CareTech Community Services Limited

Clock Tower Mews

Inspection report

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Date of inspection visit:
27 February 2017

Date of publication:
07 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Clock Tower Mews on 06 October 2016, 13 October 2016 and 11 November 2016 and found the service was meeting the required standards. We rated the service as good.

We undertook a focused inspection on 27 February 2017 in response to concerns raised to us about the safety and management of the care people received. These concerns referred to mismanagement of people's finances, a lack of staff to meet people's personal care needs and a lack of respect from staff towards service users. Although at this inspection we found no evidence to support the concerns raised, we did however identify breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to keeping people safe, managing incidents within the home, reporting concerns and governance.

Clock Tower Mews provides accommodation and personal care for up to eight people with learning disability support needs. On the day of our inspection, there were eight people using the service.

There was a registered manager in post. 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.

Risks to people's safety and welfare were not consistently responded to mitigate the risk of harm to people. People were not kept safe because incidents that occurred that may place people at risk of harm or abuse were not investigated and responded to. People's finances were managed well with robust measures in place. There were sufficient numbers of staff available to meet people's needs who had time to carry out their daily tasks in a calm and unhurried manner. The Registered Manager carried out a robust recruitment process that ensured staff employed were of sufficient good character to work in the home. Medicines were administered and managed safely by staff who had received training.

People's care records were not completed accurately as required and were also not stored in a safe and secure manner. Notifications that are to be submitted to CQC regarding notifiable events had not consistently occurred. Audits of the quality of service provided although completed were not effective in identifying gaps. Staff and relatives felt the Registered Manager was open, fair and responsive and kept them informed regarding developments within the home.

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 consistently safe.

Staff had been trained in safeguarding however processes to keep people safe were not consistently followed.

Risks were not consistently assessed and managed to reduce the likelihood of people receiving inappropriate care.

Staffing levels were appropriate to meet the needs of people who used the service.

People were supported by staff who had undergone a thorough recruitment process.

People received their medicines as the prescriber intended.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People's care records were not consistently completed when required.

Audits did not identify where there were gaps in the quality of care people received.

Notifications of events that are required to be submitted to the Care Quality Commission were not consistently submitted.

Staff meetings were held and people's views and opinions about the management of the home had been sought.

Peoples relatives and staff felt the management team were open, honest and transparent.

Clock Tower Mews

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 February 2017 and was unannounced. The inspection team consisted of one inspector and was carried out in response to concerns received about the safety and care provided to people in Clocktower Mews.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought feedback from professionals within the local authorities commissioning teams..

During the inspection we spoke with two members of care, the deputy manager and the registered manager. We looked at care records relating to three people together with other records relating to the management of the home. After the inspection we spoke with two peoples relatives for their experience of the care provided. We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs

Requires Improvement

Is the service safe?

Our findings

Staff spoken with were aware of how to report their concerns if they suspected a person was at risk of harm and had all received training in this area. One staff member told us, "We protect people from any type of harm or neglect or anything we suspect, like if they are marked or bruised we complete a special note and report to the manager . "Staff were aware of the providers whistleblowing policy and a phone line was operated where staff could report their concerns externally. Staff were aware of organisations outside of the home they could report their concerns to if they were concerned. One staff member said, "If I needed to, I would speak to my locality manager, the council, CQC or even the police." Staff had received training in relation to safeguarding adults, and where concerns had been raised, such as a recent concern regarding the consistency of people's meals, these had been discussed in meetings with the manager and staff had reflected on their practise.

Staff recorded any concerns they had on a 'Special note' form. These documents were used to record incidents, injuries or any notable information relating to a person's needs. We saw one example where a person had sustained an injury at day care, they were taken to the hospital where a fracture was confirmed and as the person was unable to communicate what had occurred and staff did not witness this, the hospital raised this as a safeguarding concern with the local authority.

However, where the Registered Manager was required to review further incidents or injuries people had sustained they had not thoroughly investigated or reported them appropriately. For example, one person was seen to have a bruise the size of a five pence on their chin. A body map had been completed, and the management team had been informed. When we looked for actions taken, we noted what had been recorded was, "Skin got better after applying zerobase cream. No further concerns." A second person had returned from day care at a local service provider with bruises on both knees and right thigh. The staff from the day centre had contacted the home by telephone on 29 November 2016 and informed staff of their findings. Staff had completed a special note, placed it in the box, but when we asked the Registered Manager what actions they had taken they said they were not aware of the incident at all. Where incidents were identified, robust procedures were not in place to investigate the cause and consider whether someone was at risk of harm. The Registered Manager had not considered whether these among other incidents required referral to the local authorities safeguarding team, or required further investigation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because upon becoming aware of an incident that may suggest a person was at risk of harm, the Registered Manager did not effectively investigate to prevent abuse of people using the service. We have reported our findings to the local authority.

We saw that risk assessments had been developed to manage risks to people's wellbeing that may leave them at risk of harm. Where a risk had been identified to a person, staff sought additional advice and guidance from healthcare professionals. For example, we saw that moving and handling assessments had been undertaken by a qualified occupational therapist. The guidance and recommendations from these assessments had been followed, and peoples care plans updated. People were provided with specialist

equipment where they were immobile, for example bespoke designed wheelchairs with pressure relieving aids and specially adapted beds incorporating pressure relieving mattresses and bed rails to keep people safe. People who were identified as being at risk from epileptic seizures were closely monitored through the night, and an alarm was attached to their bed that alerted staff in the event of a person having a seizure. In such an event, clear guidance was available to staff in relation to managing the seizure, and staff had all received appropriate training.

However, we spoke to a visiting professional who was dressing a wound for one person. This wound had developed on 13 February 2017. Prior to this date, due to existing skin integrity risks the person was repositioned four hourly when in bed. We saw that the health professional requested the positioning of the person to be increased from four hourly to two hourly on 13 February 2017, however staff did not commence this until 15 February 2017. Repositioning records we looked at prior to this time demonstrated that between 01 February and 10 February 2017, the person required four hourly positioning, but did not receive this. On each day they were positioned at 8am, 2pm, 4pm, and 8pm, and then not throughout the night.

Risks to people's health and well-being were not effectively mitigated. The registered manager had not ensured that care was provided to this person both in line with the current care plan, and also after being advised of a change in their needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an emergency evacuation plan in place, which helped ensure that in the event of an emergency people using the service were kept safe. Individual assessments were undertaken which looked at people's ability and support they would need to leave the service safely in the event of an emergency.

People's relatives told us that people were safe living at the home. One relative told us, "I visit regularly as do other members of the family, and I have not once been worried about [Person's] safety, the staff all do a fantastic job looking after them." A second relative told us, "There are no concerns about [Person] being safe from my point of view, the care is exceptional."

Due to the nature of the concerns raised to us, we asked the Registered Manager and Deputy Manager to audit people's personal money that was held. Both money held in the safe and people's personal spending money was checked and we found amounts tallied correctly in all examples. There was a robust system in place that involved two staff countersigning when money was removed, and random checks were also carried out by the Registered Manager and locality manager. Where the provider was appointee for people's finances, robust systems were followed with a clear audit of how money when and why money was spent and decisions for larger items were taken in line with the requirements of the Mental Capacity Act 2005.

Staff and people's relatives told us there were enough staff available to support people when needed. One person's relative said, "They always have enough staff to help [Person] when they need it and have enough to be able to take them all places." Staff rotas showed that there were always sufficient staff on duty which was based upon the assessed care hour's people required. The atmosphere when we arrived was calm and relaxed. Staff were seen to be calmly going about their tasks, but also had time to stop and talk to people when needed. Where staff assisted people to eat their meals or drink, they did so focusing solely on that person, and at their pace. Staff did not appear rushed or under pressure as the information we received had suggested, and there were sufficient numbers.

When staff were recruited the Registered Manager had followed a robust pre-employment process. Three files we looked at demonstrated that a complete application form had been completed with a full employment history and references had been sought. Where staff had relevant qualifications, copies of

these had been seen. Before staff began working at the home they had undergone a criminal records check to ensure staff employed were suitable to work at Clock Tower Mews.
We reviewed Medicine Administration Records (MAR) which demonstrated that people had received their medicines as the prescriber had intended. We checked the physical stocks of medicines against the stock records held and found no errors. Each person's MAR documented clearly any allergies they may have and for medicine given as required, such as pain relief, there was clear guidance in place the instructed staff when to give and due to people's difficulty with communicating, how they would indicate they were in pain.

People medicines were regularly reviewed by the GP and other health professionals, such as the epilepsy nurse or consultant. Clear guidance was in place for staff to follow in the event of a prolonged epileptic seizure, and staff had been trained to administer the appropriate medicine if required. This was in addition to training all staff had received regarding administering medicines and each staff member had their competency regularly assessed.

Requires Improvement

Is the service well-led?

Our findings

Accidents and incidents were recorded but these were not consistently reviewed and analysed by the management team to enable patterns and trends to be identified so where possible plans could be put in place to keep people safe. We found that the process for identifying, investigating and reporting incidents where people may be at risk of harm was not robust. We found a black box file held on the desk in the reception area that contained various 'Special notes.' These were documents where staff recorded an incident of injury a person had sustained, and were placed in this box for management to review. We looked at the audits completed for incidents and saw that the Registered Manager had not recorded any since the last inspection. However upon review we found that several were significant and not identified through the audit process. The registered manager when shown this was unable to tell us why this was and expressed to us they were confused as to where the incident reports had come from. They acknowledged that it had been an oversight.

We asked the Registered Manager for a copy of the repositioning records for one person for January 2017. They were unable to find these, although assured us they had completed them. This person was also on a food and fluid chart, and required their daily fluid to be recorded and totalled. We saw this was not completed accurately. The person had a daily target of between 1500 and 200 millilitres; staff had recorded only 400 and 800 on two subsequent days prior to the inspection. This meant that the health professional reviewing the care of this person was unable to fully review the care provided as an accurate record had not been maintained.

The Registered Manager completed a variety of audits within the home to monitor the safety and quality of care provided. We viewed a number of these audits and saw that these were regularly completed and where issues were identified, they formed part of the service development plan that was reviewed regularly with the locality manager. The development plan is then shared with staff for discussion and for the staff to discuss possible solutions. The registered manager told us, "Me and the team complete the audit, then my locality manager checks when they visit, and then we all agree the actions. It's inclusive so the staff are able to know what's happening and share their opinions."

However, this system was not operated effectively as there were issues identified both with the auditing process and ensuring actions were implemented. The incident audit completed monthly, had not identified an incident or injury since August 2016. We found during this inspection incidents which needed to be logged and followed up. The registered manager told us that they had improved recording in people's daily records such as food and fluid and repositioning. They said, "We had issues with cleanliness and spot checks mostly at night but this has improved and staff are completing their spot checks at night now." We asked how this was monitored and they told us that they checked people's daily records to ensure observations and records were completed. However, findings from our inspection demonstrated that this was not effective as we found continuing gaps and missing records not identified. The Registered Manager told us that the provider also had a policy for visiting the service at night unannounced to carry out a visual check. When asked when they had carried out the last visit in light of the issues they had identified, they told us they had not carried one out at all.

Risk assessments in peoples files were not consistently updated s people's needs changed. The registered manager told us that peoples care plans were reviewed six monthly or when needs changed. However we found this was not consistently carried out. For example one person's epilepsy care plan had not been reviewed since September 2016; however they had experienced a number of seizures since.

Copies of peoples sensitive reports were held in a public area where visitors to the home had access to, and therefore could easily read personal information held about people not related to them. These 'Special notes' documented for example incidents relating to personal care and injuries sustained to people.

As systems were not effective in identifying and addressing risks to people's safety and welfare, and peoples records were not completed accurately, when required, or held securely we found this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications were not submitted to the Care Quality Commission regarding notifiable events or incidents as required. The Registered Manager told us of a series of safeguarding concerns raised to the local authority since the last inspection in relation to nutritional concerns. They had not informed the Commission of this. One person was referred to safeguarding by the local hospital following and injury which was unwitnessed. This also was not reported to the Commission as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a registered manager in place and they were supported by a deputy manager and a senior care team. Staff told us they felt able to approach any member of the management team and said that they were able to raise concerns or share ideas they may have in respect of the management of the home. People's relatives told us that the manager was open and receptive to feedback. One person's relative said, "They phone me sometimes, and I phone them, if [Registered Manager] is not there I leave a message and they get straight back to me. I think because the home is so small and the manager is hands on then that helps to make them more approachable."

There were regular staff meetings and these were recorded so that staff who were unable to attend could be kept abreast of any changes. The management team were visible throughout the home and were required assisted staff when providing care to people. Staff spoke highly of the registered manager and told us they felt supported and were able to approach them to discuss matters relating to the running of the home. One staff member told us, "I don't have any problems with the management at all, we have meetings where we are told what's going on and asked how we can make things better." However, people's relatives told us that attending relative meetings was difficult due to the times of the day held and most people were at work.

The provider had sought the views of people and relatives in a survey carried out in June 2016. The Registered Manager told us that they thought the uptake of the survey was low, and they had introduced a compliments and concerns book for people to add additional comments. We saw that since the last inspection, people's relatives and visitors to the home had made very positive statements both about the care provided and the manner in which the home was managed.

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 18 Registration Regulations 2009 Notifications of other incidents Care Quality Commission (Registration) Regulations 2009. Regulation 18 (1) (2) (e) The Registered Manager upon becoming aware of incidences where people may have been at risk of harm or abuse did not inform CQC as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and treatment (1) (2) (a) (b) The registered person did not ensure that all that was reasonably practicable to mitigate any such risks to people's health and well-being was provided in a safe manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) Systems and processes although established were not effectively operated to investigate reported incidents immediately to ensure people were not at risk of harm or abuse.