Clinical Governance Review
Summary Report
Radcliffe Manor House

Introduction – Project Brief

Following a coroner's case in 2022, the clinical governance of the home known as Radcliffe Manor House was criticised. In particular, the regime for the preparation, updating and auditing of Care Plans was highlighted as in need of attention. Although some improvements were made at the time the original 'safeguarding' was raised the coroner has asked for further evidence that the Home is addressing this issue.

As a result, the trustees have commissioned Swift Management Services Limited to carry out a review of the clinical governance processes within the organisation and to make recommendations to ensure that they are adequate to ensure resident safety, transparency, and compliance with best practice.

Scope of the Review

The trustees requested that we carryout a detailed review of residents' records to ensure that care reflected within the care plan was implemented and there was a clear correlation between policy and procedure, risk assessment, care planning and review, including appropriate escalation to outside agencies. Also, that advice from outside agencies was followed through in the care plans and care delivery. The trustees asked that we review a sample of care documents in detail (30%).

The review took place over two days on site at the Home, and the details of the findings are in the report entitled "Radcliffe Manor House Governance Review 2022".

Introduction of the writer

I am Robert York, and I am a registered general nurse. I have 39 years of experience in nursing, of which 22 years have been spent specialising in elderly care within the private sector. I work as a lead consultant within a Health and Social Care Consultancy. My experience within the industry has ranged from working as a Nursing Home Manager at numerous locations, Clinical Operations Director, and a Chief Executive Officer for a care home charity acting as the nominated individual accountable for care to the Care Quality Commission and board of trustees.

I work daily with care homes and providers to address issues associated with care, compliance, and business outcomes. I often work in partnership with local authorities and regulators to improve residents' standards of care and outcomes. This work includes reviewing care provision, implementing care plans, and teaching and assessing staff to provide evidence-based, individualised care.

I act as an expert witness in criminal and civil cases, providing evidence on breach of duty relating to care for older people and care home issues.

Overview of the Service

The home is stand-alone, overseen by a board of volunteer trustees and managed on a daily basis by the registered manager. The registered manager confirms that the trustees are very supportive and hold a collective vision for the resident's well-being and the future of the home.

Due to the home being a stand-alone operation, there is no direct line management of the registered manager from anyone with up-to-date clinical/care knowledge. The manager has no internal support to keep her knowledge up to date or opportunities to learn from best practices elsewhere in the organisation. Opportunities to keep up to date via networking events and other external training have also been limited during recent Covid-19 years.

Most residents are privately funded on arrival to the home and others are supported by local authority funding as and when appropriate. There is no provision for the delivery of nursing care on-site or within the CQC registration. There is a mix of dependency levels in the home, from extremely low, to high. In some instances, some residents are more independent than would be expected in a care home, but this is likely to be due to self-funding residents deciding to move into care at an earlier stage than would be the case if state funding was to be required.

Where the home is now

The original safeguarding was taken very seriously by the trustees and management team, and several initiatives (with the active involvement of the CQC and the GP) were immediately implemented to improve safety. These included:

1. New Falls Management Policy and Procedure
2. New Falls Management flow diagram
3. Improved management oversight of care plan documentation
4. Enhanced linking between care plans and risk assessments, and incident reports.
5. Improved referral processes to outside agencies such as the falls team.

In our view the new systems in place have certainly protected residents and improved the outcomes for residents due to the early escalation of concerns concerning falls. Our detailed review of a sample of the care records showed that there has been a marked improvement in incident and accident management at the Home since the August 2021 safeguarding was raised.

However, falls are not the only risk to residents within a care home and whilst this was indeed the focus of the coroner's case, it should not be looked at in isolation from other risk issues. In the next section we highlight several areas of clinical governance which in our view require improvement.

The Governance Process

The team at the home has made considerable moves towards good governance structures on a resident-by-resident basis and the changes made show there is now a pathway for escalation to outside agencies.

However, in our view there are further areas that need attention. We found that:

- The process is limited regarding policy and procedure compliance with best practices and the Home is overly reliant on the registered manager to keep these up to date. There is a potential risk that policies and procedures are not updated in a timely manner.
- Although the manager has implemented a falls management policy and had personalised it to the home it was evident from the care plans reviewed that this policy was not yet fully embedded into the organisation's culture as the care plans did not always correlate with the policy.
- The policy folder itself is difficult to navigate as there is no division of policies to make finding policies easy.

- There was a form of trend analysis on a resident-by-resident basis. However, this did not translate into an organisation-wide action plan, and there was no evidence of staff learning from incidents and accidents.
- Care plans were present but these were not personalised and information from external agencies did not always get reflected in the care plans.
- There was no formal delegated responsibility document from Trustees to ensure that they were involved in clinical governance and that boundaries and escalation expectations were set.
- The manager undertook audits but these served more as a review of individual care plans rather than a means to improve practice across the home. The audits completed were not based on compliance with the organisation's policies. The audits acted as a review of documents, with no measure of outcomes against best practice guidance.
- The home would benefit from becoming a learning organisation with a no-blame culture to promote reported incidents and lessons learned.

Whilst there is a significant need to improve clinical governance, at no point during the visit was it considered that residents did not receive kind care.

Recommendations

The Home has made significant advances since August 2021. In addition, the Home has a dedicated manager who appears to have a good relationship with the staff, residents and trustees which makes implementing new governance systems and creating a learning environment much more achievable.

Our specific recommendations are therefore:

1. To improve policy and procedure maintenance and communication of changes the Home should implement an online total quality system provided by subscription and maintained by the system provider. Staff will have better access to policies and procedures and will be automatically informed of changes as ‘best-practice’ in the care sector continues to evolve.
2. To improve care planning and record keeping the Home should implement an electronic care planning system. If the correct system is purchased, it will prompt the linking of care plans to risk assessments, will enable good quality trend analysis and facilitate point of care delivery record keeping.
3. To improve the understanding of clinical governance, trustees and senior staff should undertake training and implement an overarching action plan and risk register.

Conclusion

The board of trustees and the registered manager are committed to making sustainable improvements. They have already made significant improvements in the management of falls and the overall clinical governance of the home.

There is a group of long-serving dedicated staff who know the residents well and provide kind, caring care but do not have the best tools to ensure that the care they provide is following best practices and based on risk management. In our view the implementation of training and electronic systems will assist the process of embedding learning, risk management and escalation to outside agencies.

The arena within health and social care, particularly relating to clinical governance, risk mitigation and escalation pathways to external agencies, came about after the mid-Staffordshire enquiry known as the Francis report published in February 2015. The report changes the focus and management within

health and social care dramatically. For all care homes with long-standing staff teams, the impact and importance of this report may not have been fully understood.

The use of risk ratings, risk registers, action plans, evidence of actions and reviews of effectiveness such as audits and policy reviews are all essential elements of good governance.

Recent events have been the catalyst for change and in our view if the recommendations we set out are accepted and acted on then these will ensure that 'clinical governance' at the Radcliffe Manor House is fit for the future.

Director
Swift Management Services Limited