Hawkfish Ltd

Queen Margaret's Care

Inspection report

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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 carried out an unannounced comprehensive inspection of this service on 13 and 17 November 2015. Breaches of legal requirements were found as follows:

Regulation 12 HSCA (RA) Regulations 2014, safe care and treatment. The provider had not ensured that risk was sufficiently assessed and acted upon to care for people safely.

Regulation 17 HSCA (RA) Regulations 2014, good governance. Records relating to the care and treatment of each person using the service were not always well kept or fit for purpose.

Regulation 18 HSCA (RA) Regulations 2014, staffing. There were insufficient numbers of well deployed, suitably qualified, competent, skilled and experienced persons to care for people safely.

After the comprehensive inspection, the provider wrote to us, and provided us with an action plan, saying what they would do to meet legal requirements in relation to the above breaches.

We undertook this unannounced focused inspection on 11 and 12 August 2016 to check that the provider had followed their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Queen Margaret's Care on our website at www.cqc.org.uk"

Queen Margaret's Care is a service which provides care and support for up to 44 older people with nursing care needs. Some of the people cared for may be living with dementia, have a learning disability and/or have a sensory impairment.

There is a passenger lift to assist people to the upper floors and the service is located close to local shops with an accessible area to the front and side of the property. On the days of inspection there were 32 permanent residents and two people who were staying at the service for a short stay. A previous suspension on admissions from the local authority had been relaxed to allow four admissions a month. This was because the local authority commissioners had decided that the quality and safety of care at the service had improved. The service was also accepting privately funded admissions.

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. A new manager had registered with CQC since the last comprehensive inspection.

People were cared for safely in line with their plans of care and associated risk management plans. People's care was consistently monitored to ensure that they were protected from harm, while not being unduly

restricted.

Staff understood the risks associated with people's care and carried out care in a way which minimised those risks. For example staff moved people in a way which protected them from harm. The people who lived at the service, their visitors, health professionals, social care professionals told us that people were cared for safely. This meant that the registered provider was no longer in breach of regulation 12 HSCA (RA) Regulations 2014, safe care and treatment.

Staffing ratios had improved to ensure people were cared for safely. Staffing was planned in line with a recognised dependency tool to ensure there were sufficient staff at all times to meet the needs of each person who lived at the home. We saw that care was unhurried and that staff had time for people. People who lived at the service, health professionals and social care professionals told us they had noticed that staffing ratios were improved. We observed that the care offered to people was well paced and attentive. This meant that the registered provider was no longer in breach of regulation 18 HSCA (RA) Regulations 2014, staffing.

Record keeping had improved across a range of records including risk management plans, care plans, daily observation notes, clinical monitoring charts and audits of such areas as infection control and medicine handling. The registered manager had implemented a range of checks and guidelines to ensure that records were completed consistently and that they contained information which was relevant to monitoring the safety and quality of care. This meant that the registered provider was no longer in breach of regulation 17 HSCA (RA) Regulations 2014, good governance.

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

We found that action had been taken to improve safety.

Staffing levels had improved and risk was assessed and acted upon so that people could be cared for safely.

The service only admitted people who staff had the skills and knowledge to care for safely.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve leadership within the service.

Record keeping had improved so that the quality and safety of care could be monitored and acted upon.

We could not improve the rating for well led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection

Queen Margaret's Care

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 and to look at the overall quality of the service under the Care Act 2014.

We undertook an unannounced focused inspection of Queen Margaret's Care on 11 and 12 August 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 13 and 17 November 2015 inspection had been made.

The team inspected the service against two of the five questions we ask about services: is the service safe and well led. This is because the service was not meeting some legal requirements in these areas at the last inspection. The inspection was undertaken by two adult social care inspectors and a specialist nurse advisor.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority and by family and friends who were important to those people currently living at the service. We also considered information shared with us by the Coroner and by North Yorkshire Police regarding concerns raised following the death of a service user at the home prior to our inspection in November 2015.

We received a Provider Information Return (PIR) from the service. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit. We examined notifications sent to CQC as part of the service's statutory duty to inform CQC of certain events and incidents.

During our inspection we spoke with eleven people who lived at the service, four visitors and eleven members of staff across the two days of inspection. The staff we spoke with included two nurses, the Registered Manager, and eight care staff. After the inspection we spoke with two health care professionals and a social care professional.

We looked at selected areas of the home, including some people's bedrooms. We looked at shower rooms, toilets and all communal areas. We looked at eleven care records and associated documentation such as clinical monitoring charts. We also looked at records relating to the management of the service; for example, staff duty rotas.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when we are unable to speak with them. We observed the lunchtime experience and interactions between staff and people living at the home.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection of 13 and 17 November 2015 we found that the registered provider failed to ensure the provision of care and treatment in a safe way for service users. Links between risk assessments, care plans and monitoring charts were not always clear or understandable. Staff did not always have a clear understanding of how these were coordinated to give a consistent approach and provide safe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was also not providing sufficient suitably deployed, experienced staff to safely meet the needs of the people who lived at the home. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, on 11 and 12 August 2016, care plans reviewed identified the person's level of risk, and records showed that these were regularly updated to reflect people's changing needs. People who were able to speak with us told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. Staff signed to show that they had read and understood risk assessments and care plans so that they had the information they needed to care for people safely.

Staff told us that they understood risk assessments and were able to correctly tell us the risk management plans in place for a number of people they cared for. Staff could describe how risk management plans were proportionate and included information for staff on how to reduce identified risks while avoiding undue restriction. For example, one member of staff told us about one person who required support to have their meals. This included sitting at a 90 degree angle when eating and having stage 3 thickened fluids. This agreed with what was written in the risk assessment. Risk management plans were linked to care plans and gave staff clear direction to support them to care for people safely.

People told us that they were being given the care they needed. One person told us, "Yes I do think they understand what care I need. They come in twos which is reassuring, because I am much better and feel confident with two." Another person told us, "They are really good about helping me to get my meals properly. There is never any bother about bringing me food I can't eat. I can relax because I know they will help me how I need to be helped."

The service also used the Malnutrition Universal Screening Tool (MUST) which is used to establish nutritional risk and this was linked to care plans around people's needs related to food and drink. The rationale for using clinical monitoring charts was explained within each care plan. Staff talked with us about the clear links between care plans, risk assessments and clinical monitoring charts to ensure they had the information they needed to care for people safely.

At the last inspection staff were not always adhering to safe moving and handling practice and some people were being moved by one member of staff when the risk assessment stated that two staff were required to move the person safely. During an inquest into the death of a person who had been cared for at Queen Margaret's Care, the Coroner concluded that a person's death during 2015 had been caused due to unsafe

care given by staff, particularly with regard to moving and handling.

At this inspection we focused on risk assessments in relation to moving and handling. These gave staff detailed instructions on how to move each individual person safely and in line with their care plans. The registered manager told us that all the people who lived at the home at the time of the inspection visit required and received support from two staff to move them safely. This meant that staff had clear instructions about how to move people safely and there was never any confusion about what was required. Staff told us that risk assessments had been discussed with them and that all moves were now carried out with two members of staff present. Staff had received training in moving and handling which was up to date. This meant they had the training they needed to move people safely. Health care professionals confirmed that when they visited the service they observed that staff carried out all moves safely. We observed that the registered manager attended rooms to monitor staff practice in this area and they told us that they regularly assessed and recorded each member of staff's practice to ensure it was safe.

At the last inspection the service had admitted a person who staff did not have the required skills or training to manage safely in line with other people's needs. This meant they could not be cared for safely and a mental health care professional had confirmed this. The registered manager explained their admission policy and their statement of purpose, which was being updated. Assessments of care needs set out what people's needs were. The registered manager told us that they assessed the suitability of a person for admission based on an understanding of the needs of the people already living there and on whether staff had the required training and skills to offer the care required. They also consulted with health care professionals when required to ensure they had the correct information they needed to make a judgement about the suitability of admission. This ensured that people were now only admitted if the service could meet their needs safely.

During the last inspection we noted that nursing staff were not using the correct colour coded bins to dispose of sharp instruments. This meant that used sharps were not always disposed of safely. We made a recommendation about this. At this inspection we noted that the nursing staff were using the correct colour coded sharps bins so that used equipment could be disposed of safely.

This meant that people were being cared for safely and the registered provider was no longer in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection people told us that there were sufficient staff to care for them safely. One person told us, "I don't have to wait long for them to come to see to me. I press this buzzer and very soon someone comes along with a smile. I do think that they are busy, but they are less busy than they were. I am never worried that they won't come." Another person told us, "If you press the buzzer round your neck they [staff] say, "Can I help you? They stay with you until you are okay."

The Registered Manager had carried out a recent visitor survey and comments about the positive aspects of the service included; "Safe and secure environment." When visitors were asked how they would rate the overall quality of care most gave a rating of eight, nine or ten out of ten. Many people commented on significant improvements in the quality and safety of care which had taken place over the past few months.

At the inspection on 11 and 12 August 2016 we found that staffing ratios had been increased with more emphasis upon nursing staff. The registered manager explained that they now used the Reece Hearn dependency tool to determine safe staffing ratios. The Reece Hearn dependency tool gives consideration to the number of people being cared for and also for people's individual needs in relation to clinical care and mobility. The registered manager has used the dependency tool to calculate that two nurses and four care

staff were required on duty each morning to ensure people could be cared for safely. They had placed two nurses and six members of staff on duty each morning which was in excess of the minimum number for safety. We also found that staffing ratios were in line with the dependency tool across the afternoon and the night shifts. Staffing was arranged with a consideration for staff skills and experience levels.

People who lived at the home told us that staff now had time to give them care in an unhurried and caring way. Staff said that they had time to talk with people, work at the person's own pace, and find out about their interests and how they were feeling. They also had time to engage people in activities, both within the home and to go on outings which they could support people to participate in safely. People told us about a trip out to the sea front, to a cricket match and a number of people told us they were looking forward to a trip to a second world war museum and memory experience in a nearby village. People also told us that they were supported to go out individually, for example, to cafes in town or to attend clubs. Staff told us there were sufficient staff on duty to facilitate these trips while ensuring there were safe staffing ratios for those people who remained at the home. A visitor told us that they were "delighted" to see that their relative was up and dressed at the time they preferred and looking smartly dressed, clean and happy.

During our observations in the home staff responded promptly to people ringing for assistance from their rooms. While viewing the premises with the registered manager, a person required support in their room. The registered manager used the call bell to summon a member of staff, who attended quickly. Staff also responded quickly to people who were sitting in communal lounges and dining areas. People all had pendant buzzers for their personal use, which meant they could summon support wherever they were. There were sufficient staff on duty to ensure that people were attended to wherever they chose to be in the home and we saw that all communal areas of the home were well used. The atmosphere was friendly and pleasant, with staff having time to chat and support people in an attentive way.

The registered manager told us that they had begun to monitor staff sickness levels and to address this with individual staff in a structured way. They had also implemented a staff recognition system so that when individual staff attendance was good they were rewarded. Staff told us that they felt much better that staff absence was being addressed. One member of staff told us, "Those of us who rarely take time off at short notice now know that our commitment is being recognised."

Health and social care professionals told us that the safety of care had improved since our last inspection. One professional said, "The nurses are really striving to do better. The staffing levels have improved. When I go in [to the home] there are always plenty of staff on the floor and it is much easier to find staff to talk with and to give you an update on your patient's care." Another professional said, "Before, it was strained because they were rushing. Now the staff are not rushing and are more confident. The people seem to pick this up and be more relaxed. I would say people feel cared for and supported. That's what they tell me when I visit." They said, "Having two nurses on duty each morning has had a hugely positive impact. People now get their medicines when they need them." Another professional said, "It is miles better than it was before. We are happy with the way things have improved."

This meant that the registered provider was no longer in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, 13 and 17 November 2015 the registered provider failed to ensure that the risks to people around their clinical care needs were minimised. This was because clinical care charts and other records were not consistently completed in line with people's care plans. This was a shortfall in good governance and was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following that inspection, the Coroner found at an inquest in respect of a person who had been cared for at the home, that the records kept by the home were not adequate.

At this inspection 11 and 12 August 2016 we noted that one person was beginning a visit to the home for a short stay. Their care plan had been updated at the end of July 2016. However, for the short stay currently taking place in August 2016, the care plans and associated risk assessments had not been updated. While a number of care plan areas had not altered since the last admission, it was unclear what stage of thickened fluids the person now required to deal with the risk they had of choking. The registered manager updated the plan and associated risk assessments on the day we found this, which immediately mitigated the risk. When we spoke with staff they understood the correct care that this person required. However, the registered manager had not ensured in this instance that the short stay care plan gave clear instructions for staff to ensure care was safe.

The specialist advisor who accompanied us on the inspection identified that for one person, it was advisable for a nutritional chart to be in place in order to monitor the person's food and fluid intake. This was immediately implemented and on the second day of inspection this was in place to ensure the person's care was safe in this area and staff had been instructed to maintain the record.

However, despite these shortfalls we noted that for the majority of people risk assessments, care plans, monitoring charts and other associated records were appropriately in place to ensure people received the care they needed.Clear instructions were recorded for staff to ensure people received the support they needed. These were written in a narrative style and were focused on individual needs. For example, we saw risk assessments in relation to mental health, moving and handling, nutrition, choking, pressure care and falls. Where necessary these assessments had resulted in referrals to appropriate professionals and their advice had been written into the plans of care for staff to follow.

We saw examples of good practice in record keeping. For example, fluid charts included a guide to care staff when emptying catheters, which reflected good practice. Those people who required this had a pre-printed diary for their catheter care. People had the risks associated with their care assessed in consultation with themselves and/or people who were important to them. This meant that staff had the information they needed to be clear about people's preferences and needs.

We looked at a number of care planning documents and associated clinical monitoring charts. Care plans were completed in a way which highlighted each person's holistic care needs with a clear set of instructions

so that staff could provide appropriate care for people's needs. Clinical monitoring charts were completed with no gaps, so that the registered manager and nursing staff had the information they needed to be sure that people had received the clinical care they needed and to notice when changes to care plans were needed.

Staff completed two day time records of observations about each person (daily notes). These recorded areas such as the person's wellbeing, the care they had received, whether health care or other professionals had been consulted and whether people had taken part in social activities or had visitors. Staff also completed one record of observations during each night. We saw that these night records were consistently completed and contained information about frequency of nightly checks, whether people were asleep or awake and whether they required and were given care, drinks or snacks. Records of daily observations were completed with no gaps. This meant that the registered manager had the information they needed to monitor people's care.

Staff showed us handover sheets which were used to inform staff of changes to people's care needs between shifts. They told us this information was useful and helped them to know when people's care needs had changed to ensure these could be met.

Each person had a personal emergency evacuation plan in case of fire (PEEP) which was kept in a prominent place within the care file A summary of the plans was also displayed next to the exit of the building, to support staff to evacuate the building in case of a fire.

This meant that the registered provider was no longer in breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home told us that they liked the registered manager and found them approachable and helpful. One person said, "[They] are so kind and cheerful. I am always pleased to see [them]." Another person said, "The manager knows people really well. [They] get talking to people and finds out what we like to do." The registered manager had carried out a survey of people's views including the views of visitors to the service. A visitor had written that the registered manager was, "A delightfully caring and compassionate person."

A health care professional told us, "[The registered manager] really understands people's needs. They have been on the palliative care training course at the hospice which means they understand about this area of care." Another professional told us, "[The registered manager] is open to asking us for support. They are pre-emptive and don't wait for problems to arise before contacting us. They have a very good rapport with the surgery." Another professional said, "[The registered manager] is good at learning from their mistakes. They invite us in and take notice of what we say."

The registered manager was visible around the home and people told us that they were often in the communal areas and available for people to ask questions and seek support. The registered manager based themselves in an office near to where visitors entered the building and so was the first member of staff many visitors saw. People told us this made them feel that the registered manager was approachable.

The registered manager carried out a variety of audits around the safety and quality of care. For example, we saw medicine audits, health and safety audits, room checks including infection control audits, care plans audits, and audits of other records such as daily notes and monitoring charts. The registered nurse on duty undertook a daily audit of Medication Administration Records (MARs) to check if any medicines had been

omitted or refused and to check stocks. This had resulted in swift action to rectify errors. This meant that the registered manager had the information they needed to monitor and improve the quality of people's care.

We noted that a number of improvements to the management of people's care had been introduced by the Registered Manager following consultation with people, professionals, staff and relatives and friends of people who lived at the home. These included for example, the introduction of a menu in a pictorial format to support people to make a choice at meal times, a Queen Margaret's Care Newsletter, which contained details of events and people's news. There was also a more personalised care planning document which included people's interests and aspirations.

The registered manager surveyed visitors for their views and was in the process of arranging surveys for the people who lived at the service. A survey had already taken place to gather the views of relatives and friends and the registered manager was working to implement what people had suggested. For example, the registered manager had worked alongside one person who had an interest in Morris Dancing and had organised for Morris Dancers to visit the home for the benefit of everyone. This mean the registered manager consulted with people and acted on their suggestions.