Margaret Clitherow Housing Association Limited

Margaret Clitherow House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 23 November 2016 and was unannounced. It started at 07:30am to allow us to meet with the night staff going off duty, and observe staff being organised for the day ahead.

Margaret Clitherow House is a care home without nursing, registered to provide accommodation for up to 41 people needing personal care. On the day of this inspection there were 26 older people living there. The home has strong links to the local Catholic Church and is physically joined to the church building. However the home welcomes people and staff of all faiths or none to live and work there.

The home had a registered manager. A registered manager is a person who has registered with the CQC 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 registered manager was overseen by a management committee who met at the home regularly and carried out visits to monitor how the home was operating.

Concerns about the management of risks to people at Margaret Clitherow House had been identified at inspections in September and December 2014 The home was rated as "Requires Improvement". The provider sent us an action plan, and later wrote and told us they had carried out the changes needed.

On 6 January 2016 we re-inspected the home. We found concerns over people's nutrition, complaints, person centred care and people's capacity to consent, pressure ulcers, records, medicines, and a lack of audit and management oversight. Following that inspection we issued the provider and registered manager with warning notices in relation to Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Good Governance) and Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Safe Care and Treatment). The home was rated as requires improvement overall but inadequate for the key question of well led.

On 22 June 2016 we carried out an unannounced focussed inspection to follow up on the warning notices. We found that although some improvements had been made the provider and registered manager had not taken sufficient action to meet the requirements of the warning notices. The home was rated as inadequate and placed in 'special measures'. We re-issued the warning notices and met with the provider and registered manager to ensure they were clear about the actions that needed to be taken. We contacted the registered manager regularly to discuss progress being made, and regularly reviewed progress with the local Care Trust who were supporting the home to improve.

On this inspection we found improvements had continued, and although some areas of development were still needed they did not have a significant impact on safety or well-being of the people living at Margaret Clitherow House. We received feedback from the local Care Trust that improvements were continuing and they were continuing to assist the provider with the development of the home.

The improvements mean the home has come out of 'special measures' and is now rated as 'requires improvement'.

People lived in a comfortable clean and well-maintained environment, which was adapted to meet their needs. Risks to people's health and well-being, for example from the environment were assessed. Where additional concerns were identified during the inspection the registered manager took immediate action to address them. We found for example that there were two large, heavy and unstable items of furniture that could present risks if someone fell against them. The service had carried out an assessment of risks from furnishings following the previous inspection and had ensured where unstable furnishings were securely fixed to the walls. However these had not been included in the risk assessment.

Some other risks to people were not always being well managed. For example, people were placed at potential risk of poor health outcomes because risks from poor hydration were not always being identified.

People told us and we saw staff had the skills, knowledge and experience to support people effectively. Staff told us they were well supported, and worked well as a team. We saw staff care and support practices were good and were well understood by staff. However these were not always linked to the home's policies and procedures which were in some instances inaccurate or incomplete. This meant effective policies were not always available to guide staff on actions to take in the absence of other information, for example with regard to managing infection control issues.

People were protected from the risks associated with staff recruitment. A full recruitment procedure was followed for new staff and there were enough staff on duty both day and night to meet people's needs. We saw staff being able to respond to people's needs in a timely way. One person told us staff took a long time to respond to their calling for assistance, but other people told us staff responded quickly to any requests for support. The home had a new staffing tool which identified there were sufficient staff on duty to meet people's needs.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected. Staff had a good understanding of people's wishes, lifestyle choices and the support they needed. People could be confident concerns and complaints would be investigated and responded to. The system for the management of complaints ensured these were recorded and any concerns appropriately escalated to the management committee or other agencies.

People could expect to receive their medicines as they had been prescribed because safe systems were in place for the management of medicines. Staff received training in the safe administration of medicines and appropriate records were being completed. Medicines were being stored safely.

People's rights were respected, and the home was following the best interest's framework of the Mental Capacity Act 2005. People's choices were respected and we saw staff asking people for their consent before delivering care. All care was delivered in private. Signs were available for people's room doors to ensure people did not knock while they were receiving personal care.

People experienced good medical and community healthcare support. We saw people had access to support from community nurses, GPs and other support services. People were supported to attend hospital appointments if they needed this, and we saw evidence of other services being provided such as podiatry, optical and dental. People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes. Some people were not happy with the quality of some of the food and the home's management were working to improve this.

People were able to influence change at the home as they were consulted about their views on how the service could be improved. This included through questionnaires and attendance at residents meetings. Members of the management committee met with people on their visits to help assess the quality of their experiences. People's needs and wishes regarding their care were understood by staff who ensured they were followed and respected.

People benefitted because they were able to exercise their religious beliefs and live amongst 'like-minded people'. Visitors were welcome at any time, and family members were being encouraged to take part in providing more person centred activities. We saw staff addressed and related to people in a friendly and positive manner, however people told us sometimes staff were a bit abrupt. We saw staff respecting people's individuality and respect. When they spoke or wrote about people's needs this was done respectfully and with a caring attitude. Staff told us they felt the home was caring and they were proud of the improvements that had been made.

People benefitted because staff were aware of the risks of social isolation and made efforts to engage with people throughout the day. New activities were being developed in accordance with people's interests, as some people had said they had not previously enjoyed the activities on offer. This included relatives and other visitors being encouraged to develop groups. For example we saw one relative was setting up an art class for people the day after the inspection. We spoke with the registered manager who told us this had been well supported and would be repeated at people's request.

The management committee had undertaken training and were presenting a more visible presence in the home. This meant they were in a better position to exercise effective governance over the service. Changes had been put into place following the last inspection to make improvements and meet legislation, for example more regular audits had been implemented. The home had been working with the local Care Trust on a service improvement plan, and took advice following this inspection on changes to be made to the home's infection control policy.

We identified a breach of legislation during this inspection.

You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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 were protected from the risks of poor nutrition. Some elements of the systems for assessing risks from poor hydration needed development to ensure people were fully protected.

People lived in a comfortable clean, and well-maintained environment. Some risks in the environment had not been identified by the home's risk assessment systems, but these were addressed immediately following the inspection.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected.

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. There were enough staff to meet people's needs.

People could expect to receive their medicines as they had been prescribed because safe systems were in place for the management of medicines.

Is the service effective?

Good

The service was effective.

People's rights were respected, and the home was following the best interest's framework of the MCA. People's choices were supported.

People lived in an environment that had been adapted to suit their needs.

People benefitted from good medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes. Some people were not happy with the quality of some of the food and the

home's management were working to improve this.

People were supported by staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect.

People benefitted because they were able to exercise their religious beliefs and live amongst 'like-minded people'. Visitors were welcome at any time, and family members were being encouraged to take part in providing more person centred activities.

People's privacy and dignity were respected and supported.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff who ensured they were followed and respected.

People benefitted because staff were aware of the risks of social isolation and made efforts to engage with people throughout the day. New activities were being developed in accordance with people's interests.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's safe, high quality care was not consistently supported because staff could not safely rely on the home's written policies and procedures to give them accurate information about how to support people's care.

Risks to people's health and well-being were assessed. Where additional concerns were identified during the inspection the

registered manager took immediate action to address them.

The management committee had undertaken training and were presenting a more visible presence in the home. This meant they were in a better position to exercise effective governance.

Changes had been put into place following the last inspection to make improvements and meet legislation. Regular audits had been implemented.

People and others were able to make changes at the home as they were consulted about their views on how the service could be improved.

Margaret Clitherow House

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 checked 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.

The inspection took place on 23 November 2016 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this instance Adult Social Care Services.

We looked at the information we held about the home before the inspection visit. We looked at information the provider had sent us in a provider information return (PIR), and information that we had received about the home since the last inspection. We contacted other agencies such as the local authority business and quality improvement team who were supporting the home to make improvements. At the time of the inspection the home was not having placements made by the local authority, as they were considered to be in default of their commissioning arrangements. Following the inspection the nominated individual and registered manager sent us additional information we had requested, and updated us on actions they had taken.

We spent time observing the care and support people received, including staff supporting people with their general care needs. The majority of people living at the home were able to share their views with us about their experience of care at Margaret Clitherow House. On the inspection we spoke with or spent time with 11 of the 26 people who lived at the home, 2 visitors, the registered manager, the nominated individual and chair of the management committee, a visiting health care support worker and 7 members of both day and night staff.

We looked at the care plans, records and daily notes for five people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We looked at two staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation

provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Requires Improvement

Is the service safe?

Our findings

Following the last comprehensive inspection of Margaret Clitherow House on 6 January 2016 we issued the provider and registered manager with warning notices in relation to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Safe Care and Treatment). This was in particular in relation to the management of pressure ulcers, ensuring people had sufficient nutrition to maintain their health and safe medicines management. This key question was rated as requires improvement.

We followed this up on 22 June 2016, and found that some progress had been made, although the warning notices had not been fully complied with. We re-issued the warning notices with a new date for the service to complete the work they needed to do. We met with the provider and registered manager to ensure they were clear about the actions that needed to be taken. The provider subsequently requested an extension to the end of October 2016 to complete the work needed, which we granted.

We returned to the home on 23 November 2016 to carry out a comprehensive inspection. We found that improvements had been made to people's safety, and the warning notice in relation to safe care and treatment had been complied with.

People told us they felt safe at Margaret Clitherow House. One person said "I feel very safe here" and another said "certainly do" when we asked them if they felt safe. A relative told us their relation was prone to falling, despite measures being in place to reduce the risks. They said "Mum falls but the carers do take care of her as needed". The person told us they felt staff would respond to them quickly if they fell. The person had an alarm around their neck to enable them to alert staff to them needing support in an emergency.

People had assessments and management plans that included guidance to assist staff reduce risks to their health and well-being. These covered risks from falls, pressure ulcers, poor nutrition and hydration and in the case of fire. Some of these still required development to ensure people were fully protected from the risks associated with their care. For example, one person had been assessed as being at risk of poor nutrition and hydration. Their records showed they had lost weight. Their care plan clearly recorded that their weight was being monitored and they had been referred to their GP and dietician. Supplements and high calorie foods such as milky puddings were given as the person liked these and all diet and fluids were recorded. However, there was no target amount of fluids to aim for, for this person to ensure their health could be maintained. There was no system to ensure anyone had regular oversight of these records to review patterns or the overall fluids taken in over a period of time.

On some days the records for another person who was very frail showed the person had taken in less than 450 mls of fluid in a 24 hour period, despite regular encouragement from staff. We discussed this with a staff member who had been supporting the person to drink and the registered manager. The registered manager told us that all agencies concerned with the person's health were aware of the person's situation, they were being regularly reviewed and that staff used the charts as a tool to encourage them to support the person to drink as much as they were able to.

The registered person is recommended to take advice from a suitably qualified person and follow best practice in relation to the monitoring of risks associated with people's intake of fluids.

Where people were having their food intake monitored to reduce the risks of poor nutrition we saw food charts had been completed clearly and were up to date. Food charts showed the amounts of food the person had eaten in each meal for example, all of the chicken, ½ of the mash, ½ veg. This meant it was easy to monitor if the person was taking enough food. Food that had been refused had been documented however, nothing was written about any actions taken in response to the person refusing food. These entries were occasional refusals and did not indicate a pattern.
Risks to people were reduced because each person's risk assessments identified risks to them from their care and how these were to be managed. For example, whether people needed to be repositioned at set times throughout the day to prevent pressure ulcers. One person at risk of pressure area skin damage had a very detailed risk assessment in place for staff to follow. The risk assessment included body maps and detailed descriptions of areas of skin damage. Plans described what action was necessary to reduce the risk of further damage, such as through regular relieving of pressure on people's skin. We looked at records to see if this was reflected in practice and found that it was. Staff on both day and night duty told us that they ensured that they regularly checked the person's pressure areas and moved their position as described in the care plan. We spoke to a visiting healthcare professional who confirmed that the pressure areas were improving and that staff were following their instructions and the care plan. Since the last inspection in June 2016 staff told us they had received training in prevention of tissue damage and management of pressure ulcers. Staff told us they had more confidence and knowledge about raising any concerns about people's skin early, to help prevent deterioration.

People benefitted because staff were aware of the risks associated with people's care and how they could be reduced. Staff members we spoke with told us how they kept people safe. One for example told us that they ensured bed rails were put up, kept wheelchairs well maintained, used appropriate supports to stop people falling and ensured people were well positioned in their chairs before leaving them. Another staff member told us about ensuing people were safe with hot drinks and making sure people were always able to reach drinks easily.

One person had requested to move rooms as they were concerned about climbing steps with impaired eyesight. The person had been supported to move rooms and their assessment, updated in November 2016 stated the person "feels safer in new room". The home had purchased electronic devices which flashed to alert staff when a person who was reluctant to drink had not drunk independently for a set period of time. This gave staff the opportunity to intervene and encourage the person to drink. Risk assessments covered people's healthcare needs, such as how staff needed to support catheter care to reduce any risks, such as infection.

People's medicines were stored, administered and disposed of appropriately and securely. We looked at the Medicine Administration Records (MARs) for people. People had individual MAR which included their photograph. The records showed people were having their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines, were recorded. Medicines were stored securely within locked trolleys. These trolleys had thermometers and temperatures were checked daily. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. As required medicines (PRN) were recorded on the MAR and signed for by staff when administered. The home was in the process of writing individual guidance for staff on administering PRN medicines. Prescribed creams for topical application were kept in locked cabinets in people's rooms. Creams were dated on opening and all were discarded monthly. Topical administration charts and body maps were used to inform staff where cream

needed to be applied. A robust system was in place to ensure that people's medicines were re-ordered and disposed of safely.

Some people managed their own medicines. We looked at the risk assessments in place for one person to do this. The assessments said that it was "Important to (person's name) to ensure she keeps her level of independence", and identified they were able to do so safely. The assessment had last been reviewed in September 2016, where it stated "Service user states she still wants to deal with her medication". This told us the staff kept this under review.

People were being supported by sufficient numbers of staff. Since the last inspection the registered manager had developed a staffing tool to help them assess the numbers of staff needed on duty. This identified the daily care requirements of each person and the numbers of staff needed to support them with these activities. Dependency levels and numbers of people living at the home had decreased since the last inspection, and we found there were sufficient staff to meet people's needs in a timely way. Some people still felt that staff did not always respond very quickly to them, others told us this was not the case and that staff responded very quickly. One person told us they had to wait for "up to half an hour" if they needed care but this was not other people's experience. We discussed this with the registered manager who showed us the alarm system was audible throughout the building and could not be cancelled without staff attending to the person's room. They told us they would be aware and would investigate if an alarm had been ringing for that length of time. The home's rota showed there were five care staff, a deputy manager and registered manager on duty in the day, along with domestic, catering, gardening, administration and laundry staff for 26 people. At night there were two waking night staff and a sleeping senior person.

People were protected from the risks of abuse because systems were in place to ensure staff had a clear understanding of safeguarding and protecting people. This had been achieved through the provision of training, policies and procedures. The home's safeguarding policy was being reviewed in conjunction with the local Care Trust, to ensure it included information about different types of abuse. Training had also been provided for members of the management committee, to help with their oversight of the home. A new whistleblowing procedure was in place to help staff understand how to raise concerns and the protection in law they would be given when doing so.

There were no open safeguarding concerns about the home. Safe and transparent systems were in place to record any money being held by the home's office for safekeeping.

We looked around the home to make sure that the environment was safe for people. The provider had carried out a risk assessment of the environment, looking at potential risks to people who lived there. We found radiators were all covered and windows had restrictors or locks. There were hand rails in the corridors and on staircases. Seats were placed next to the lifts so that people could sit down and wait. The majority of the free standing furniture was stable or fixed to the wall. We found one bookshelf and a cabinet with a heavy clock on top was unstable and could be pulled down on top of a person, causing injury. A cupboard holding electric circuit boards was left open with no lock. Arrangements were immediately put in place to manage and reduce the risks from these, and the registered manager told us they would ensure they were permanently fixed the day after the inspection. They contacted us the day after the inspection to let us know this had been addressed. All fire equipment was in date and fire exits were clear from obstruction. Fire alarm testing took place during the inspection and staff responded quickly and well. Staff told us they received regular fire training, and could tell us about where alarm points and extinguishers were sited. A member of the night staff team told us "Night staff get fire training every six months". Information was available to tell staff who to contact in the case of an emergency.

The home's water systems had been inspected for the risks of legionella bacteria regularly, and an action plan was in place to manage any risks. However an asbestos survey carried out in 2006 had indicated that there was a small amount of asbestos in a boiler room and that this should be inspected annually by a competent person to ensure it had not been disturbed. We saw that this had not happened. The nominated individual arranged for this to be inspected on the Monday after the inspection to ensure it continued to be safe.

An analysis was being carried out of incidents such as falls on a month by month basis. Incident forms were being completed and 'signed off' by the manager, and systems to ensure significant issues were escalated to the committee were in place. The system as it was being operated made information difficult to monitor, which might mean actions to identify and respond to risks might be delayed. The manager told us they would resolve this by storing the information in a more accessible way.

At the last inspection in June 2016 we identified the home's infection control audits and policy had not identified risks in relation to the disinfection of linens. On this inspection we saw the infection control policy had been updated, but did not provide sufficient guidance for staff on other areas, such as 'barrier nursing'. Following the inspection the registered manager told us they had taken advice from a community healthcare professional and made changes to the policy to reflect their advice. We saw gloves and aprons were available throughout the building to help staff control or manage any infection control risks, and staff had received training to help them do so. There were no identified infection control risks at the time of the inspection.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff including disclosure and barring (police) checks. No new staff had been employed since the last inspection. We sampled two staff files, and identified a full recruitment process had been followed in each instance.

Good

Is the service effective?

Our findings

At the last full comprehensive inspection of the home in January 2016 this key question was rated as requires improvement. We had found there was not a clear understanding of the Mental Capacity Act 2005 in practice. On this inspection we found improvements had been made.

People were supported by staff who demonstrated the skills and knowledge to meet their needs. We saw staff supported people confidently, including assisting them to drink and administer medicines. Staff told us they felt they had the skills and training they needed to help them carry out their role. One told us "We are always getting training, especially recently" and another said "You won't find much wrong here. This is a good place to work".

Staff took advantage of training opportunities being provided, for example the registered manager told us three staff were attending training the week after the inspection on supporting people with swallowing difficulties. A staff member told us "We can always learn more from training, especially manual handling. We have to learn new things". The registered manager told us that in addition to core training such as first aid and moving and positioning staff had requested additional training in Dementia, Continence care and tissue viability, which were open to all staff. We identified some staff were behind the home's programme in receiving training or updates in core subjects. We did not however find the delay had impacted significantly on the care people received, or that staff did not have the skills to provide care and support for people. Staff told us there was always someone senior to call on if they needed additional advice or support. At night the staff told us there was a sleeping senior staff member they could call upon if they needed additional experienced support.

Staff received supervision and support on a one to one basis throughout the year. The two staff files we saw showed staff received supervision which covered awareness of safeguarding practices, morale and training. Supervision practice for one staff member had been completed four times in 2016. The staff member concerned was very experienced. Staff overall told us they felt supported, but one staff member told us they felt frustrated as they were not always listened to when they were trying to improve practice at the home. Staff told us they supported each other well, and although sometimes there were interpersonal issues these were resolved. One said "definitely we work together well. It's important to be a team player". We saw staff working well as a team. Staff were aware of what other team members were doing and were able to respond to call bells quickly. We saw them escalating information about one person to a senior staff member for action. Staff told us they would raise any concerns about another member of staff's practice for management to address.

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. At the inspection of the service in January 2016 we found there had been a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to the

implementation of the MCA. On this inspection we checked whether Margaret Clitherow House was working within the principles of the MCA.

We found the home was taking appropriate actions to protect people's rights. Staff were aware of people's right to refuse support. We saw people being offered choices and asked for their consent throughout the inspection. Records indicated discussions had been held and best interest decisions made regarding areas where people lacked capacity to consent. For example one person who was living with dementia became distressed when being bathed. The person lacked capacity to make the decision or insight into their situation. A decision had been made that staff would support the person to have a thorough wash each day in their 'best interests'. This had reduced their anxiety and distress. Some best interest's assessments had been undertaken by a social worker supporting the home to develop their practice. We understand they had requested some other community social workers carry out additional best interest assessments, but these had not yet been completed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No applications had been made for authorisations to deprive people of their liberty at Margaret Clitherow House. The registered manager was due to undertake training in the MCA and DoLS the day after the inspection. We discussed one person with the registered manager, as we felt they may now need an assessment for considering whether authorisation for DoLS was needed. The registered manager agreed to discuss this with their social worker, and following the inspection confirmed they had done so and further actions were being taken to ensure the person received an assessment.

People received the healthcare support they needed. We saw evidence in people's files of support from opticians, podiatry services, specialist support services such as community mental health teams and GPs. People were supported to attend hospital appointments and clinics. The community nursing service had decreased the amount of time they needed to spend at the home in recent weeks, but still visited three times each week. We heard a visiting healthcare worker asking if there were "any other people to add onto the list" when they visited. This told us they kept an oversight on all of the people at the home not just those they had come to visit by appointment. It also meant the home's staff could quickly refer people for initial advice to help prevent deterioration in the person's condition.

On previous inspections people had given us mixed feedback about the food they received. On this inspection we saw that was still the case. Some people we spoke with said they were very happy with the food and they always got a choice. Comments included, "Quite good really, it's reasonable, sometimes too much" , "it's good for the money we pay, very nice" and "it's usually very good, the food". However, one person told us that the food was 'terrible' and was unhappy with how and when they were asked for their menu choices for the day, saying "how am I supposed to know at breakfast what I want for my evening meal?" Another person said "They do a lot of sandwiches, which I don't like", but confirmed that "They always ask what else do you like if I don't want the sandwiches".

We discussed the meals with the nominated individual and registered manager. They told us about the efforts they made to help meet people's choices and preferences. They acknowledged feedback they had received, and were working with the head chef to reflect people's choices and requests. The chef attended residents meetings to help look at people's menu choices. This had covered people's likes, dislikes and requests. They had sat and worked with individual people about their wishes and preferences. Some of the feedback received had related to differences in quality between the chefs who worked at the home, for example with regard to the breakfast porridge. The head chef had tutored the other chefs to try to ensure

greater consistency between them. Some people gave the chefs direct feedback about things they had not liked, whilst others completed complaints slips or spoke with the home's management. Minutes from the resident's meeting said that people "only had to ask if they wanted something different on the menu (with a little bit of notice)".

People could choose where they wanted to eat their meals. We saw some people had their meals in their rooms and others in the dining room. We saw the menu choices were displayed in the dining room for people to see and in people's rooms. Tables were attractively laid with table cloths, napkins, placemats and condiments. There was fresh fruit and jugs of water available for people. People were offered hot drinks and snacks throughout the day.

While we were at the home a visitor was discussing with the registered manger how one person had requested a particular food be bought into them from a local shop. The registered manager said they were very happy with this and would either do this themselves or ensure it was prepared as the person wanted. This showed us the home were trying to support people's wishes regarding their food choices.

Margaret Clitherow House is a care home located within a period building, originally constructed as a convent, and attached physically to the local Roman Catholic Church. People told us they liked the building, as it had character, and one person told us they found it "uplifting". There were extensive and beautifully maintained gardens which people also enjoyed and took advantage of in the warmer months. These also supplied produce for the home's kitchens. Rooms were individual, and many people had personalised their rooms with their own furnishings to make them more homely. Other people had created living and bedroom areas, to help make their rooms a more sociable space where they could entertain.

The building presented some challenges in terms of maintenance and access for people with difficulties with their mobility. This meant for example that not all rooms were suitable for people who needed the use of a hoist to move and transfer. Adaptations had been made to the building to minimise difficulties for people wherever possible, including adding lifts and levelling many floors. All areas of the home seen were clean, warm, odour free and comfortable. Some parts of the home had religious items, statues, paintings and religious architecture linked to the Catholic faith. People told us they liked this, along with being able to "go straight into the adjoining Church without having to go outdoors".

Good

Is the service caring?

Our findings

At the last full comprehensive inspection of Margaret Clitherow House in January 2016 this key question was rated as requires improvement. We had seen concerns about practices that were institutional, and a failure to respond to people in a caring way. We saw overall improvements had been made.

People's experiences of caring at the service were not always consistent. People gave us mixed feedback about the caring nature of staff at the service. For example, one person said "some are very kind but others are very abrupt at times", and another that "Staff are always friendly, but you get the odd one who will ignore you". However most people we spoke with were full of praise for the staff and their caring approach. They told us "The carers are magnificent" and "The carers always have a smile. I can't fault them". This mixed feedback had also been the case at the previous comprehensive inspection in January 2016. We discussed the disparity with the registered manager. They told us they had not had any recent concerns raised with them about staff being abrupt and were not aware of any concerns having been raised to committee members about this. However they agreed to raise this with the staff team for their attention. Throughout the inspection we saw people communicating with staff in a positive manner, and this being returned.

We observed staff working with people in a calm friendly manner. People were addressed by their preferred names and the staff responded to requests for assistance quickly. People were well presented and their personal care needs had been attended to. For example we saw one person's care plan said it was important to them that the person chose their outfit for the day and had their nails done and make up in place. We saw the person was very frail and was being supported in bed. However their personal standards of dress and personal care had been attended to as they would have wished. Staff had made sure their room was nicely presented, tidy and comfortable, with soft lighting. The registered manager told us in their PIR that "as staff have worked with the residents for many years they have over time built relationships and therefore learn some of the very small details about a person that enables them to give more personalised care. This could be small details such as what a person's favourite colour nail varnish is, there favourite hand cream or sweets." We saw these details were being attended to.

Many people had moved to the home specifically because they wanted to live with people who shared their faith and values. One person told us "My faith is very important to me, as is living with like-minded people." They told us they found the home had a positive atmosphere where they could follow their chosen and valued lifestyle.

People were relaxed and comfortable in the presence of staff throughout the inspection. We saw examples of staff engaging in good humour and laughter with people. For example, one person had a difficulty with their walking frame which had led to much hilarity between themselves and staff. People told us "I'm quite happy here really, they look after me well" and "I couldn't stand a place where you just sit and stare at each other". We saw a person walking down a corridor with two staff supporting them. They were all laughing and chatting happily. Although much of the communication and interactions we saw was based around care tasks we saw staff making the most of those opportunities to engage with people.

We saw examples of positive, caring support being given to people. We saw one person being wrapped warmly in a cosy blanket by staff when they had fallen asleep in a hallway. People were free to choose how and where they spent their day, for example some people chose to stay in their rooms rather than the communal areas. When people were in their rooms we saw staff popped in and out throughout the day checking they were alright or if they needed anything. Staff told us they were proud of the care they gave people and that they had worked hard since previous inspections to make improvements. One staff member challenged us about the Inadequate rating for the home. They told us "That made us feel dreadful – it doesn't reflect what the staff are like. We really care here".

We observed people being treated respectfully and with dignity. Doors remained closed to people's rooms when they were being supported with personal care and staff knocked and waited for a response before entering rooms. Doors had signs which indicated the person in the room was receiving personal care to warn other staff the person was not available at that time.

People were being encouraged to take a greater involvement in the running of the home if they wished. For example, one person was 'taking charge' of the Christmas decorations. Another person and their relative were working to try to develop an art session for people living at the home. People had opportunities to give feedback to the service's management through regular resident's meetings and visits from committee members. The minutes of the last meeting showed people had not been afraid to challenge the service about improvements they wanted made. The home also had a monthly newsletter, compiled by the registered manager. This kept people up to date with changes in the home and forthcoming events.

Visitors were welcome to the home at any time. One person told us they understood people were not able to visit the home in the evenings. We checked with the registered manager who told us this was not the case. The registered manager told us they would make sure people were aware of this at the next resident's meeting.
People's confidentiality was respected. Files were kept securely in a locked office or cabinet, and care files did not contain information that staff did not need to know, for example about people's finances.

No-one at the home was receiving end of life care, but people recently had done. We saw feedback from relatives who had complimented the home on how people had been supported at this time.

Good

Is the service responsive?

Our findings

At the last full comprehensive inspection of Margaret Clitherow House in January 2016 the home had been in breach of Regulation 9 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (Person Centred Care). This was because assessments of people's needs had not been carried out and care and treatment had not always been designed to meet people's preferences about their care. We had also identified a breach of Regulation 16 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints). This key question was rated as requires improvement as a result. On this inspection we found improvements had been made.

People told us they were satisfied with the support they received from Margaret Clitherow House. People told us they were "receiving very good care" and a relative said of their relation "I wouldn't want her to be moved". Another person said the care was "Very good, the staff are excellent here".

People's needs were assessed prior to moving to Margaret Clitherow House to ensure the home would be able to meet their needs and aspirations for their care. These assessments were then used to compile a care plan, recording people's needs and wishes on how their care was to be supported. Since the last full comprehensive inspection a new care planning system had been implemented. A staff member had worked with each individual to develop a plan of their care that meant people received consistent, personalised care, treatment and support. People's plans we saw were well maintained. Some plans would have benefitted from additional detail being included or more consistent reviewing, but we did not see any instances where people's needs were not correctly identified or where changes had not been recorded. This told us people's plans were an up to date reflection of their needs. We saw evidence people had been involved in the updating of their plans, for example one person had put a hand written note into their file updating staff on a recent visit to a hospital clinic. Other plans contained clear instructions for staff, for examples with regard to moving and transferring needs and equipment needed to do this safely.
Staff were knowledgeable about the individual support people needed to manage their day to day needs. For example two staff told us about the needs one person had for the prevention of pressure ulcers and how they supported this. This was reflected in their care plan, and in other records related to their repositioning. We saw another staff member supporting a person being cared for in bed to drink. They were able to discuss with us how they did this safely and in ways that helped the person feel comfortable.

People's care plans provided staff with relevant and appropriate guidance on people's preferred routines and life history. Care plans contained a "This is me" tool to help staff get to know the person. "This is me" is a tool for people to complete that lets health and social care professionals know about people's needs, interests, preferences, likes and dislikes. Where people had chosen to not share this information this was also recorded. Care plans included information about what people could do for themselves, such as mobilising with the aid of a walking frame.
Care plans included how people wanted to spend their time, for example one person's care plan told staff that they enjoyed crossword puzzles and reading crime novels. Another person's care plan said they enjoyed television, including quizzes.

People benefitted from plans to make activities more 'person centred' and in tune with people's wishes. Relatives and other volunteers were being encouraged to have a greater role in supporting the home with activities, such as crafts. This included the development of an art group, and had come as a suggestion via a resident's meeting. Art equipment was left out in the conservatory for people to use as they wished. We spoke with the manager after the inspection who told us this session had been enjoyed by 11 people and would be repeated. We saw the home's activities organiser was also taking a greater role in one to one support for people who did not wish to join in larger group activities. For example we saw in one person's notes that the activities organiser had sat with this person, looking at photographs and articles in relation to the person's family history. They had then read poetry together which the person had really enjoyed. This was a reflection of the person's recorded interests. We observed an activity session in the morning of the day of the inspection. People enjoyed taking part in a music and movement session. People we spoke with told us they had enjoyed the session, however one person told us they only took part in the activities because they were bored.

At the last comprehensive inspection we had identified concerns over how complaints were investigated and analysed. This led to a breach of Regulation 16 Health and Social care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found that improvements had been made. The home had implemented a system that recorded and collated all concerns raised. The complaints policy was displayed on the wall in people's rooms. In the main corridor downstairs there was a table with feedback forms to make a complaint, suggestion and compliment for people to use. Systems ensured that concerns were sent to the management committee for their oversight and investigation as needed. We looked at complaints that had been raised since the last inspection. These included some concerns that had not been resolved, such as quality issues around the food. Some of these were preference issues such as people wanting less cream on their dessert, crispier bacon or the consistency of the porridge. The provider showed us evidence of the extensive actions they had taken to try to resolve these issues. Some minor changes were needed to the complaints procedure to ensure it reflected agencies outside of the home to whom concerns could be raised. The registered manager agreed to address this.

Requires Improvement

Is the service well-led?

Our findings

Following the last comprehensive inspection of Margaret Clitherow House on 6 January 2016 we issued the provider and registered manager with warning notices in relation to Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Good Governance). This was because quality assurance systems were not effective in ensuring people received high quality and safe care and poor record keeping had placed people at risk of harm.

We followed this up at the inspection on 22 June 2016, and found that some progress had been made, although the warning notices had not been met. We re-issued the warning notices with a new date for the home to complete the work they needed to do. We met with the provider and registered manager to ensure they were clear about the actions that needed to be taken. We also met with the local commissioning team to discuss the support they were providing to the home and progress being made. The provider subsequently requested an extension to the end of October 2016 to complete the work needed, which we granted.

We returned to the home on 23 November 2016 to carry out this were seen across all the key questions CQC uses to monitor and review services, although some areas still needed further development to ensure people consistently received high quality, safe services. We found there were still some issues with the service meeting the warning notice, but the impact of this on people was not significant.

People's safe, high quality care was not consistently supported because staff could not safely rely on the home's written policies and procedures to give them accurate information about how to support people's care. This was the case in five out of the six policies and procedures we looked at. For example, the policy on "Residents property and money" referred to forms or practices that were not in use at the home. Other policies did not contain sufficient detail or reflect best practice. All of the policies and procedures we saw had been 'signed off' by the registered manager or nominated individual since September 2016 as having been reviewed and found to be accurate.

This was a repeated breach of a part of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) 2014. However, we found the impact of this on people living at the home was low. Staff practice, such as those for the safekeeping of people's money and property were good. However if staff needed guidance from the home's policies and procedures, the policies in place would not effectively guide them on the correct actions to take. It also meant the home could not hold staff to account for poor practices not covered in their policies.

Other records were well completed, including daily notes completed by staff, which were respectful and timely in their completion. MAR charts and other records in relation to the administration of medicines were completed well. Facilities were available for the secure storage and destruction of records no longer needed by the home. Notifications had been sent to the CQC as were required by law. The manager was aware of the 'Duty of Candour' in relation to being open and transparent with people about where there had been incidents involving their care.

Systems to assess, monitor and improve people's safety had not always been robustly operated. Assessments were in place to monitor risks to people and others. These had been completed and reviewed regularly. However, we identified potential risks within the environment that had not been identified through the home's own risk assessments. We did not identify this had had any impact on people's care or well-being, and immediate action was taken to address the minor issues raised. The nominated individual told us that improvements were being made to the way environmental risk assessments were carried out. The person due to carry them out in future had additional skills in that area.

People benefitted because regular audits were being carried out to ensure the quality of the services provided. The service had been working with the local Care Trust business improvement team on a service improvement plan, which had substantially been completed. Some management systems were still in development. For example there was a staff training matrix in place. This identified the training staff had undertaken and where additional training or updates were needed to ensure staff competencies were maintained. The registered manager had set their own timescales for when they felt training needed updating based on the needs of people at the home, for example with regard to infection control or moving and positioning people (annually) to meet people's needs However the matrix showed us that of the 26 staff who needed training in infection control 17 were not up to date with their training and some had not received this since 2014. The registered manager told us they had an action plan in place to address this. The action plan did not contain dates or names of people due to attend, but covered areas of training needed, and months they were planned for.

Progress had been made on ensuring the service presented and promoted a positive culture that was person centred, inclusive and empowering, for example with the improvements to care planning systems. Additional work was being undertaken to support the further development of person centred activities. A staff member told us that communication with managers was "much improved" and that another staff member said the manager had made "a concerted effort to improve the service". A senior staff member said "Have we improved – absolutely". In their PIR the registered manager told us staff were "encouraged to discuss any concerns with the manager on duty when issues arise and both staff and residents are able to speak to members of the board of trustees at least twice a month when they visit." However a staff member told us they felt that managers "underestimate the carer's opinions" and felt that there was at times "a divide between managers and staff on the floor". A staff member told us staff felt unable to 'voice their concerns' or bring up issues with the manager. They said they felt the home was very task focused and staff didn't get time or were not encouraged to spend time with people and just talk. This told us the changes that had been made were not consistently leading to improvements in the culture of the home or people's experiences.

People living at the home knew the registered manager and had some understanding of the staffing structures in place including the role of the management committee. We received some feedback that the registered manager should have additional support from the committee to resolve issues at the home and develop their management skills. The registered manager told us they had been receiving increased support since the last inspection. Work had been undertaken to increase the oversight from the management committee of the running of the home, and this was continuing. Some committee members had left and new people were being welcomed who were bringing additional skills and knowledge. Committee members had visited another local home similarly operated by a charity and management committee. This was to see how changes the other home had made to their committee structure had impacted on the quality and safety of the services people received. The registered manager told us that the committee had learned from the visit the importance of having a 'visible presence' in the home. Since the last inspection there had been an increase in the 'visibility ' of management committee members during their visits to the home, with them spending more time talking with people living there. Committee members had received training in areas of

care practice, such as safeguarding and tissue viability to help them understand issues that may occur during their regular monitoring visits. We saw the chair of the committee had presented a new monitoring visit tool for committee members to ensure their feedback from visits was more robust. The registered manager told us they used the internet, CQC website and care press to support their learning and development. They told us they also attended a local forum for managers but had not done so recently.

People benefitted because the service monitored the quality of the care delivered through effective quality assurance systems. Questionnaires were sent to relatives, visitors and visiting professionals to gather their views about the operation of the home. Following the return of the questionnaires the results were analysed and an action plan drawn up. Questionnaires were due to be sent out again to people living at the home and their relatives. Following the last set of questionnaires being sent out feedback had been received that people wanted a wider range of activities. The registered manager told us that as a result they had "employed two different entertainers. Residents have also been busy during the year making various items i.e. painted bird feeders to put in the garden next spring, One of our activity co-coordinators does personal one to one activities monthly, which are aimed at residents who for whatever reason could not attend group activities." Staff feedback had led to them seeking additional training in areas of staff interest. There were regular staff and resident's meetings. The registered manager told us they had also received feedback from relatives about the CQC rating for the home, and had re-assured them that actions were being taken.

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 17 HSCA RA Regulations 2014 Good governance Records, policies and procedures were not all well maintained.