court.

At the time of this inspection visit, Margaret Court staff supported six people in six apartments. Therefore, for this inspection, we only looked at the care and support for those six people receiving personal care from this provider. All six people continued to be independent and did not have any complex care needs.

The service had a registered manager. 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.

At our last inspection we rated the service Good overall, however at this inspection we found some aspects of the management of the service required improving so the overall rating has changed to Requires Improvement. In 'Well led' we found a lack of evidence and embedded practices that had not identified some of the concerns we found that has resulted in one breach of the regulations. We found evidence in 'Safe' that had potential to place people at unnecessary risk. Where risks associated with people's health and wellbeing were known, there was no information to tell staff how to manage those risks. Some risks for particular health conditions were not included within care plans and staff's practice of administering medicines was not in line with NICE guidance, which had potential for staff not to provide consistent support.

People were pleased and satisfied with the quality of care provided by a consistent, kind and caring staff team. People and relatives were complimentary of the service and staff and people said there were enough

staff to provide them with the care and support they needed, at the times they preferred.

People were supported to remain as independent as possible so they could live their lives as they wanted. People made day to day choices about what they wanted to do for themselves and how they lived their lives. People were encouraged to maintain important relationships with family and people built friendships with others living at Margaret Court.

Care plans were not person centred and did not contain all of the information required for staff to provide consistent and safe care. For people assessed as being at risk, care records did not include important information for staff to help minimise risk. When people's needs changed over time, there was no updated care plan or process to ensure staff delivered care in line with those changing needs which meant there was an inconsistent approach in how staff supported those individuals.

Staff knew how to keep people safe from the risk of abuse. Staff and management understood what actions they needed to take if they had any concerns for people's wellbeing or safety. People told us they felt safe living at Margaret Court and felt relaxed when staff provided their support.

Care staff did not always receive sufficient training to effectively meet and support people's health conditions and the lack of effective management of training meant refresher or essential training was not completed within the provider's expected timescales.

Staff worked within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where 's capacity was fluctuating, staff's knowledge ensured people received consistent support so the right decisions and outcomes were made. Care records needed better documentation to show what decisions people had limited capacity and understanding to make. Staff told us they sought people's consent before they provided care and support and recognised this was an important part of their role in promoting choice and independence.

People received support from other healthcare professionals and relatives told us they were notified whenever changes in their relative's condition had happened, and health professionals were referred to for advice and treatment.

Some people took responsibility for their own medicines management while staff supported others. For those who needed staff support, there was no effective management to show medicines were stored safely, and given as prescribed.

The registered manager could not provide us with any examples of completed audits and checks that gave them and the provider confidence people received a safe, responsive and effective service. We asked to look at audits for incident and accidents, analysis of falls, care plan audits, complaints, medicines and survey questionnaires to see how actions had been taken to drive improvements. However, these records were not completed so we could not be confident, actions would be taken to make improvements to the service people received.

Further information is in the detailed findings below.

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.

People's needs were assessed but risks to their safety were not always identified, recorded and followed. Staff knew about safeguarding procedures and understood what action to take if they suspected abuse. Some people received their medicines from staff, however some staff were not trained in line with the provider's expectations. Records could not demonstrate staff were assessed as competent to give medicines and for medicines given 'as and when', there was no guidance for staff to ensure they were given safely. There were enough staff to meet people's needs and people's care hours were provided at the times people needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always trained to meet people's needs and some staff new to the provider, had not received training. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and supported people to make their own decisions. However, there was limited evidence to show when decisions should be made in people's best interests or with the support of those closest to them. People were supported to maintain their health and staff involved other health professionals when needed.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems used to monitor the effectiveness of the service were not effective and a lack of managerial scrutiny and

oversight and sufficient records meant we could not be confident actions were taken or improvements had been identified. Systems to monitor known fire risks, medicines checks, staff training, care records and learning from accidents and incidents required further improvements to ensure people received a good quality service.

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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 announced comprehensive inspection took place on 26 July 2018 and 27 July 2018. We told the provider we were coming so we could speak with people using the service, with their consent, and to speak with staff. Both inspection visits were carried out by one inspector.

Before the inspection visit, 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 found the PIR was not sufficiently detailed, nor had it identified the issues we found during our visits. We asked the registered manager during our visits to tell us what they had recognised worked well for people and what they had identified they wanted to improve.

We looked at information received from statutory notifications the provider had sent to us and from commissioners of the service. Commissioners are representatives from the local authority who provide support for people living at this location. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection visit we spoke with two people living at the service who received personal care and a relative on the day of our visit, by telephone. Other people receiving personal care were either out for the day or we were unable to speak with us.

We spoke with the registered manager who was responsible for the day to day management of the service and a deputy manager responsible for how the care shifts and care records were managed. We also spoke with two care staff.

We reviewed three people's care plans, daily logs and medicines records to see how their support was planned and delivered. We were unable to review the records of the checks the provider and registered

manager made because they had not been completed.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we rated this area as 'Good' because people felt safe living at Margaret Court and they were supported by enough staff to meet their needs. People we spoke with told us they felt safe living at Margaret Court, especially when staff came into their home to support them with personal care. People told us they had built up good relationships with staff and other people living there, so felt relaxed and safe in their company.

We found staff kept people safe and protected from poor practice. Staff knew the actions they should take if they had any concerns about people's safety. One staff member said, "I would report it to the manager or higher if it was them." However, staff were not confident who to report it to outside of the provider. We shared this with the registered manager who agreed to remind staff about the local authority, safeguarding protocols and CQC. The registered manager knew the actions they would take to safeguard people. There had been no notifications made to us indicating people were at risk of harm.

People and a relative said there were enough staff to meet their individual needs and that their care was provided by 'familiar faces'. One person said, "I see the same faces which helps, they know what I like." A relative said sometimes staff stayed longer than the planned care call to ensure everything was completed and that support was provided by a consistent staff team. People told us they did not feel rushed and whenever they wanted or requested help by pressing their call alarm bell, support was given without delay.

Staff said there were enough staff to help people and staff also said the timing of their care calls meant they were able to stay longer if people needed more time with their personal care. The registered manager was confident staffing levels were right because they were able to cover all care calls at the scheduled times. The registered manager said they had flexibility to increase staffing levels if needed so they could continue to support people's needs.

Risk assessments did not always reflect people's support needs or had not been completed which had potential to put people at unnecessary risk. For example, the provider's accident and incident records showed one person had fallen six times from April 2017 to 2 March 2018. The provider began supporting this person with personal care from 3 March 2018, but the person's records did not record their history of falls, how staff should reduce the risk of falls and the actions staff needed to take, to limit the potential of further falls. We spoke with this person who said they now had a walking frame which they found reduced their risk of falling. However, there was no record of this person's mobility or use of equipment to ensure they mobilised safely or to remind staff, to promote the use of a walking frame.

Risks for individual moving and handling, transferring, the use of equipment when providing personal care or risks within people's own home environment were not considered and recorded. We asked staff how they supported people with managing known risks. Staff responses were inconsistent and in some cases, staff were not aware what individual risks people faced or what to do when supporting them to manage those risks.

Risk assessments did not influence individual care records which we found lacking in detail. There was no specific care plans that we would expect to see such as what to do on each care call, how people preferred support in line with their wishes and routines and what help people needed from staff. For people who had limited mobility, there was limited information about how staff ensured they transferred or moved around their home safely. We raised our concerns with the registered manager who assured us they would improve their risk assessments and care records to make them more detailed and focussed on people's needs.

The registered manager did not complete any accident and incident analysis so we could not be confident when incidents occurred, actions were taken to reduce further similar incidents. For people at risk of falling, there was no evidence to show the cause or actions to prevent similar falls. We asked the registered manager why they did not monitor accidents and risks to people. They were unable to give us an explanation or reason why they were not completed.

People raised no concerns to us regarding their administration of medicines. However, staff and the registered manager's understanding of prompting and administering medicines was not always consistent and NICE guidance for safely administering medicines was not always followed. Staff administered prescribed medicines to the majority of people who received personal care. Staff completed medicine administration records (MAR) but in one medicine record we found a gap and there was no explanation given to show whether or not the medicine had been given.

Medicines given on an 'as and when required' basis were administered to people, but there was no guidance in place to ensure staff gave people these medicines safely and consistently. Safe practice is to record dosage amounts within specified time periods so staff do not give people too much medicine or too often. Staff applied prescribed creams and patch medicines to some people but did not complete any records to show when and where these types of medicines had been applied. Patch records are used so staff are consistent in where to apply certain prescribed medicines to reduce the potential for irritation. This meant we could not be assured people's medicines were given in line with manufacturers' guidelines. We spoke with two care staff about where and what creams they applied and were given inconsistent responses with where and how many types of creams were applied to one person.

People's medicines were not always given by trained and competent staff. Some staff had not received medicines training from the provider, other staff had not received refresher training since 2014. We asked the registered manager if they had assessed staff as competent to administer medicines. They told us there were no checks or records made on staff competency, or checks on their practice so they could be assured, people received their medicines safely. Whilst we had no evidence to show people had come to harm and that people were able to make informed decisions about their medicines, we raised these shortfalls with the registered manager. They assured us they would implement safe practices and ensure staff were trained and competent so people received their medicines safely.

The registered manager told us they rectified any maintenance issues and completed regular fire checks within the home environment. We saw a fire authority visit in May 2016 identified two concerns with the premises that were not meeting fire safety standards. We checked and found one concern still failed to meet the fire authority's recommended action and the registered manager said they would take action to rectify this without delay.

People told us staff helped them with cleaning tasks within their own home. A relative commented how clean their relatives home was, as well as how their family member was always clean and well presented. Care was provided in people's own homes so we could not see staff apply their infection control practice. However, staff knew how and what to do to limit the risk of infection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we rated this area as 'Good' because people told us staff knew how to support them effectively. At this inspection we found staff were not always trained or knowledgeable about supporting some people in line with their assessed needs. We have changed the rating to 'Requires Improvement'.

People were unable to tell us whether they felt staff were trained, but they said whenever they received support from staff, their actions and how they were supported showed them staff knew what to do.

Speaking with staff about certain topics and health conditions showed us they were not always accurate or consistent. For example, staff were confident to report safeguarding but were unclear who to report it to outside the provider. We asked them general questions related to risk assessments, nutrition, mobility, moving and handling and medicines for people in their care. Staff responses were inconsistent and in some areas, they were unable to provide us with a response.

The registered manager completed a training schedule to record staff's training and when specific refresher training was due. This document outlined the provider's expectation for certain types of training and when this should be refreshed. Staff training was not completed in line with expected timescales. We spoke with one staff member who had been at the service for almost 12 months. They told us they had not received any training with this provider, and relied on their knowledge from training with their previous employer. The training schedule showed us some training had not been refreshed and annual observations for moving and handling had not been completed since February 2014. This meant we could not be confident staff had up to date knowledge to support people in line with current practice and guidance.

For people with certain health conditions, we found staff had a lack of awareness and knowledge. Staff's understanding of supporting people who were at risk of falling, or those who had limited mobility was not always consistent.

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 Act 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 MCA. The provider had not referred any people for a community DoLS because people had no restrictions on their freedoms. People could leave Margaret Court without any restrictions or direct supervision from staff. People had 'key' access to their homes 24 hours a day so they were not reliant on staff letting them have access to their home.

People's capacity to make informed decisions, was not always recorded for those with a cognitive impairment. In the care records we sampled we could not see people's capacity to make some decisions had been considered, or included within a specific care plan to show what decisions needed to be made in the persons' best interest or with support of family members. However, people and relatives told us they

were included in their care decisions.

Staff told us some people had limited capacity and they explained how they continued to promote choices, even if people did not always understand. Staff told us they promoted visual choices such as what to drink, eat or wear and this helped people make an informed decision. For other decisions where capacity varied, a relative was their legal representative and records showed they had the legal authority to be involved in health decisions. We spoke with one relative who told us the staff were very good at keeping them informed about any changes or decisions and were always proactive rather than reacting to issues once they had happened.

People's apartments had their own kitchen area and they were encouraged to prepare their own meals and drinks where possible, to promote independence. Where people could not do this, staff helped prepare meals and encouraged people to eat a balanced diet. Some people visited the communal restaurant and could choose from a menu with two options and if this was not to their taste, alternatives were provided. People told us the food was very good and plentiful and they enjoyed the 'social occasion'.

People had access to other healthcare organisations and people told us they or their family would make any healthcare appointments, however staff could also do this on their behalf. Staff told us whenever people experienced any pain or discomfort they informed relatives and considered contacting the GP. All those people receiving personal care could voice their concerns and staff followed people's request by contacting family or other healthcare professionals. One relative told us they were always informed when changes in their relative's health had been noticed.

Good

Is the service caring?

Our findings

At our last inspection, we rated this area as 'Good' and we continued to find people received a service from staff that were kind and considerate. People were relaxed in the company of staff and two people and a relative told us they felt the staff team were kind, patient and supportive. Both people we spoke with told us they enjoyed living at the service and the relative said the care their family member received was, '"Amazing." One person who used the service said, "It is marvellous, they are all very good and I am absolutely happy."

Because care and support was delivered personally to each person in their own home, we could not see first-hand, how staff engaged with people. However, when we spoke with staff and the registered manager about those people in their care, they spoke about people in a caring and respectful manner. We asked care staff what qualities they had and what delivering a 'caring' service meant to them. One staff member responded, "Patience" and explained that good care was working at people's own pace, not rushing them. They told us they had time to support people and if they needed extra time to finish supporting people they were able to give it. Another staff member said their role was to look after people and give them the time they needed. Both care staff told us the Margaret Court had a good atmosphere which made for a caring and relaxed service.

People told us they were supported to be as independent as possible. People told us they continued to want to do things for themselves, and the little things staff did for them meant they could still do some things independently. For example, one person needed staff to 'put their socks on' but said they could still wash and dress themselves. This person said they wanted to continue doing this whilst they were able to, and staff recognised this. This person said they made their own breakfast but if they needed help, staff were on hand to provide assistance.

Both staff told us they found promoting people's independence rewarding so people continued to do as much for themselves as possible. One staff member said, "You can't take it (independence) away and once you take it away, you are affecting their rights." Staff told us they enjoyed working at Margaret Court and cared a lot about the people in their care.

People told us they continued to feel comfortable when care staff supported them with personal care. We asked people if they had expressed a choice of gender of staff. People told us they had not, but were comfortable with those staff who assisted them. People said although they had not been asked, they did not mind and this was not a concern to them. The registered manager said they did not have male care staff and no male care staff had applied during a recent recruitment drive. The registered manager had not considered asking people as part of their pre- assessment process but agreed to consider this in future.

Good

Is the service responsive?

Our findings

At our last inspection we rated this area as 'Good' because people received a service that was responsive to their needs and continued to promote their social inclusion. At this inspection we found the service continued to respond to people's health, emotional and social needs, however care records required more information to ensure staff continued to provide a responsive service.

People had capacity so they could direct care staff to the help they needed so we were confident, based on what people told us, staff responded to their wishes and requests for support. However, we reviewed three care plans and found a lack of person centred information about people, their life history and their overall health. Care plans did not always record people's diagnosis, what was required on each care call and some care call timings had changed which was not reflected in people's care plans.

Staff told us they were consistent in who they supported which meant they got to know the person, what they needed, and if there were changes in their health and moods, they would notice. Staff said if there were changes in people's support needs or they needed longer calls, they were informed by the registered manager and deputy manager at a handover. Staff said they communicated well with each other and with family members so any changes in care delivery would be acted on. People told us care staff were always asking them if there was anything else they needed and they would tell staff if they needed additional support. A relative told us they had not seen a care plan in their relative's home but was confident staff provided what was required.

People were supported to maintain relationships with their friends and families if this was what they wanted. The registered manager said people and their relatives had a key fob which meant they could visit whenever they wanted, without restriction. A relative said they visited when they wished to and knew staff were on hand to provide any support required. They told us of one example where staff had sought equipment such as a wheelchair and a shower chair to 'make life easier'. They said they were, "Very lucky" having their relative at Margaret Court. They said they were confident their relative was well looked after and if there were any changes, they would be contacted without delay. People said if they needed help or asked for support in between care calls, staff assisted them.

People told us they had forged positive relationships with others and we saw people sat with the friends they had made. People used the communal areas of the home to sit, relax and chat with each other. People said having meals in the dining room made a pleasant and social occasion and they got to see others and engage in conversation. People said they enjoyed meeting others which reduced their chance of becoming isolated and they enjoyed the luxury of choosing to stay in their home or joining others. During our visit we saw people use communal areas to sit and watch what was going on, to read books and newspapers and some people sat together in the lounge area having a chat.

The registered manager said there had not been any complaints. People and relatives were complimentary to us about the service and felt no need to raise any issues. If they did, they knew who to speak with and were confident their concerns would be addressed.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we rated this area as 'Good' because a programme of audits and continuous feedback from people helped ensure the service met people's expected needs. At this inspection we found the rating had changed to 'Requires Improvement'. This was because the provider did not have consistent and effective measures to ensure the service maintained good standards and the lack of managerial oversight had not identified the concerns and quality issues we found. Because of our concerns, there was a breach of the regulations.

People and relatives were complimentary about the management of the service and felt the provider was approachable and if actions were needed, they were listened to. One relative told us how staff had arranged for equipment to be given to their relative, without them raising it which they found extremely thoughtful.

During our inspection visit we identified a lack of proactive management and leadership from the provider that affected the quality of service provided. For example, the registered manager told us the provider had identified the role of a senior person to provide increased support to the registered manager. There was also a senior manager who ensured the registered manager fulfilled their role and responsibilities and effectively completed their audits, checks, management of staff and training. The registered manager said both these managers had been off for periods of time and there had been no action taken to backfill these posts to ensure important tasks were completed. The registered manager was not solely citing this as the reason, however it was evident they needed support and guidance to fulfil the provider's regulatory responsibility.

Systems for the oversight of care plans and risk assessments were ineffective. The deputy manager and the registered manager reviewed care plans annually or when changes were needed. Some care plans reviewed in November 2017 failed to identify the lack of information and risk management that we found. There were no structured audits that recorded what should be checked, when and what actions had been taken.

The registered manager's audit process did not record what systems they checked. We asked for a number of audits we would expect to be completed which assured the provider that the service was good, safe, effective and well managed. For example, we asked for audits for medicines, care plans, risk assessments, health and safety, and records of how they sought feedback from those they provided a personal care service to. We were given no records. We asked why, and the registered manager said, "I am not going to lie…I don't record them."

We found one gap in a person's medicines record but there was no evidence to show why and what they had done to reduce this from happening again. Training records were not always up to date to record when staff had completed their training. The records, together with the responses from staff, meant we could not be assured that staff had completed all the training necessary to meet people's needs safely and effectively. We discussed this with the registered manager who was confident staff knew how to care for people. The registered manager said following conversations with a senior manager, the provider had considered changing the training provider, but progress was slow and as a result, training had not been completed.

The registered manager told us they reviewed daily logs, but there was no record of what they had checked. We looked at examples of daily records and found some of these records for the frequency of visits, did not match people's call schedules. Although people told us they received their calls when required, the provider's records did not support this.

Health and safety checks of the communal areas were completed, however risk assessments of people's own home environment had not been completed. The registered manager said they completed regular fire safety checks however they had not complied with a fire authority visit from May 2016. We discussed this with them and they agreed to rectify the risk without delay.

The provider did not have effective arrangements in place to monitor, improve and evaluate feedback about the quality, safety and welfare of people using the service. This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider displayed a copy of the report in their office from their last rating inspection and the provider's website also had a link to our website for people to refer to.

We had not received any statutory notifications from the registered manager. From our discussion we found they were not clear when and what to refer to us in line with their legal requirements. We advised them of the regulations and gave typical examples of what we would expect them to notify us about. We did not find any examples where we should have received a statutory notification.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).