Care UK Community Partnerships Ltd

Muriel Street Resource Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 29 September and 11 October 2016 as a result of concerns that we received and an increased level of safeguarding adult's notifications since April 2016. The concerns related to medicines management, falls management, skills and knowledge of staff in relation to supporting people with mental health conditions and dementia and the general quality of the care being provided at the home. This report covers our findings in relation to the concerns recently raised and issues we found during the inspection. At our last comprehensive inspection in June 2015, we found that the service was meeting all of the standards that we inspected.

Muriel Street Resource Centre provides nursing care to men and women with a range of needs including physical disabilities, dementia and mental illness. The home is able to accommodate a maximum of 63 people over three floors.

The home did not have a registered manager. However, there was an interim manager in post at the time of our inspection. 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.

The previous registered manager had left the service in December 2015. Since this time, there had been one permanent and three interim managers at the home. One of the interim managers left after our first visit on 29 September 2016 and a further interim manager was in post on our second visit on 11 October 2016. We were advised that recruitment was underway for a permanent registered manager and that the provider was awaiting final recruitment checks.

Managers and staff were not always aware of people's status in relation to methicillin-resistant staphylococcus aureus (MRSA) infections. Infection control procedures were not always in place or being followed to ensure the safety of service users and staff.

Disclosure and Barring Service (DBS) checks were carried out before staff commenced working with people to ensure their suitability for the role. However, effective systems were not in place to monitor that the rechecks took place as well as following up on positive DBS outcomes. A positive DBS is disclosure and barring check that may reveal a matter that might impact on the suitability of an individual to carry out their role.

Agency staff including nurses did not always have appropriate identification when working at the home. Managers on duty at the home were unaware if staff had the qualifications, competence, skills and experience to carry out their role safely.

People had an up to date Personal Emergency Evacuation Plan (PEEP) on their record. However not all staff

were aware of the systems in place to safely evacuate people in the event of a fire.

Supervisions and appraisals for staff were not always consistent. Mandatory training was provided and 70% of staff were up to date with most of their mandatory training, however only 52% of staff had received the face to face fire safety training and 59% of staff received face to face moving and handling training.

Staff were not always appropriately deployed to meet the needs of people staying at the home.

Support was not always person centred and appropriate to people's needs and preferences

A combination of a lack of day to day management oversight and the frequent change of managers within the home had led to an unstable management structure. Feedback received from a health and social care professional and relatives indicated that the lack of consistent management had impacted on communication with them.

There was a relative's survey completed for 2016. The general satisfaction level had declined in all areas since the previous survey in 2015. Amongst the lowest scores were, making new residents welcome, the laundry service and making the most of residents capabilities at the home. An action plan had been devised to target and monitor improvements in these areas.

We identified four breaches of regulations relating to infection control, checks in relation to fit and proper persons employed, staff supervision and training and person centred care. You can see what action we have asked the provider to take at the back of the full version of this report.

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. Infection control procedures were not always in place or being followed to ensure the safety of service users and staff.

Effective systems were not in place to deal with staff who may be no longer fit to carry out the duties required of them.

Staff were not always appropriately deployed to meet the needs of people staying at the home.

Appropriate arrangements were in place for the safe administration and storage of medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Supervision and appraisals were not always being carried out consistently.

Staff face to face training in moving and handing and fire safety was not up to date.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans included a summary of people's support needs, healthcare issues, communication, and personal hygiene. However, they were not always person centred to people's needs and preferences.

Care plans were reviewed by staff monthly to take account of any changes in a person's condition or circumstances.

Is the service well-led?

Requires Improvement

The service was not always well led. The home did not have a registered manager. There had been four interim managers since the previous registered manager left. This had an impact on continuity and leadership of the home.

Communication between management, health and social care professionals and relatives was not always effective.

Recent surveys had been competed for relatives and staff and action plans had been put in place to monitor improvements.

Muriel Street Resource Centre

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.

We carried out an unannounced focused inspection of this service on 29 September and 11 October 2016 as a result of concerns received by the Care Quality Commission and an increased level of safeguarding adult notifications The concerns related to medicines, falls management, the skills and knowledge of staff, the quality of the care provided and the increase in safeguarding adult's notifications. This report covers our findings in relation to the concerns recently raised and issues we found during the inspection.

During our inspection we spoke with seven people using the service, five relatives who were visiting and eight members of staff including three nurses, five care assistants, the interim manager, two operational support managers and the interim clinical support lead. After the inspection we spoke with the regional director. Prior to our inspection, we spoke with commissioners for adults in Islington and the safeguarding adults leads.

We reviewed five care records, five staff records as well as policies and procedures relating to the service. We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

Requires Improvement

Is the service safe?

Our findings

We saw the home was not adhering to safe infection control practice, which put people at risk. On our first visit, a care worker was observed carrying soiled linen under her arm to the sluice room. She was not wearing gloves and was holding a person who was using the service by the hand. We saw that she did not wash her hands afterwards and continued to hold the persons hand. We also noted that six hand sanitizer's dispensers were empty in ten rooms we visited. Staff with told us they were expected to use them. They also confirmed that sanitizers were empty on a regular basis and they made regular requests to management to have them refilled. One staff member told us that the person responsible for changing them had a special key and they had not been at work. On our second visit we spoke to relatives, who told us they always used sanitizers if they were available as they saw it as added protection for their family members and others at the home. They also told us that hand towel dispensers at the home were often empty and reported an incident where hand towels had been unavailable in a communal area for over a week. We discussed this with the manager and they told us they were arranging for a maintenance person to come from another home to refill the dispensers and they would also ensure that hand towels were regularly refilled.

We observed a nurse completing the medicines round on the first morning of the inspection. We saw the nurse dispense tablets from a plastic medicine spoon. There were only three plastic medicine spoons on the trolley. Once the plastic spoons had been used, the nurse used the same metal teaspoon to administer medicines to four people. The nurse then realised that this was observed by the inspection team and rushed the trolley back to the clinical room. We accompanied the nurse to the clinical room and once there, we asked as to whether she thought it acceptable that she had used the same spoon. The nurse said no but there were no more plastic spoons left. She then went to the kitchen and was given four metal teaspoons and one soup spoon which she rewashed between administering medicines to people. We discussed this with the interim manager, who told us that they had run out of plastic spoons but they had now been ordered.

On the first day of the inspection, the acting manager and operational support manager were both unclear as to whether a person's leg wounds were still MRSA positive and the care plan did not clarify this. On 12 June 2016 was the last entry that stated that the person was MRSA positive and should be 'Barrier Nursed' (Barrier nursing is a set of stringent infection control techniques used in nursing).There was no other recording of this after this date. However, we saw no procedures in place regarding infection control, for example a specific linen bag and clinical waste bag in the person's room. We were not informed in advance of the person status and to follow infection control procedures. When we returned on the second day, we were told that a swab had been taken the day before and we saw that infection control procedures were now in place. We were informed after the inspection that the swabs had come back negative for MRSA. This meant that the person was being wrongly treated in terms of infection control for MRSA because staff had not appropriately considered test results and carried them through to the care plan. It was only after we raised the issue that action was taken.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Disclosure and Barring Service (DBS) checks were carried out before staff commenced working with people to ensure their suitability for the role. However the provider's policy states, 'Where relevant renew their DBS certificate at regular intervals (typically this would be every 3 years proportionate to the risk) dependent on their role'.

Information sent to us following a request after the inspection found that seventeen members of staff had not had a DBS renewed after the three year period. Systems were not in place to monitor that the re-checks took place.

We heard from the Regional Director on 14 October 2016 that risk assessments were being undertaken and process had been put in place to ensure that re-checks were done as soon as possible.

A recent safeguarding case highlighted that a nurse at the service had continued working, despite having a positive DBS recorded in October 2015. A positive DBS is disclosure and barring check that may reveal a matter that might impact on the suitability of an individual to carry out their role.

The provider told us that their human resources department should send confirmation of a positive DBS to the manager at the home in order for them to discuss the contents with the staff member in question. Once this had been done, information should have been sent to an internal risk panel for consideration of the disclosure and to assess the risk with regards to working with people at the service, should the nurse continue their role. This did not happen and the nurse remained in service without the risk to people being assessed or appropriate processes being carried out. We found that the provider did not operate robust procedures in relation to undertaking relevant checks. They did not have in place on-going monitoring of staff to ensure they remained able to meet the requirements, and they did not have appropriate arrangements in place to deal with staff that may be no longer fit to carry out the duties required of them.

When we arrived at the home on 29 September 2016, we saw an agency nurse had started giving medicines from the trolley. We asked to see the nurse's identification badge but she was unable to provide any form of identification. When we asked the nurse if she had worked at the home before, she stated that it was her first time and that she had only started work that morning. We also saw a care worker who was not in uniform, she confirmed that she had come from an agency and although it was her not her first time working at the home, she also had no identification.

We checked the agency staff profiles that were kept at the home and we saw that there was no photograph or PIN number recorded for the nurse or any other nurses from that particular agency or any record that she was competent to administer medicines (A PIN number is the personal number of a nursing registration in the NMC (Nursery and Midwifery Council, which is the regulatory public institution of nurses in United Kingdom). There was also no photograph of the care worker or any care worker supplied by this agency. We discussed the inability to appropriately identify staff from the agency with the interim manager and the operational support manager. They advised that they were in the process of requesting information from the agency to ensure the information they held could be used to identify staff and satisfy them of their competencies in specific areas. They told us that the clinical lead had checked the agency workers PIN number in the morning, however, this was not recorded anywhere on the staff profile file.

The provider was not appropriately assessing the risks to the health and safety of people using the service and doing all that was practicable possible to minimise the risks of them receiving unsafe care and support. They were unaware if staff had the qualifications, competence, skills and experience to carry out their role safely.

When we went back on 11 October 2016, we saw that action had been taken to update agency worker profiles with photograph and PIN numbers for nurses. We spoke with two agency nurses and a care worker on duty and they were all able to show us identification with photographs.

The above is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had an up to date Personal Emergency Evacuation Plans (PEEP) on their record. Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency. As part of the PEEP assessment, there was a 'dot' system in place which identified people's ability to evacuate their rooms safely in the event of a fire and identified the people who needed assistance. A red dot indicated that people needed assistance and a green dot indicated that people were independent and able to evacuate safely themselves. On our first visit we saw that not all doors had a red or green dot located on the front of them. This was brought to the attention of the managers and they told us they would ensure that it was rectified.

On the second day of the inspection, we spoke with five agency staff members and two permanent staff members to gain their understanding of the 'dot' system in place. Four of the agency staff and one permanent member of staff who had worked for the provider for over one year were unable to tell us what the system meant. We looked at the local fire plan for the home and the 'dot' system was not included in it. On the agency worker induction checklist, it made reference to the local fire plan and the need for staff to read it, however as the 'dot' system was not included and therefore agency staff in particular would not have known about it. The potential risk to people if staff were unaware of the system in place would be that staff would be unable to prioritise who needed assistance and valuable time could be lost. This was discussed with the managers and after the inspection we received information that the 'dot system' was included in the fire safety face to face training and there would also be a new maintenance induction programme which should include the management of PEEPs and the 'dot' system. We were also informed that the agency worker induction checklist was being amended for all Care UK homes to add the 'dot' system to ensure staff became familiar with it as soon as they start working in the home.

We saw from fire safety records that fire alarm testing was carried out weekly and evacuation drills had been carried out regularly during the day and at night. Outcomes of these drills showed an appropriate response to evacuation plans and general fire safety.

The home used a dependency tool to ensure there were sufficient staff to meet the needs of people at the home and we found this to be the case of the day of the inspection. However, when we arrived at the home and were being showed around, we saw three people unattended in the dining room waiting for their breakfast. There was an altercation between two people and the manager had to intervene and try to defuse the situation as clearly both people were becoming very agitated. We later discovered that one person involved in the incident was being supported one to one by a care worker but this did not start until 9am. We saw that no arrangements were in place to ensure the person was appropriately supervised between the time they woke up in the morning and the time the one to one care worker started work.

Some staff also expressed concerns about staff deployment and, in particular, when staff had to accompany people to appointments they were left short. One staff member said it was poor management and as they knew that people had appointments and they always failed to provide staff cover for them while they were out of the building. The interim manager's response to this when discussed after the inspection was, that this practice may have happened in the past but they had now put systems in place to cover staff if they have to go outside of the home and for other events like training.

As well as concerns about the frequent management changes, relatives raised issues about the high use of agency staff. They felt that their loved ones, many of whom were living with dementia, were not being supported by staff that were familiar to them and the situation meant the service was not providing continuity of care. They also raised concerns about permanent staff having to spend time showing agency staff what to do.

We discussed the issues of staff deployment and cover with the interim manager as we observed first-hand the impact it was having on people and their experiences at the home. We were told that staff had been made aware that there should be at least one person staying with people during the morning whilst others were being supported with personal care but this did not appear to be happening. The interim manager told us that this would be again addressed with staff. The interim manager also advised us that they were actively recruiting for care staff but this process was quite lengthy as recruitment checks had to be completed. In terms of agency staff, we were told that they always tried to secure staff that were familiar with the home but it was not always possible.

In the care records we looked at, risks were appropriately assessed and the action taken to mitigate identified risks was recorded. Appropriate referrals had been made to the falls team for people who had recurrent falls and the speech and language team (SALT) for people with swallowing difficulties.

Appropriate arrangements were in place for the safe administration and storage of medicines. Controlled drugs were also stored and administered appropriately. There were three pain patches due for return from 26 September 2016 and we were assured that they would be returned with the next few days as stated in their policy.

Requires Improvement

Is the service effective?

Our findings

Staff files and the staff supervision matrix showed that supervision was taking place. However this was not consistent. According the providers own policies, staff should receive supervision at least six times throughout the year. This could include one group supervision and one appraisal. An annual appraisal should also be undertaken for all staff.

On our first visit we looked at four staff files and saw that two staff had had two supervision sessions in last twelve months. Two other staff had only one supervision session recorded and one of those was group supervision. On the second day we looked at a further three staff files, one staff member had three supervision sessions recorded and two other staff members had one supervision session recorded.

To ensure we gained an accurate figure in terms of how many staff supervision and appraisal sessions were conducted, we looked at the staff supervision matrix. It showed that, that 70% of the staff team had up to three sessions in the past twelve months. Less than 10% of staff had an up to date appraisal in the past twelve months. This included managers, nurses, unit managers, team leaders, nurses, care workers, activity co-coordinators, domestic staff, chefs and catering staff. Minutes from staff meetings showed that there had been two general staff meetings in the past twelve months, on 25 February 2016 where thirteen staff attended and on 26 April 2016 eight staff attended.

One staff member told us that they last received supervision in June 2016 and said, "We work as a team and if I need support, I go to the nurses". However, another staff member told us they had not had a proper induction when they started and they were "Thrown into the deep end." We looked at the staff matrix and saw they had only received one supervision session since they started around six months ago., A '10 to10' meeting was planned to take place on a daily basis to discuss general management and clinical issues. The meeting was for nurses, seniors and team leaders on shift. However, on 11 October 2016 we saw that only four of these meetings had taken place since 26 September 2016.

Training for staff was being undertaken and there were systems in place to flag up when refresher training was due. Mandatory training included safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS), moving and handling, safeguarding adults, dementia awareness, infection control, medication awareness, fire safety and food and nutrition. We saw that 70% of staff were up to date with most of their mandatory training. However only 52% of staff had received the face to face fire safety training and 59% of staff had received face to face moving and handling training. The manager told us that new fire training was being arranged and steps had been taken to arrange for staff to undertake moving and handling training.

Two staff we spoke told us they had had training in the MCA and DoLS. However, they did not understand the process for supporting people who had a DoLS in place. 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

They told us that the training was not discussed in supervision or any other meetings in order to check their understanding. We saw that staff were not always appropriately supported to enable them to carry out the duties they were employed to perform.

This was raised with the interim manager on the first day of the inspection who told us that they would be looking at ways to ensure staff knowledge was checked after training. We also discussed staff supervision and the need to ensure supervisions take place on a regular basis. The new interim manager told us that the matrix should be checked by the home manager on a weekly basis to ensure staff were being appropriately supervised. Although she had only been at the home for two days we saw that a number of sessions had been arranged or were taking place on the day of the inspection. We also saw that regular weekly clinical review meetings were taking place and were attended by nurses and unit managers.

The above is evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

The care and support was not always appropriate or responsive to people's needs individual and did not always reflect their preferences. Care plans included a summary of people's support needs, healthcare issues, communication, and personal hygiene and were reviewed monthly to take into account any changes in a person's condition or circumstances. However, care plans were not always person centred to people's needs and preferences. For example, there was an incident during the inspection when we saw a person become very agitated as they wanted to have a cigarette. Despite the person's smoking preferences being identified in the care plan and that they smoked between ten and twelve cigarettes per day, there was no formal way in which the person could be supported to pursue their personal preferences. This caused the person distress which challenged staff as they did not know whether they had been supported to have a cigarette or not as there was no schedule or support plan in place.

On the first day of the inspection, we saw that a person whose life history and individual support needs identified that being supported by male staff was unsuitable. However, the person's care plan did not reflect this and we saw that there were occasions when two male staff had supported the person despite female staff being available to assist. We raised this with the interim managers who told us that staff knew that the person should not be supported by male staff and that the care plan would be reviewed immediately. On the second day of the inspection, we found that the care plan had not been reviewed. We raised this with the new manager and clinical support lead who agreed to initiate a review and change of care plan. We were informed after the inspection that the care plan had been updated to reflect that only female supporters should support the person with her care and support needs.

During the inspection, we noticed a person with extremely swollen feet who was not wearing any slippers or shoes. When we asked the nurse on duty for the ground floor about it, they responded by asking us if we think they should refer the person to the GP. We discussed this with the clinical support lead who told us that the person had seen the GP over a week ago and bloods were taken. They also explained that the person's feet were so swollen that they would find it difficult to get slipper to fit. He told us that after our discussion he was arranging for her to have a recliner chair in order to elevate her legs in order to possibly provide some relief and improve the swelling. We could not see anywhere in the person's care plan that any actions were in place to support this person appropriately in respect to her condition. It was only after our conversation that we saw staff trying to make improvements. When we returned on the second day, we were informed by the clinical support lead that the person had been referred to the occupational therapist to have an assessment for appropriate support for her condition.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager had left the service in December 2015. Since then, there had been one permanent manager and three interim managers at the home. One of the interim manager left after our first visit on 29 September 2016 and a further interim manager was in post on our second visit on 11 October 2016. We were advised that recruitment was underway for a permanent registered manager and that the provider was awaiting final recruitment checks.

We spoke with people and their relatives regarding the management and leadership within the home. One relative told us that the problem with the home was that the managers kept changing. They said sometimes the place was not friendly and "a bit grim" and continued by saying there used to be a good manager and that this manager had left a big gap when she left. They also felt there was a lack of motivation amongst staff. Another also expressed concern about the management of the home and the attitude of a particular manager in the way they spoke to staff. One relative said, "Staff morale is not good but they do their best". Another relative said they had visited about once a week for about eighteen months. They told us, the staff were 'excellent' and 'good as gold.'

We had feedback from relatives and friends regarding communication with the home and in particular when trying to telephone the home to speak with a manager, they reported this to be worse at the weekends when the phone would ring continually. One relative complained that when they did get through they would promise to ask a manager or staff member to call them back but it never happened.

Health and social care professionals and commissioners we spoke with also raised concerns generally about the management turnover and high use of agency staff and all expressed their concerns about the impact it was having on the care and support provided as well as staff morale. They were also concerned about the communication between the home and the multidisciplinary teams.

Staff we spoke with on the upper floors and some on the ground floor expressed concerns about the visibility of managers. Some told us that they did not come out onto the floor and this only seemed to happen when there was an inspection. They told us they had never seen the managers so much as during the days we visited. They told us they would normally ring around instead to ask if everything was all right.

A combination of a lack of day to day management oversight and the turnover of managers within the home had led to an unstable management structure. Feedback received from a health and social care professionals and relatives indicated that the lack of consistent management had impacted on communication with them. We were advised that recruitment was underway for care staff and a permanent registered manager and that the provider was awaiting final recruitment checks. Systems were also being put in place to improve communication.

We saw from a recent completed survey from relatives that the general satisfaction level had declined in all areas since the previous survey in 2015. Amongst the lowest scores were, making new residents welcome, the laundry service and making the most of residents capabilities at the home. There were a number of

negative comments in relation to the smells of urine and faeces in the home, the lack of engagement by care staff supporting people, laundry going missing, lack of activities and a general mistrust of management and staff. Muriel Street was ranked 104 out of 111 qualifying homes in the Care UK group. We saw an action plan had been devised to target and monitor improvements in these areas. For example, one action was 'Staff responsiveness to matters of concern'; the first date for actions to be achieved was 11-30 November 2016.

A staff survey conducted in 2016 showed that staff were generally satisfied with were they worked and the work they were doing. However, the lowest scores were in the area of equipment and tools to do their job. Other low scores related to communication from the provider and senior staff taking time to visit them. An action plan in put in place after the survey, focused on improving communication, recruitment and induction for news starters. The actions were scheduled to be completed by 30 September 2016 and the first date to which work was started on the plan was 5 October 2016.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and support was not always person centred and appropriate to meet people's needs and did not always reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that the required standards were in place in regards to assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that associated with health care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed They did not have in place on-going monitoring of staff to ensure they remained able to meet the Disclosure and Barring Scheme requirements and they did not have appropriate arrangements in place to deal with staff who may no longer be fit to carry out the duties required of them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always appropriately supported through supervision and training to enable

them to carry out the duties they were employed to perform.