First For Care Limited

# Mill Lodge Care Home

**Inspection report**

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## 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? | **Requires improvement** |

## Overall summary

The inspection took place on 23, 24 and 25 September 2015 and was unannounced. At the last inspection in June 2015 we required the provider to improve how care was provided and to improve how staff were checked prior to their employment. The overall management of the service also needed to be improved. We found that some actions had been completed and further improvement was required in some areas.

Mill Lodge Care Home is a residential home providing accommodation for 20 older people who require personal care. At the time of the inspection there was no registered manager in place. 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.

People's needs weren't always met at the time they needed support due to staff not being on hand to help them. The provider had improved their recruitment processes to ensure staff employed were suitable.

# Summary of findings

People told us that they received their medicines as prescribed. We observed safe systems in place around the management and administration of medicines. People told us that they felt safe living at the service. Staff could identify potential signs of abuse and knew how to report concerns if they were to arise.

People were not always protected due to effective risk assessments not always being in place to identify and manage any risks to their health and well being. Accidents and incidents were recorded and monitored in order to minimise any future risks to people.

People's human rights were not always maintained in line with the requirements of the Mental Capacity Act 2005 (MCA). Staff were not identifying where people might lack capacity to make decisions for themselves and making 'best interests' decisions in line with this legislation.

Some people told us that staff had the required skills and knowledge to support them effectively. Others told us that they felt staff needed to develop skills further in certain areas. Staff told us that support and training was much improved in recent months.

People told us they enjoyed the food and drink they received at the service. People were given a choice of meals and drinks. People were supported to access healthcare professionals where needed.

People's dignity was mostly upheld, however, we were told that some people were not always wearing their own clothes.

People told us that staff were very caring. We observed kind, patient and compassionate interactions between staff and people living at the service. People were involved in some day to day choices about their care. Visitors were encouraged and people were supported to maintain important relationships.

People told us that they had not been involved in the development of their care plan. The provider had begun to obtain personalised information about people's life history and preferences to help develop individual care plans.

People living at the home, visitors and staff told us that activities were improved within the service although there was still not sufficient stimulation for people living at the service.

People told us that they felt able to provide feedback to the provider and make a complaint if necessary. They felt that their concerns would be listened to and acted upon.

The provider did not yet have effective systems for ensuring that risks to people were identified and mitigated. People were not always supported by staff whose competency had been checked by the provider. Quality assurance systems were being developed and the provider had begun to complete checks within the service.

People were supported by a committed team of care staff who were passionate about their work. They spoke highly of the management of the service. Staff spoke of the high levels of improvements made within the service by management. People living at the home, visitors and staff told us that they felt the culture was open and management were approachable.

We found that the provider was in breach of some regulations under 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 the 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?**
The service was not consistently safe

People were kept safe through robust recruitment procedures but did not always receive support when they needed it due to levels of staffing. People were not always protected by robust risk management.

People felt safe living at the service and staff knew how to respond if any concerns arose. People received their medicines as prescribed.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective

People's human rights were not always protected where they lacked the capacity to make decisions about their own care.

People were cared for by staff who felt supported in their roles. People enjoyed the food and drink they received and were supported to meet their day to day health care needs.

**Requires improvement**

**Is the service caring?**
The service was not consistently caring

People were supported by staff who were caring and developed positive relationships. People's dignity was mostly upheld. People were not always involved in making choices about their plan of care.

People were supported to maintain relationships with people who were important to them.

**Requires improvement**

**Is the service responsive?**
The service was not consistently responsive

People told us that activities had recently improved although they did not yet meet their needs. People and relatives were not involved in reviewing their care plans.

People were able to make complaints and provide feedback about the service and their concerns were acted upon.

**Requires improvement**

**Is the service well-led?**
The service was not consistently well-led

People were not supported by systems that were fully effective in identifying and mitigating any risks to their health and well-being.

**Requires improvement**

# Summary of findings

People were supported by a motivated leadership team who had developed a committed team of care staff. People felt the provider was approachable and that the culture was open and transparent.

# Mill Lodge Care Home

**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 23, 24 and 25 September 2015 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification is information about important events which the provider is required to send to us by law. We reviewed information that the provider had sent regarding the progress they had made to make improvements to the service since our last inspection in June 2015. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with eight people who lived at the service. Some people who lived at the service were unable to share their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven members of staff, the two directors / owners of the service, two visiting health care professionals and five visitors. We reviewed records relating to medicines, six people's care, six staff files and records relating to the management of the service. We also carried out observations across the service regarding the quality of care people received.

Requires improvement

# Is the service safe?

## Our findings

At the inspection completed 16 to 18 June 2015 we found that the provider was not meeting some of the regulations. We required the provider to improve how care was provided and to improve how staff were checked prior to their employment. We took enforcement action against the provider regarding these breaches in regulation. We found at the inspection completed 23, 24 and 25 September 2015 that the provider had made some improvements.

We saw that people did not always receive support when they needed it. On the first day of our inspection we observed someone using the service struggling to get out of their chair. This person was unstable on their feet and needed support to stand. There was no staff member available at the time to support them. On the second day of our inspection we observed that despite an additional member of staff being on shift, people were waiting for support at certain times. We observed on one occasion someone struggling to get up in the dining room however all staff members were busy supporting other people. One relative told us, "There's never enough [staff]". Staff said that they needed one additional member of care staff at night. We were told "one buzzer goes, if a second buzzer goes and people are still in the lounge they don't have enough cover." One of the directors advised that they were reviewing staffing levels and looking to make improvements to how staff members were deployed.

Recruitment practices had improved meaning that people were better protected from potential risks. We reviewed staff files and found that the provider was completing all appropriate pre-employment checks. The provider had completed risk assessments where appropriate to assess the suitability of staff members for their role. New staff told us that they were interviewed before they received an offer of employment. New staff also told us that they were not allowed to commence work until all of their pre-employment checks had been completed. We found that the provider managed the performance of staff and had taken disciplinary action where this had been required.

People were happy with how their medicines were administered. One person said, "[Care staff name] stays with you until you've took them. Very good like that." We observed medicines were administered safely and the senior carer followed safe procedures. We saw the senior carer ensured people had a drink to help them take their medicine and observed people taking their medicines before they signed medication administration records.

We found medicines were stored securely in a medicines cabinet and in the drug trolley which was kept secure during the medicines rounds. We saw a new fridge which was maintained and at an appropriate temperature to ensure medicines remained effective. We looked in detail at four people's medicine administration records and their care plans to see if people were getting their medicines as prescribed. We found administration of inhalers for one person was not always recorded by senior carers. After discussing with the senior carers, we found evidence that these inhalers were used but lacked recording on the medication administration records.

We found one person was refusing medicines and inhalers. Staff had contacted this person's GP and this was being reviewed. We were informed by the provider of a recent medicine administration error. The local safeguarding authority had been promptly informed. The provider advised that they would review their processes to ensure that the likelihood of this error reoccurring was reduced.

We found only trained senior carers administered medicines. Senior carers had received training but lacked on going training, competency assessments and supervision to ensure they remained competent. We were informed that a recent medication audit had taken place but a record of this was not available. We were assured that spot checks and weekly medicines audits took place.

People told us that they felt safe living at the service and would feel confident in raising concerns if they arose. One person told us "They look after us. You feel as though you're in your own home". One visitor told us "If she was unhappy, she'd tell me or [relatives name]. [Person's name] speaks their mind." Staff told us how they would identify signs of potential abuse and they knew how to report any concerns about people.

The provider was in the process of implementing a new care plan format at the time of the inspection, which included risk assessments for people's specific needs. Risk assessments were not always in place to identify and manage the risks to people's health. For example; one person was diagnosed with diabetes although their care plan and risk assessment did not identify the risks to this

Requires improvement

# Is the service safe?

person or describe how to keep them safe. We spoke to staff about this person's condition and they were unable to consistently describe what actions were required to effectively manage the risk. Staff members had not identified how this person's blood sugar would be monitored in order to manage the risks to them.

Accidents and incidents were recorded and monitored in order to manage the risks to people. We found that there was a maintenance programme in place to ensure that the risks to people as a result of the environment were managed. The provider advised that they were working with staff to make risk management less restrictive for people living at the service so their independence was promoted.

Requires improvement

# Is the service effective?

## Our findings

At the June inspection we found that the provider was not meeting the regulations regarding the need for consent to care. We took enforcement action against the provider regarding this breach in regulation. We found at the September inspection that the provider had made improvements, however, further improvements were required.

People's human rights were not protected in line with the requirements of the Mental Capacity Act 2005 (MCA). Staff told us that they would formally assess someone's capacity on their admission to the service and this would then be reviewed monthly. The provider had implemented a rigid structure to assessing and reviewing people's capacity. They had not focussed on individual people and decisions and therefore were not working to the requirements of the MCA. Capacity assessments had been completed for everyone living at the service although not everyone had a reduction in their capacity to make decisions about their care. Staff were not able to describe how they should assess people's capacity on an ongoing basis. Staff were not able to describe how to effectively make a decision in someone's 'best interests' in line with the MCA.

We looked at the capacity assessments that were in people's care plans. We found that some capacity assessments were contradictory in that they identified people as having full capacity but then went on to outline the various elements of their care that they did not have capacity to make decisions about. Where capacity assessments identified people as not having capacity to make certain decisions, best interests decisions had not been made in line with the MCA.

Staff told us that one person regularly demonstrated signs of distress while being showered. A best interest decision had been made for this person, however, the principles of the MCA had not been followed. The provider had consulted one relative who had stated that they wished for the shower to continue and this was recorded as a best interest decision. The provider had not worked to find alternative ways of involving the person in the decision and had not considered who else may be able to contribute to an effective decision in the best interests of this individual. We found during the inspection that one staff member had identified a way of conducting the shower that reduced the distress to this person, but this had not been shared as part of a best interest discussion or with the remainder of the staff team.

We spoke to relatives of people who had been assessed as not having the capacity to make decisions about their care. All of the relatives that we spoke with during the inspection confirmed that they had not been involved in providing information to assist the provider in making any best interests decisions about their relative's care.

The provider had submitted 17 applications to the local authority to deprive people of their liberty under the Deprivation of Liberty Safeguards (DoLS). We were not able to confirm if all of these applications should have been submitted as the principles of the MCA had not been effectively followed. The provider had issued a DoLS and MCA summary document to all care staff. This document did not focus on the five key principles of the Act including assuming capacity and making the least restrictive decisions in someone's best interests. The document focussed on the restrictions that can be put in place for people.

Staff had received training on the Mental Capacity Act in the week prior to our inspection. Staff had a much improved knowledge of what the Act was compared to our inspection in June 2015. Staff told us "I learned it's choice. Not automatically making assumptions", "One person might be able to walk to the shop, another wouldn't" and "Certain people can make decisions and not others. The time of day is important." The provider had not yet effectively implemented learning from this training and ensured that the Act was being followed in care practice.

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

People assumed to have capacity told us that staff were involving them in decisions about their care. We observed staff seeking consent regularly around day to day decisions in the home. One person told us, "I just ask and they do it for me. They're there if you want them." A relative told us "They guide [person's name]. They don't give [them] orders."

Some people told us that they felt staff had the required skills and knowledge to support them effectively. One person said, "They seem pretty good." Some visitors told us

Requires improvement

# Is the service effective?

that they felt their relatives were supported by staff with the right skills. Others told us they felt more training was needed in certain areas. One visitor said, "I think they need more knowledge on how to stimulate – games and stuff [activities]. This needs to be done and they need more training."

Staff told us that the level of support and training had recently improved. The provider confirmed that supervisions and appraisals had been completed for all staff which was resulting in improved performance. We saw that the provider had completed additional training with staff since the inspection in June 2015. Staff told us that they felt training had increased their confidence when supporting people. Further training was booked for staff in October 2015 for moving and handling and first aid.

People told us that they were happy with the food and drink they received at the service. One person said, "I think it's fine. We have good food", another said, "It's good. I like the fish." A visitor told us, "Oh, they're excellent. Last night [person] had red salmon sandwiches that [staff name] bought in special." The provider had introduced a greater choice of options for people at mealtimes. People were given a range of breakfast cereals to choose from and they were given two meal choices at lunch and dinner time. We were told by staff that if people didn't like the options available then an alternative would be made for them. We observed that people were given alternative choices at lunch and dinner times. People were not involved in creating menus, however, staff and the provider said that they would work to improve this.

Meals were cooked on the premises using fresh ingredients. Two people had received support from speech and language teams due to swallowing difficulties. These people ate a soft diet and the cook ensured that their food was well presented and appetising. One person had diabetes however there was not an effective care plan in place to ensure this persons dietary needs were met. Staff knew that this person used an artificial sweetener instead of sugar but they were unclear as to whether their diabetes was controlled through diet, medication or both.

One visitor told us that they'd like to see drinks available for people to help themselves to throughout the day. The provider told us that they'd recently started putting a drinks trolley out in the dining area all day for people to get their own drinks and we observed this in place. Staff told us that people hadn't got used to this yet but one person had got their own cup of tea on the morning of the second day of the inspection. One person told us, "I go and help myself."

People told us that they were supported to access outside healthcare professionals when required. One person said, "They've done all that while I've been here. I had a sore throat. I only told the girl and she told the doctor, no trouble." A visiting relative told us, "They told me the other day the doctor was coming as she had a pain in her leg." We saw in people's care plans and daily records that a variety of healthcare professionals had been contacted by care staff to ensure that people's healthcare needs were met. The provider told us that they'd worked with staff to ensure that everyone knew it was their responsibility to seek healthcare support for people and to build the confidence of staff. Staff showed us how they recorded information about people's healthcare in their care plan and how they used a communication diary to ensure appointments and requests for support were followed up.

Requires improvement

# Is the service caring?

## Our findings

Several visitors told us people's dignity was not always upheld. We were told that they had been having issues with missing clothes. One visitor told us that their relative had been wearing someone else's slippers and other people's clothes were in their room sometimes. Another visitor told us, "We're just having a few issues about missing clothes and glasses. [Person's name] doesn't look very tidy but if the hairdresser hasn't come it's not their fault." Another person told us, "They're nicely dressed. If they had their own clothes!" We observed two visitors of one person complaining to a senior carer that their relative's clothes had gone missing. They told us that their, "clothes and glasses regularly went missing." We observed in the laundry room that people's clothing was not separated, for example we observed that hosiery was not separated or labelled. We discussed this issue with respecting people's dignity with the provider who said that they would review this practice.

On the second day of our inspection we observed a visit from a General Practitioner (GP) and a nurse who were completing medicine reviews and offering flu jabs to people. The GP was required to consult with people in a conservatory area with other people present. The conservatory had glass doors which meant that people could also been seen while having their appointment with the GP. We discussed this with staff and the provider who acknowledged that they could take actions to better protect people's dignity while seeing the GP.

People gave very positive feedback about care staff and how caring the service was. One person said, "They've been very kind and good to me. They come and help me on a morning, undress and do. I can't find no fault with them, they've been so kind.", "They've been good to me, that's all I know. Very nice. They're very kind. They're always polite, that's one thing." One visitor said "They're always kind to all of the residents. They go out of their way to make sure cups of tea are within reach, and make sure they can hold them properly."

We observed kind, patient and compassionate interactions between staff and the people living at the service. One member of staff said, "I like caring for them. I treat them how I'd like to be treated myself." Another said, "It's not about us, it's about [the people], it's their home." Staff told us that they felt the choices available to people had improved recently and told us that staff were spending more time with people on a one to one basis and learning more about individuals.

We observed people being involved in making every day choices. One person was discussing with a member of staff when they were going to go to their room and the staff member was heard to say, "It's your choice when you go". We saw that people were given flexibility around the time they got up and went to bed if they asked staff. One visitor said, "[Person's name] can stay up as late as she wants." We observed one person being supported to have breakfast at 10.55am as they had decided to have a lie in. We observed staff supporting people to enter the lounge area and asking people where they would prefer to sit.

Staff were not confident in taking positive risks to support people's choices and independence. One person told us that they'd really like to have a 'black and tan' drink and a staff member was concerned about a negative interaction with this persons' medicines. The staff member reflected on this person's wishes and recognised, "We're taking away his independence". The provider confirmed that they were working to encourage staff to promote people's independence as much as possible.

People told us that they felt their independence was protected. One person told us, "I'm not making myself dependent on other people. I don't want to do that." A visitor told us, "They give her little jobs – folding towels and putting cups out." Most people told us that they felt their privacy was respected and protected. One relative said, "They give you privacy. The staff are conscious of other residents and guide them away." One person said, "I don't really think there's much privacy round here."

We saw that visitors were warmly welcomed into the service and people were encouraged to maintain relationships with people who were important to them.

Requires improvement

# Is the service responsive?

## Our findings

People told us that they hadn't been involved in the development of their care plan, one person telling us "Not as I can recall." A visitor told us "[They've] never had a care plan. No one's ever talked to us about [person's] care. Never had any discussions." We saw examples in people's care plans of reviews of people's care being completed by staff although there was no evidence of involvement of people and their relatives. One relative told us that they hoped that the new manager at the service would involve them more in planning people's care and activities.

The provider told us that they had begun a programme to involve families in providing life histories and more personalised information about people living at the service. We saw examples of where this had been done, including a bright and simple diagram summarising key information about one person. The staff that we spoke to were aware of the personalised information that had been learned about these people. We observed that staff used this information to engage with people and also to support people more effectively. For example, to support people when they became distressed.

People told us that they didn't have access to adequate activities and stimulation at the service. One person said, "You spend a lot of time waiting. Don't move out of your chair much", another said, "Nothing really. What can I do here in any case? I'd like to walk round the garden on my own". One person said that they loved art and would like to be able to do this at the home. Visitors to the service told us that activities needed to be improved. One visitor told us "They have had singers on and put the radio on but that's it", another said that activities could be improved in addition to "Use of the garden." Another visitor also said "They had the garden done but they never go outside".

We observed an increase in activities and involvement of people living at the service compared to our inspection in June 2015. We were told that the cook was working for an additional hour twice a week to bake with people. People told us that this was well received and enjoyed. We observed staff working to engage people in activities during our inspection including skittles, a quiz and card games. Staff told us that the activities programme within the service was improving and said that, "[Staff] can do more things with [people] now". The provider told us that they were working to develop a range of activities, however, people's views around their preferences for leisure activities were not being fully considered. One person told us, "They've got activities but not ones I like doing". We asked staff what the barrier was to one person walking around the garden as they'd asked and we were told that "they didn't have a risk assessment in place." The provider told us that they would work to promote people's choices around their leisure activities and promote their independence.

People told us that they felt they could complain to the provider and care staff if required. The provider had recently added a confidential complaints and compliments box to the reception area. People, visitors and staff all told us about the box and said that they would provide feedback if required. We saw that one relative had provided feedback into the complaints box on the day prior to the inspection. People and their relatives said that they felt their concerns were listened to and dealt with. One person said, "All the carers are approachable. If that didn't bring results, I'd go straight to the owner."

Requires improvement

# Is the service well-led?

## Our findings

At the June inspection we found that the provider was not meeting some of the regulations. We asked the provider to make improvements regarding their quality assurance, systems and management of the service. We took enforcement action against the provider regarding this breach in regulation. We found at the September inspection that the provider had made improvements.

The provider had not had a registered manager in place since January 2015 which is a breach of their conditions of registration with CQC. At the time of our inspection the two directors and owners of the business were covering the management of the service. A manager had been appointed and was due to take up their position on 5 October 2015.

The provider was not always ensuring that the risks to people were identified and mitigated. Care plans were being updated, however, the provider was not effectively ensuring that these plans always identified and managed risks to people. For example, staff were unaware of the needs of one person who had diabetes and their care plan did not identify and manage these risks. The provider had not effectively assessed staff members' competency in identifying and managing the risks to this person and therefore had not provided sufficient support to staff.

People were not fully involved in the development of the service. The provider had not developed systems to proactively obtain the views of people living at the service to ensure they were fully involved in decisions such as menu planning or activities. Systems had not been developed by the provider to ensure that people's human rights were protected through the effective implementation of the Mental Capacity Act 2005.

At the last inspection in June 2015 we found that the provider had not met their legal obligations around submitting notifications to CQC and the local safeguarding authority. The provider is required to notify ourselves and the local authority of certain significant events by law. At the inspection in September 2015, we found the provider had met their legal obligations and had submitted the required notifications.

We found that the provider had started to develop a quality assurance and governance system within the service since our last inspection. We found that events such as accidents and incidents were being analysed and monitored for trends and patterns in order to identify and mitigate risks to people. A programme of internal checks on the environment to keep people safe had commenced. The provider advised of a full programme of quality assurance and governance that was being introduced. The provider also confirmed that they would be completing spot checks on the work of the new manager once they were in post.

People and their relatives spoke highly of the directors at the service. One person said, "They're good. I'm not putting it on. They're good". Another person said, "He's a nice man. He's the boss and he's always coming round. He always says 'hello [person's name]' and I like that. Very friendly." A relative said, "He's very nice and I've seen him go round and speak to [people]." We observed both of the directors of the service being visible and interacting with people living at the service. People knew who they were and appeared to be relaxed and comfortable and able to speak to them with ease.

People were supported by a team of committed and care staff who displayed passion for their work. Staff told us that the culture within the service was becoming more open and transparent and that things were improving. Staff told us that they felt able to question practice and processes within the home and we observed this happening during the inspection. One member of staff said, "It's improving. We needed a kick, a shake up", another said, "They're [directors] doing their best to change things around. Things are improving", another said, "They're brilliant at the minute. You can drastically see the changes." Staff told us that they'd not previously been encouraged to communicate openly with the directors. We were told by staff, "We were told that [director] wasn't approachable but this has been opened up now" and, "They're here a lot more, more approachable". The provider told us that they'd been working to implement a new management style throughout the service; listening, doing and instilling confidence in staff.

People were supported by a management team who were displaying motivation in driving improvements within the service. The provider was able to demonstrate that they'd made significant improvements within the service since the inspection in June 2015. Relatives told us that they had seen improvements. One relative said "The place seems to

Requires improvement

# Is the service well-led?

have ticked over nicely so that's a reflection on them." A staff member told us "Now we can approach Mr [name] and Mrs [name]. We couldn't before. They will sort the problem out."

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 11 HSCA (RA) Regulations 2014 Need for consent<br><br>People's human rights were not always protected with the effective implementation of the Mental Capacity Act 2005. |