Margaret Clitherow Housing Association Limited

Margaret Clitherow House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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 33 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 see how the home was operating.

Concerns about the management of risks to people at Margaret Clitherow House had been identified at an inspection in September 2014. In December 2014 we carried out another inspection and found that the required changes to management systems had not been made and that this amounted to a breach of legislation that corresponded to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). 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.

We re-inspected the home on 6 January 2016. At the inspection on 6 January 2016 we identified concerns over a number of breaches of legislation including for safe care with regard to nutrition, 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 provider and registered manager needed to comply with the warning notices by 8 April 2016 (Regulation 12) and 27 May 2016 (Regulation 17). The home was rated as requires improvement overall but inadequate for the key question of well led.

This focussed inspection took place on the 22 June 2016. It was carried out to ensure the provider had met the requirements of the warning notices for Regulation 17 (Good Governance) and Regulation 12 (Safe Care and Treatment), and to follow up information we had received in relation to pressure ulcer prevention. Other areas for improvement identified during the inspection of 6 January 2016 remain part of the home's ongoing action plan, and will be looked at on the next comprehensive inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Margaret Clitherow House care home on our website at www.cqc.org.uk.

At this inspection 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, and were not always providing safe, high quality care for people.

Some risks to people's safety had not been properly assessed or actions taken to mitigate them, which meant that people could not be confident of receiving safe care. For example risks to people from tissue damage, poor nutrition or the management of long term health conditions were not always being identified or plans put in place to reduce them. Following the inspection we received information that told us that risks to people from pressure area care were being managed well by the home, in conjunction with the community nursing team.

Additional staff had been provided recently as the registered manager told us there had been an increase in people's dependency levels. However this was not based on a systematic analysis of the changing needs of people at the home. We have recommended a tool be used to determine the safe level of staffing based on people's needs.

The provider and registered manager were not operating effective systems to ensure people received consistent safe high quality care. Systems to audit and assess risks for example from medicines, the environment or poor infection control practices were not always thorough or accurate. Where risks had been identified there were not always clear actions in place to reduce risks to people from their care. We did however also see some developing good practice in this area. For example the service had recently taken prompt action to support a person accessing early support from the district nursing team.

Records, policies and procedures were still in many cases out of date or did not relate to the operation of the home. People's care plans did not always reflect their needs, or risks associated with their care and how they should be supported.

The management committee were developing their skills and operating greater oversight over the home. However they had failed to take sufficient action to protect people or ensure high quality and safe care.

We found that sufficient changes had not been made to meet the warning notices or improve the previous rating of inadequate for the key question for well led. Other ratings areas identified on the 6th January 2016 have not been changed as a result of this inspection but will be updated at the next comprehensive inspection. A comprehensive inspection will take place to inspect all five questions relating to this service. These questions ask if a service is safe, effective, caring, responsive and well led. At the next inspection we will also check to ensure improvements made for this inspection have been sustained.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. This is because the 'Inadequate' rating for well led has not improved.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's safety had improved in some areas, but this was not consistent. Some risks had not been properly assessed or actions taken to mitigate them. People could not be confident they would receive safe care.

Systems for assessing or reducing risks for example from the environment or cross infection were not thorough.

Systems to audit, identify and manage risks from medicines were not thorough or accurate.

Where risks had been identified there were not always clear actions in place to reduce risks to people from their care. We did see some developing good practice in this area.

The home were not using a tool to determine a safe staffing level dependent on the needs of people at the home. We have made a recommendation about this.

Is the service well-led?

Inadequate

The service was not well led.

Although there had been some improvements, the provider and registered manager had not taken sufficient actions to fully comply with the previously issued warning notices.

The registered persons were not operating effective systems to ensure people received consistent safe high quality care.

Records, policies and procedures were still in many cases out of date or did not relate to the operation of the home. People's care plans did not always reflect their needs, or risks associated with their care and how they should be supported.

The management committee were developing their skills and operating greater oversight over the home.

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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The inspection was also planned to look at actions taken by the provider and registered manager in relation to the warning notices issued following the inspection of 6 January 2016.

This inspection took place on 22 June 2016 and was carried out by one adult social care inspector and a specialist advisor. The specialist advisor had recent professional expertise in the assessment of people's healthcare needs including pressure ulcers. We looked at the information we held about the home before the inspection visit, including the inspection history, previous reports and the action plans sent to us by the provider. We spoke with the district nursing team and received information from them about the number of people with pressure ulcers they were supporting at the home. We contacted the local quality monitoring team from the local authority.

On the inspection we met with the registered manager. We spoke with five people receiving a service, four staff members, and a visiting district nurse. We looked at areas of the building, and sampled policies and procedures. We viewed the changes to the quality assurance and management systems that had been made since the last inspection. We sampled records including five people's care plans.

We also looked at risk assessments, minutes of meetings, sampled policies and procedures, audits and discussed the home's action plans and progress being made on the overall concerns identified.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 6 January 2016 we identified concerns had not been properly addressed in relation to the assessment and management of risks to people from their care needs, medicines management and risks from the environment. 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 to be complied with by the 8 April 2016.

At this inspection in June 2016 we looked to see what changes had been made and how risks to people were being managed and reduced.

We found that there had been some improvements. However, systems and practice was still not ensuring that risks to people were consistently being managed and mitigated or that care and treatment was being provided in a safe way. The warning notices had not been fully complied with.

Since the last inspection and the issue of the warning notices the registered manager told us that audits had been undertaken of risks within the environment. These had included portable radiators which had been removed, and the risk assessing of non-safety glass in some furnishings. We looked around the premises with the registered manager. We identified that although the risk assessments had been undertaken they were not thorough enough to identify all the potential risks to people. For example, we found a wall unit in one person's room that could be pulled over and other large items of furniture that were not secure.

Risks with regard to people's nutritional intake were not being consistently assessed or well managed. We looked at the care plan for one person who had diabetes. Their care plan indicated they needed a diabetic diet and medicine to manage this condition. However their daily notes indicated they regularly refused meals. They had lost 6 lb in weight in a period of five weeks. The person's overall weight was still at a healthy level. The home's records stated the person was to be weighed the next week, but there was no record of what other actions to take to monitor any risks to the person's health and well-being or support them to have good nutrition. No record was being maintained of their food intake and a risk assessment for their nutritional status had not been updated. Other people who were having their food intake monitored did not have this recorded consistently. Therefore it was not possible to assess the amount of food the person was having or if this was sufficient to maintain their health. For example some people's food intake records just indicated "Porridge" or "pudding" without any information about the amounts taken.

One person's notes indicated they were low in mood and refused food regularly. The person had lost nearly a stone in weight in less than 4 weeks, but there was no care plan or guidance for staff on how to support the person to eat a healthy diet or improve their mood. Another person's notes indicated they had been seen by the dieticians and advice had been given that they should have a fortified diet including a pint of fortified milk a day due to being at risk of poor nutrition. We spoke with a staff member and cook who told us this person was not having a fortified diet provided. The person's weight was reasonably stable. Staff told us they achieved this by giving the person sweets and chocolate. They said they were giving her chocolate

biscuits and bars "as we know she will eat those". This was helping to maintain the person's weight but was of questionable nutritional value.

The care notes of one person living with dementia indicated there had been incidents where their behaviour presented risks to themselves or others when staff were supporting them with their care. There was no clear guidance in the person's notes about how staff should support them with the risks presented by their distressed or agitated behaviour. The only guidance was recorded as "Client has continued to be aggressive and hitting out to carers despite being told why we need to wash and change" them. This did not demonstrate an understanding of the person's behaviour or psychological needs. There were no adaptations to the person's environment to help them make sense of their surroundings or to reduce risks from their confusion. This person had been referred by the home's management to the local Older Person's Mental Health Team for review.

Information about the management of individual infection control risks associated with people's care was noted in their files. Some areas of the assessments were not provided in sufficient detail. For example "Care plans to reflect care for catheter and stoma care" but no detail about what this would include.

We found that risks associated with medicines were still not all being well managed. Creams in people's rooms were not marked with an opening date, so it was not possible to see how long they had been in use for, and therefore staff could not judge if the creams were still effective or safe to use. For example, we found a prescribed pain relieving cream in one person's en-suite bathroom issue dated from March 2012.

People were not always being protected from the risks of infection. The registered manager told us that an infection control audit had been carried out at the home in April 2016. We looked at this and saw it did not cover all potential risks at the home, for example the disinfection of potentially contaminated linens. We went with the manager to the laundry and spoke with the staff there. The home did not have information or policies about the safe systems for laundering potentially infected linens. The laundry staff on duty could not find any information or policies about this, although they had an understanding of basic systems, such as the use of dispersible bags. Information in the laundry stated that "linens should be treated according to the policy", but there was no policy in place.

Concerns had been raised through a safeguarding process about the development of pressure ulcers at the home. We looked at the care records of three people in detail, sampled others and discussed their care with staff, a visiting district nurse and the registered manager. We looked at the care records for one person who had multiple pressure ulcers that had developed whilst living at Margaret Clitherow House. The person had moved to the home with a recorded concern from their previous placement that they had a reddened area to their sacrum. There was advice that this needed to be monitored and the area creamed, however the person had refused care and support from Margaret Clitherow House staff for several days. The person's records indicated that six days after their admission to Margaret Clitherow House the person had developed pressure ulcers to their heels and sacrum. Advice had not been sought from the district nursing team until the ulcers were discovered by a healthcare professional. A body map and other records had not been completed fully or were inconsistent. The daily notes indicated the person had been refusing care, but no action had been taken to review the person's skin integrity or review the risks to their health and well-being. The safeguarding process was still open at the time of the inspection.

The failure to ensure people received safe care and treatment is a breach of Regulation 12 (1) and (2) (a) (b) (d) (g) and (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014 – (Safe Care and Treatment).

Following the inspection and as a part of the safeguarding process the tissue viability service visited the home. We received information to show that they were satisfied that the service was managing people's needs for pressure relief in conjunction with the community nursing team. Additional training was being provided for staff in pressure relief and the prevention of pressure ulcers. Community nurses were visiting the home daily and reported to us that staff were referring people at an early stage for advice on pressure area care. One person had been recently admitted to the home with concerns over their skin. They had received a more thorough assessment and a referral to the district nursing service for support and appropriate equipment had been made in a timely way. This had been effective in managing the risks and reducing the risk of additional harm.

Staffing levels had been increased to meet people's needs as the registered manager felt there was a higher dependency level, but this was not based on a formal assessment of need. The registered manager told us they were intending to meet with the chair of the committee to discuss the provision of additional staff. The registered manager told us they had not managed to find a staffing assessment tool that met the home's needs, and acknowledged that this was a piece of work that they "haven't done yet". We recommend the provider identifies and implements a tool designed to assess staffing levels based on the needs of people living at the home.

Improvements had been made to the fluid balance charts which were now being completed well.

We saw a member of staff supporting one person by emptying their catheter. This was managed well, with appropriate infection control practices in use. Areas of cleanliness had improved. For example, some cleaning schedules had been provided, and new medicine cupboards were being fitted in people's rooms to safely secure their creams.

Inadequate

Is the service well-led?

Our findings

At the last inspection of Margaret Clitherow House on 6 January 2016 we had identified concerns over the lack of effective governance, leadership and systems in place to monitor the quality and safety of services. These had in part been of concern from the preceding inspection of 2014. 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 key question was rated as inadequate.

On this focussed inspection in June 2016 we looked to see what had changed as a result of the warning notices. We saw although some improvements had been made, sufficient action had not been taken to ensure effective governance of the service. There were still concerns over records, auditing systems, quality and safety.

Effective systems had not been put into place to assess, monitor and improve the quality and safety of the services provided. The registered manager had a list of regular audits that needed to be put into place, and had commenced these. However, despite some audits having been carried out we identified that they were not always highlighting the concerns we were identifying. For example, a medicines audit had been carried out in June 2016. This had indicated that labels on creams had an opening date recorded. However when we looked we found this not to be the case. Systems to ensure risks to people's care were not always being identified, managed or mitigated. Environmental audits had not always identified risks to people from the building or furnishings. The infection control audit had not identified a lack of policy or information about the management systems for potentially infected linens.

Records were still not being well maintained. Policies and procedures we sampled were out of date in many cases. The registered manager told us that some policies and procedures had been recently purchased from a records management company. However these were also out of date and had not been amended by the registered manager to be fit for use at Margaret Clitherow House. For example the 'new' medicines policy and procedures referred to predecessor regulators and previous regulations now out of date. Policies were not in line with basic practice at the home, for example the home's skin integrity policy indicated that each person at the home should have their pressure ulcer risk assessment updated weekly. The registered manager told us that this was not what happened and we saw from the files that this had not taken place.

An accurate, contemporaneous and complete record of the care and treatment provided was not being maintained for each person living at the home. A new system for care planning had been introduced, but the new system had not ensured that people's records were being kept up to date or reflected their needs. The registered manager told us the new system was clearer for staff to use and we saw that most care plans had been completed. However some of the plans still had gaps or areas where updates were needed. Some days there had been no individual recordings for people, which made it difficult to track the progress of concerns or improvements to the person's condition. Assessments and care plans had not always been developed in a timely way as a result of concerns. The failure to have systems in place that effectively assessed and managed risks to people's health safety or welfare had left people at risk of poor outcomes.

Systems had not been put in place to ensure risks to people were being analysed or had been reduced where possible. At the last inspection in January 2016 we had concerns that there was no system in place for analysing incidents and accidents to help prevent a re-occurrence and learn from the outcome. On this inspection in June 2016 the registered manager showed us a log that they had provided which listed incidents, accidents and what had happened. However there was no clear system as part of this for the in depth analysis of incidents, reporting of concerns to other agencies and the management committee or of recording learning and changes made to prevent a re-occurrence.

The registered persons had not put in place effective measures to address the long standing concerns about the management of the service or meet the requirements of the warning notices.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Good Governance).

There had been some improvements at the service. The management committee had increased their oversight of the home and were undertaking further training to help them monitor the practice at the home. For example training in safeguarding practices. External professional advice and support had been provided from a management consultancy, to provide support to the registered manager and undertake some training for staff. District nurses were planning to attend the home to support staff to understand good practice in pressure ulcer prevention.

There had been improvements to some records, for example the completion of repositioning charts and monitoring or pressure relieving equipment had improved. Staff were regularly checking and recording the settings of pressure relieving equipment to ensure it was appropriately adjusted to the person's weight.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way. Risks to service users had not been properly assessed or actions taken to mitigate them. Medicines were not being managed safely. Regulation 12 (1) and (2) (a) (b) (d) (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have issued the provider and registered manager with a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not being protected because there was not an effective system for assessing, monitoring and improving the quality and safety of the services provided. An accurate and complete record was not maintained for each person; and records related to the management of the service were not up to date. Records were not being properly Regulation 17 (1) and (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have issued the provider and registered manager with a warning notice in relation to this breach