Care Quality Commission

Margaret Clitherow Housing Association Limited

Margaret Clitherow House

Inspection report

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Date of inspection visit: 6 January 2016
Date of publication: 26/04/2016

Ratings

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

Overall summary

This inspection took place on 6 January 2016 and was unannounced.

Margaret Clitherow House is a care home, registered to provide accommodation for up to 41 people needing personal care. On the day of the inspection there were 36 people living at the home, all of whom were older people, some of whom were living with dementia. 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 or work there.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager of the home is supported by a management committee of trustees.

Margaret Clitherow House was inspected in September 2014 when there were a number of concerns identified in relation to people's safety, including breaches of regulations in respect of risk assessments and medicines management.

On 2 and 3 December 2014 we carried out another inspection to check what improvements had been made. We identified concerns about failures to assess risks to people or update risk assessments including those relating to pressure area care, which amounted to a

Summary of findings

breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home was rated as requires improvement. Following the inspection the provider organisation sent us an action plan telling us what they intended to do to put this right. They later wrote and told us they felt they had made the changes needed.

This inspection was undertaken to review the changes the home had made. We found that although there had been some improvements there were areas that had not improved, and some additional concerns were identified. These were similar to those identified at the inspection in September 2014. This told us that improvements that had previously been made had not always been sustained.

Risks to people were not always being assessed, or actions taken to minimise the risks of harm. We identified risks in relation to people's care needs or the environment were not always being identified or addressed. Where risks had been identified, actions were not always recorded to ensure staff were aware of the care and support the person needed to reduce the risk. Medicine practices were not always safe. We saw evidence of one instance where one person's prescribed cream had been used for a person for whom it was not prescribed. However we also saw good practice with regard to medicines; people told us they received their medicines on time and when they needed them.

While many people told us they were very happy at the home, some people told us staff were not always respectful to them or did not always listen to their wishes about their care. We saw some practices were in place that showed us the home was not always operated with the people living there in mind. People's dignity was not always being respected. However we also saw some good practice that showed staff cared about people at the home. Records showed respectful language was used to describe people's care, but these were not always being maintained confidentially. Activities provided by the home were not always person centred and did not always reflect people's interests, although people enjoyed the activity on the day of the inspection. Some people who spent most of their time in their room were at risk of social isolation.

Care plans did not always accurately record people's wishes or needs consistently or for example reflect the impact of any dementia. People who were at risk of poor food or fluid intake were being monitored to protect their health. However records regarding their nutrition or hydration were not always being completed in enough detail to ensure people received the food and drink they needed to maintain their health. People had access to community healthcare services to meet their needs, and visiting healthcare professionals told us they were satisfied with the standards at the home

We received mixed feedback about whether there were enough staff to support people, and there was no system in place to determine the appropriate staffing level based on people's needs. People told us staff were always busy. We did not identify that people's needs were not being met on the day of the inspection, however people told us sometimes it took a long time for their bells to be answered. We have recommended the home use a staffing assessment tool to identify the staffing levels required based upon an assessment of people's needs.

Complaints and concerns were not always managed well. Although systems and policies were in place they were not up to date. Not all concerns and comments raised or actions taken were recorded, so it was not possible to see what actions had been taken to remedy the concern or if the issue had been raised on several occasions. People were clear about who was 'in charge' at the home and had access to members of the committee who regularly visited the home if they wished to raise a concern.

Staff understood their responsibilities with regard to safeguarding people, and told us they would act upon any concerns that they had about people's welfare or well-being. Staff received the support and training they needed to do their job. They felt supported by the registered manager, and wanted to develop further in their role. However, staff were not clear about the requirements of the Mental Capacity Act 2005 (MCA) in assessing people's capacity to make decisions, or ensuring any decisions made about people's care were in their best interests. Assessments had not been completed or best interests assessments made in line with the MCA.

The building presented challenges due to its layout and design, but all areas seen were clean, warm and comfortable, and people told us they enjoyed the

Summary of findings

'character' of the rooms. Adaptations had been made wherever possible to ensure people's needs could be met. People had bought their own belongings into the home to make it comfortable and familiar to them.

People were consulted about the operation of the home and how improvements could be made. Some quality assurance systems were in place, including questionnaires for stakeholders and meetings to enable them to have a say in how the home was run. There were regular 'residents meetings ' and people had opportunities to meet with members of the management committee. There was a monthly newsletter to share information about the home. Most people overall expressed satisfaction with the home and told us they were happy there. A visitor told us "If I had to go anywhere it would be here".

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The home was not always safe.

Risks to people were not always being assessed, or actions taken to minimise the risks of harm.

Medicine practices were not always safe.

Staff understood their responsibilities with regard to safeguarding people, and told us they would act upon any concerns that they had.

We received mixed feedback about whether there were enough staff to support people, however there was no system in place to identify the number of staff required based on people's needs. Recruitment procedures at the home were robust enough to protect people.

People who were at risk of poor food or fluid intake were being monitored to protect their health, but records regarding their nutrition or hydration were not always being completed in enough detail to ensure their health and well being was maintained.

Is the service effective?

Requires improvement

The home was not always effective.

Staff received the support and training they needed to do their job.

Staff were not always following the Mental Capacity Act 2005 in assessing people's capacity to make decisions, or ensuring any decisions made about people's care were in their best interests.

People had access to community healthcare services to meet their needs

The building presented challenges, but all areas seen were clean, warm and comfortable. Adaptations had been made wherever possible to ensure people's needs could be met.

Is the service caring?

Requires improvement

The home was not always caring.

People told us staff were not always respectful to them or did not always listen to their wishes about their care. We saw some good practice that showed staff cared about people at the home.

Some practices were in place which showed us the home was not always operated with the people living there in mind.

Summary of findings

People's dignity was not always respected. Records showed respectful language was used to describe people's care, but were not always being maintained confidentially.

Is the service responsive?

Requires improvement 

The home was not always responsive.

Care plans did not always accurately record people's wishes or needs consistently or reflect the impact of any dementia across all aspects of their life.

Activities were not person centred and did not always reflect people's interests. Some people were at risk of social isolation.

Complaints and concerns were not being managed well. Although systems and policies were in place they were not up to date. Not all complaints or actions taken were recorded.

Is the service well-led?

Inadequate 

The home was not always well-led.

The provider and registered manager had not fully addressed areas of concern from the last inspection. Audits that had been put into place had not always identified concerns, and additional areas of concern had been identified on this inspection.

Some records were not well maintained.

People were consulted about the operation of the home and how improvements could be made.

Some quality assurance systems were in place, including questionnaires for stakeholders and meetings to enable them to have a say in how the home was run.

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 registered provider was 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. It was also to look at improvements that had been made to the home since our last inspection of the home in December 2014. At that time we had identified a number of concerns about the home. Following the inspection the provider sent us an action plan telling us what changes they intended to make.

This inspection took place on 6 January 2016 and was unannounced. It was carried out by two adult social care inspectors.

On the inspection we spoke with 17 of the 36 people who lived at the home, three visitors, a visiting district nurse, a visiting healthcare assistant and six members of staff. We spoke with the staff about their role and the people they were supporting.

Before the inspection we contacted the local authority quality team to gather their views about the service.

We looked at the care plans, records and daily notes for six people with a range of needs. We looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We reviewed three staff files to check the home was operating a full recruitment procedure, as well as 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

Margaret Clitherow House was inspected in September 2014 when there were a number of concerns identified in relation to people's safety, including breaches of regulations in respect of risk assessments and medicines management. On 2 and 3 December 2014 we carried out another inspection to check what improvements had been made. We identified concerns about failures to assess risks to people or update risk assessments including those relating to pressure area care, which amounted to a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home was rated as requires improvement for this key question. At this inspection we looked to see what had changed.

On this inspection we saw people were not always being protected from risks from the environment or with their healthcare needs. Some improvements were needed to the systems for medicine administration.

Risk assessments had not always been undertaken for people's care needs, and where in place these had not always been updated to reflect people's changing needs. Not all assessed risks had action plans associated with them, aimed at reducing the risks to people. For example one person's care records in December 2015 indicated they had a reddened and vulnerable area on their sacrum. On 28 December 2015 the person's care notes indicated the previously red area had become a sore. The district nurse had assessed this and ordered a pressure relieving mattress be obtained for the person, which was provided. However prior to this there had been no entries on the person's notes regarding how to manage the sore area and prevent deterioration. We asked a member of staff if the person had pressure sores. They told us "Not as far as I am aware".

Not every person living at the home had an accurate and up to date care plan, based on an assessment of their needs. One person was at the home for a period of at least a months respite care but there was no plan in relation to their care needs or how they were to be met. Although the person told us they were relatively independent, no assessment of their needs was in place, and there was minimal information available on their clinical profile to enable staff to identify any potential healthcare needs, risks associated with their care or what support the person wanted.

One person had a urinary catheter in place, but there were no risk assessments in place to identify or manage any infection control risks associated with this. We observed staff delivering care to a person in their bed. We saw they wore gloves but not aprons. We asked them if they would usually wear aprons to support the person and one told us "sometimes we do". There was no care plan or clear understanding in relation to managing any risks for controlling infection for this person.

One person had recently been hospitalised with a long term health condition. There was no risk assessment in relation to the management of the long term condition in their file either before or after their admission. There was no plan in place to manage the assessed high risk to them of pressure ulcers.

Risks to people from the environment were not always identified or addressed. Central heating radiators had been covered to protect people from coming into contact with hot surfaces. However a number of people had unguarded or unsecured electric radiators in their rooms which also had very hot surface temperatures. High windows were opened with looped cords which could present a ligature risk. Some furniture in corridors contained period glass rather than safety glass at heights that would injure people if they fell against them. A wash hand basin had a cotton hand towel for people to dry their hands on, which could present an infection control risk. Some aerosols and cleaning chemicals had not been locked away. The registered manager told us they assessed the safety of the environment through regular daily visual checks, but these risks had not been identified or addressed.

Accident forms were completed by staff and people were assessed for their risk of falling, but there was no system in place to audit incidents or accidents in order to prevent a recurrence.

One person with significant ill health was having their food and fluids recorded on a balance chart. The food and fluid balance charts did not always include the amount of food or fluids taken in, for example some entries just recorded "tea". There was no suggested target amount to maintain the person's health or a daily total of the fluids they had drunk. This meant it was not possible to assess if the person was getting the fluids they needed. No fluids had been recorded as being given to the person after the

Is the service safe?

evening meal over the six nights previous to the inspection. The registered manager told us they thought this was because the night staff had not recorded this rather than the person not having been offered fluids overnight.

One person had been weighed regularly and their care notes indicated they had lost 6.5 Kg in weight over a period of three and a half months. There was a risk assessment in place to identify the risks to this person from their weight loss. However there was no associated care plan or records of actions that had taken place to support the person's health and well-being to mitigate the risks. The person's daily notes indicated they had regularly refused food, but there was no record of what actions were being taken to support the person with their eating. There was no monitoring of the amounts of food or fluids taken by the person to ensure risks to their health were being mitigated.

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

People's medicines were not always managed safely. On the inspection we saw evidence staff had used a prescribed cream belonging to one person on another person for whom it was not prescribed. Information about this had been left on a note by a member of staff to inform the home's management on the day of the inspection. We identified devices to help people use their inhalers more easily were not being cleaned adequately in accordance with the manufacturer's instructions. One person had been prescribed an inhaler for "as required usage". This had been used twice a day for the last month. This had not been escalated to the prescribing GP for review.

Systems for the management of medicines were regularly audited by the registered manager, but they had not identified the concerns we had raised.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff supporting people to take their medicines. This was done well with the person given time to take them. Medicine administration records were completed well by staff. Where people required regular health monitoring due to the use of specific medicines there were effective systems in place to ensure, for example that regular blood tests were carried out. People told us they received their medicines when they needed them and we saw staff giving people time to understand and take medicines at their own pace. Storage arrangements were secure.

Systems were in place to ensure staff understood what to do to identify and report any concerns about people's well-being. Information about who to report concerns to was available in the home's office. Policies and procedures were available to remind staff of what actions to follow in case of concerns in safeguarding and whistleblowing policies. Staff had received training in understanding about abuse. Staff did not all know how to find information on where to report concerns further if the home's management did not respond to alerts made, although information was available on a notice in the dining room. They told us they would find out and do so if they were concerned. An incident that had been reported to the local authority safeguarding team by another agency had been investigated and found to have been managed well by the home. We did not identify any incidents where reports should have been made to agencies that had not been made.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff. We reviewed three staff files, and found the home had followed a full recruitment process, including disclosure and barring (police) checks for their appointment. One file only contained one reference for the staff member but we saw that other information was available in relation to their work history that demonstrated their good character. The registered manager was developing plans to involve the people living at the home further in the staff recruitment process, including interviewing potential new staff.

We received mixed information about whether there were sufficient numbers of staff on duty. The home was busy and active, but on the day we visited there were enough staff on duty to identify and meet people's needs in a timely way. Some of the people living at the home felt there were not enough staff at times. One person told us call bells took a long time to be answered, and another that staff were "overworked". Another person said "I ring them but they take a long time to come". However other people told us their needs were met in a timely way, and staff told us they felt there were enough of them to do meet people's needs.

The home's rotas showed that there were usually six-seven care staff on duty in the morning, including one or two

Requires improvement

Is the service safe?

members of the management team, an accounts clerk, dining room staff, laundry staff, a cook and kitchen assistant, domestic and gardening staff for 36 people needing care. This fell during the afternoons to five staff.

The registered manager did not have a tool to use to assess the staffing levels needed. We asked them if they felt there were enough staff on duty. They told us "More is always nice as there is more time for staff to sit and talk. Sometimes residents feel there are not enough staff". There was no evidence of what actions were taken to address this with people or to clarify their experience.

We recommend the home use a staffing assessment tool to identify the staffing levels required based upon an assessment of people's needs.

Requires improvement

Is the service effective?

Our findings

At the last inspection of the home in December 2014 this key question was rated as requiring improvement. At that time we had identified concerns over the home not ensuring they had an effective oversight over whether people were eating and drinking enough.

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.

We checked whether the service was working within the principles of the MCA. We found there was not a clear understanding of the MCA in practice with regard to people lacking capacity. The majority of people who lived at the home had the capacity to make their own decisions. However, where there was any doubt about a person's capacity, assessments to ascertain or clarify their capacity had not been completed. No 'best interest' processes had been followed or recorded to ensure people's rights and wishes where known were respected where they lacked capacity to make decisions for themselves.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty 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). The registered manager told us no applications for authorisations had been made, however they were considering whether one was now required for one person, and were preparing to make an application.

We received conflicting information about the meals served. Most people told us they really enjoyed the meals, which had improved since the last inspection with additional options available and reviewed menus. One person told us "Food very good and good choice" and another said the food was "marvellous". However, other people told us they did not have as much choice as they would like. One person told us they had not been asked for their food preferences and the menu was made a month in advance so there was little opportunity to change. They felt the home did not take sufficient account of their dietary choices, and there was not enough variety in foods available, especially at the weekends.

We spoke with the chef on duty. They told us that the menus were changed every three months in line with people's known preferences, choices and seasonal variations. There was a main meal option but people could choose something else like soup, salads or jacket potatoes as an alternative. The head chef had attended the most recent resident's meeting to gather people's views about menus and choices, and changes had been made to the menus as a result. Additional suggestions had been made for more salads, more choices on weekend evenings and some different soups which had been provided. The changes were then to be reviewed at the next resident's meeting. The most recent resident's survey indicated that most people were satisfied with the meals.

Information was available in the kitchen about people's known food preferences or special dietary needs. Meals could be prepared with artificial sweeteners to support people with diabetes, and in a liquidised or softened format for people with swallowing difficulties. The chef told us that in their opinion people ate well, and that the staff also ate meals on duty which "speaks for itself".

Staff files recorded the training staff received when starting at the home and on a regular basis throughout the year. Staff had received an induction programme that helped them understand their role at the home. One staff member told us they had shadowed a senior carer for a month, to ensure they had the skills they needed and understood how people liked their care delivered. No staff at the home had started completing the care certificate but the registered manager was aware of the qualification and told us they would use it when new staff were appointed. This is a nationally recognised induction programme aimed at staff across all care sectors.

Staff told us they were up to date with training they needed to do their job. Their files contained copies of certificates for training, including core subjects such as first aid and health and safety. Staff also had attended training in areas to support individual people living at the home, such as eating and swallowing and dementia. Staff told us they

Requires improvement

Is the service effective?

would like to do more training in areas of specific interest. They also told us they felt supported by the registered manager. This included regular supervision sessions and observations of their practice.

People had access to healthcare services in the community. This included dentists, podiatrists, speech and language therapists, psychiatric nurses and GPs. District nurses came to the home if needed to review and support the home with people's pressure area care and to manage any nursing needs. We spoke with a visiting district nurse and healthcare assistant. They told us they were satisfied with the standards at the home. They felt they were called in early enough to help support and manage any concerns about people's health. They said staff were always available to help them if needed, communication had improved and staff were able to give good feedback about people's conditions.

Margaret Clitherow House is a care home located within the building of an old convent. This presents challenges in terms of maintenance and access for people with problems with their mobility. Adaptations had been made to the building to minimise challenges to people wherever possible, including adding lifts and levelling floors. All areas of the home seen were clean, warm and comfortable. People told us they liked the building, even though it meant some rooms were smaller or had high windows, as it had character. Many people had personalised their rooms with their own furnishings, and some people had created living and bedroom areas which they told us made them feel more able to entertain friends and feel at home. Systems were in place to respond to maintenance challenges and staff were employed to keep the home clean, manage the laundry and maintain the gardens. A cleaner told us that they had all the resources they needed to keep the home clean.

Requires improvement

Is the service caring?

Our findings

The home was not always caring.

People's choices about their care were not always respected and the home had some practices that did not reflect the home being run for the benefit of the people who lived there.

We received mixed information about the caring aspects of the home. Most people told us the staff were kind and caring. One told us the staff were "very good, friendly, will do anything for you" and another said the staff were "so wonderful, so good". A visitor told us "If I had to go anywhere it would be here". However one person said "They treat you like idiots" and that there was "no respect from younger ones. So petty".

We saw people being supported well by staff during the inspection. But one person told us they felt they had been spoken to rudely that morning by staff. We discussed this with the registered manager with the person's permission. The registered manager undertook to speak with the person to look into their concerns.

We saw evidence the home was not always run in ways that encouraged people to think of it as their home. For example we saw a sign on the dining room door. This stated mealtimes were at "9am, 12:30pm, and 6pm. No entry until 15 minutes before the mealtime." We asked the registered manager about this. They told us this was a health and safety issue as the dining room staff were laying out items. This did not reflect a homely atmosphere or a comfortable environment for people. A person living at the home told us that "all activities were on a timetable" and another that everything was done by routine.

Some records were not being maintained confidentially. We saw some records used to monitor and interpret a person's behaviour in a corridor where they could be seen by anyone passing. Other records were kept in the main office or clinical areas. Records that we saw were written in a respectful way.

People's dignity was not always respected. We saw one person was in their room during the afternoon. They were very confused and unable to communicate with us about their experiences. They had been given a tablet as a part of their lunchtime medicines which had left a chalky residue around their mouth and tongue. This was still there at 3.10pm when we went into their room. People's privacy was respected and personal care was provided in private. Staff knocked on people's doors before entering.

Staff knew people's needs well, and told us they enjoyed working with people at the home. The registered manager told us staff took enjoyment in sharing their lives with people at the home, for example a member of staff had recently bought in their kittens for people to see. We observed a member of staff giving out cups of tea in the afternoon to people in their rooms. We saw they interacted sensitively with each person, encouraging and supporting them. We also saw two staff members supporting a person who was being nursed in bed. They spoke with the person throughout the procedure offering them re-assurance and friendly support. Staff spoke kindly about people they were supporting. One visitor told us "If I had to go anywhere it would be here".

We saw that at a recent 'resident's meeting' people had requested staff call them by their names and not use terms such as "sweetheart, pet or darling". This showed a potential lack of respect, and the manager told us this had been shared with staff to ensure they did not do this in future. We did not hear this happening on the inspection.

There was a newsletter to share information with people living at the home. This included information such as who had a birthday and any new people living at the home. This was in a large print format and coloured fonts to help people read the information.

Requires improvement

Is the service responsive?

Our findings

At the last inspection in December 2014 there were concerns over care records lacking significant details on people's care needs. Information contained in care plans was not consistent and people or their relatives had not been involved in writing the plans in relation to their care. On this inspection we looked to see what had changed.

The registered manager told us since the last inspection the care plans had been re-written to include much more 'person centred' information, and detail about how people liked their care to be delivered. However, we found care and treatment was not always designed to identify or meet people's preferences, because the care planning systems did not identify sufficient information on people's choices in relation to their care. Systems for the management of complaints were not robust, and activities were not always person centred.

People and their relatives could not all remember being involved in the initial care planning. However they told us they would be happy to discuss them with the registered manager if there were any changes. Plans were being audited by the registered manager, who confirmed that although they had made significant progress they acknowledged some areas were still work in progress. Staff told us they understood how people liked their care to be delivered. They could tell us for example how people communicated their wishes and told us that people's choices were respected.

However, care plans seen did not always include enough information to help staff meet people's needs in the way they wanted, and we found people's care was not always delivered in accordance with their wishes. One person's plan contained information on their preferred going to bed and getting up times, and another person told us they got up when they wanted and had breakfast in their room from choice. But another person told us that the time they 'were made to get up' depended more on which staff were on duty. Another person told us staff had not respected their wishes in relation to bathing. They said "They insisted I be bathed by them – I could do it myself". They told us they had felt uncomfortable at having this done. This did not demonstrate that the home was always working in accordance with people's preferences about their care.

Several care files contained incomplete documents in relation to people's wishes about their care or life history. The care plan of one person who was living with dementia had an "All about me" form that had only been partially completed. Under the section for "interests" this said that the person liked to 'watch television', but gave no indication of what programmes they enjoyed. This told us staff did not always have the information they needed to meet people's care preferences if the person was not able to tell them what they wanted.

We were told one person who had dementia spent much of their time upstairs in their room, as they became 'anxious' when in groups of people. The home's staff did not bring them downstairs to the communal areas as a result, which meant they were essentially confined to one area of the home. We met the person in their room. They engaged happily with us and followed us down the corridor, eager to talk to people. Their care plan had a section to be completed to give staff more information about what made the person worried or anxious, and how they could be supported at this time. However, this had not been completed. A staff member confirmed the person got agitated or distressed at times and that staff managed this in different ways, dependant on the day. This was not guided by information learned from previous experiences, the person's known wishes or a knowledge and understanding of the person and their behaviours in the context of the life they had lived.

A person at the home for respite care had no records to evidence discussions had taken place with them over their care needs or preferences while at the home.

The home did not use tools to support staff to understand when people who might not be able to communicate with them verbally might be in pain and require pain relief. However we did not identify any instances where people had not received the pain relief they needed, and staff were able to tell us how they would understand if people were in pain.

Care files contained some information on people's individual preferences for activities, hobbies and interests. However it was not always possible to see how this had been reflected in the activities that were available. For example one person told us they had an interest in photography, and that the activities at the home were not to their taste. Many people told us they would like to participate in more trips out. A visitor told us they felt there

Requires improvement

Is the service responsive?

were not a lot of activities available at the home, and that they could be improved with more variation. One person's plan indicated "I like to spend my mornings in my room, afternoons in my room, evenings in my room" with no further detail.

There was an activities schedule in place. On the day of the inspection there was an armchair exercise session which people enjoyed. A timetable for the month of January showed weekly activities with 'Sarah' on a Monday, Bingo on Tuesday, Wednesday musical exercises, Thursday activities with 'Sarah' and Saturday a knitting club in the gazebo, run by people living at the home. On Monday 11 January it indicated that one to one sessions were carried out. However, there was no evidence of the support or activities provided to people who spent most of their time in their rooms through ill health. This could leave people at risk of social isolation.

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

There was a policy in place for dealing with any concerns or complaints, and this was on display in the home. However this was out of date in that it did not reflect all relevant organisations outside of the management of the home to whom concerns could be addressed. One person told us they had felt the need to discuss staff member's attitude in the past with senior staff, but nothing had improved. This was not at the level of needing a safeguarding referral. We spoke with the registered manager about this with the person's permission. The registered manager told us the staff member had been spoken with, but when we checked this was not recorded in the staff member's personnel file or supervision records or as a complaint. This meant it was not possible to see what actions had been taken to address the concerns. There was no system to audit concerns, and some issues that had been raised by people had not been properly recorded. This meant that it was not possible to identify if the same issues were re-occurring.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection in December 2014 we had identified concerns over a lack of audit processes and systems to ensure the quality and safety of people at Margaret Clitherow House. The home was rated as 'requires improvement' for this key question, and the provider sent us an action plan telling us what they were doing to address the concerns. The home had also been working with the local authority quality improvement team to improve standards at the home.

On this inspection we identified that although some improvements had been made, the home was not always being well led.

The registered manager had told us they were confident they had made the changes needed following the last inspection. However, we found the home had not taken sufficient actions in relation to the findings of the last inspection, although some improvements had been made. For example the care plans had been updated and re-organised to include an index to make it easier to access information. However there was still a lack of clear personalised care planning reflecting people's needs and wishes regarding their care, and in one instance there was no plan of care for a person at the home for a months respite care.

Systems were not in place to ensure people received care in accordance with their wishes, as care plans or the care people recieved did not always reflect their choices. Systems were not in place to ensure the home acted in accordance with the Mental Capacity Act 2005 to support people in making decisions. Some people remained at risk of social isolation as systems had not been put in place to ensure their needs for activity and stimulation were met.

Since the last inspection a system for auditing medicines management at the home had been implemented. However the system had not identified the concerns we found on this inspection with regard to medicines management. This told us the system for auditing medicines that had been put into place was not operating effectively.

We identified risks to people from the environment that had not previously been identified through the home's own audit systems. Systems were not in place to analyse accidents or incidents to help prevent a re-occurrence.

Complaints or concerns were not always being acknowledged or managed effectively and systems were not in place to ensure staff understood their responsibilities in relation to whistleblowing.

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The committee had made improvements to the monitoring and auditing systems they carried out at the home since the last inspection, with an improved recording and reporting process. People were aware they had opportunities to raise any concerns with committee members on their visits which were publicised in advance. However the reports produced following these visits had not identified concerns for example with regard to care planning systems or risks in the environment. This told us they were not operating as an effective system to audit the home against best practice or to challenge and review the home against best practice.

Records were not all well maintained or up to date. At the last inspection there had been concerns over the quality of the records being maintained. At this inspection we found systems had not been put into place to ensure records were up to date, comprehensive or fully completed. For example care records were not all accurate or reflective of people's wishes. Fluid balance charts were not being completed properly by staff to protect people from the risks of poor hydration and maintain their health. They were not recording the amounts of fluid people were taking, or a fluid target for that person to aim for to maintain their health. Records were not being completed over a 24 hour period, so it was not possible to assess the fluids people had drunk. People's weight was being recorded regularly, but where they had lost weight there was not always an action plan or care plan in place to demonstrate what actions were being taken to support the person and reduce risks to their well being. Records of the management and mitigation of risks were not thorough.

Ineffective leadership was not pushing forward developments at the home. We found that the improvements that had been made since the last inspection had been made in response to the last inspection report and not as a result of quality improvement initiatives devised by the home. Care and support provided to people was in some instances intuitive rather than being guided by good practice, for example with the support offered to people with dementia.

Inadequate

Is the service well-led?

Margaret Clitherow House had a registered manager, who had been in post for two years. The provider organisation had an established management committee who visited the home regularly and made themselves available to speak with anyone at the home if they wished. However this stability had not led to sufficient improvements in governance or clear leadership and development of the home.

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

Staff told us they had confidence in the registered manager and felt well supported by her. There was a defined management structure at the home, including the registered manager, deputy managers, and senior care staff. Care staff understood who they needed to report concerns to. People living at the home told us they knew who was "in charge" and most told us they had confidence in the home's management to resolve issues. However one visitor told us they felt at times the home's management was 'indifferent' and 'not visual enough'.

Questionnaires had been sent to relatives, staff and other supporters of people who lived at the home to gather their views about the service. These had been collated and feedback made available to people who had participated. Some suggestions had been made as a result of the survey, for example changes to the menus which had been implemented. There were also regular residents meetings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: Assessments of people's needs and preferences were not always being carried out. Care and treatment was not always designed to meet people's preferences about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: Assessments had not been made of people's capacity to make decisions for themselves and best interests decisions made on behalf of people lacking capacity were not assessed or recorded in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

Robust systems had not been established for the management of complaints.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) and (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: 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 maintained

The enforcement action we took:
We have issued the provider and registered manager with a warning notice with regard to this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) and (2) (a) (b) (d) (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met:

This section is primarily information for the provider

Enforcement actions

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.

The enforcement action we took:
We have issued the provider and registered manager with a warning notice with regard to this regulation.