Wessex Care Limited

Milford Manor Care Home

Inspection report

Milford Manor Gardens
Salisbury
Wiltshire
SP1 2RN

Tel: 01722338652
Website: www.wessexcare.com

Date of inspection visit:
31 July 2017
01 August 2017
07 August 2017

Date of publication:
27 November 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Milford Manor provides care and support for up to 30 older people with complex mental health needs and some living with varying degrees and types of dementia. At time of our inspection, 27 people were resident at Milford Manor.

The service had two registered managers 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.

We found mental capacity assessments were in place to assess if a person had the mental capacity to make key decisions affecting their daily living needs and chosen lifestyle. However, for more significant decisions, such as having door gates in front of people's rooms, mental capacity assessments were not in place. We saw evidence that least restrictive options had been discussed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff had received training to provide them with the skills and knowledge to support people. A health and social care professional said "The staff have the skills, patience and expertise to work with individuals in a holistic and meaningful way.".

Staff displayed a good understanding of how to keep people safe from potential harm or abuse and what actions they would take should they suspect abuse had taken place.

People were not able to tell us if they felt safe living at Milford Manor. We observed people moving freely around the home. Comments from relatives included: "They are fantastic here, I feel my (husband) has safe care, they explain what they are going to do before they do it and there are always two helping to turn him. He can't get out of bed now but when he needed the hoist there were always two and they knew what they were doing", "I have never seen anything which makes me uncomfortable and I come here every day", "They go above and beyond the line of duty" and "Can't fault them at all.".

Visiting professionals spoke positively about the support people received. Feedback received included "As a specialist mental health team we rely on providers who can meet the needs of clients who have complex and often challenging needs." and "I am confident that the service is meeting people's needs in a very challenging environment.".

People were treated with dignity and their right to privacy was respected. Staff knocked on people's doors before entering and sought people's permission before undertaking any care tasks. We found staff had a good understanding of people's needs, interests, likes and dislikes. We observed a range of positive and

caring interactions during our inspection.

People were supported to have sufficient food and fluids. People were offered a choice at meal times and where people did not want what was on the menu alternatives were available.

People's medicines were managed safely. Systems in place ensured that people received the medicines as prescribed and at the correct time.

There were systems in place, which encouraged relatives to share their views on the service. Complaints were investigated and responded to appropriately.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

Staff told us they felt supported by the management team. The management team had a clear vision of developing the service for the future and providing quality care to vulnerable people, living with complex mental health needs.

We have made a recommendation about mental capacity assessments for specific decisions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Clear strategies for managing behaviours that could be challenging, were in place. The service sought guidance from a number of different professionals.

Peoples' medicines were managed and administered safely.

Staff understood their responsibilities to keep people safe from harm. Staff knew the processes for reporting concerns and said they felt management would take appropriate actions where required.

Staff understood their responsibilities to keep people safe from harm. Staff knew the processes for reporting concerns and said they felt management would take appropriate actions where required.

Is the service effective?

Good

The service was effective.

People were supported to have maximum choice and control of their lives. Consent to care and treatment were sought.

People were supported to have sufficient food and drink and to maintain a balanced diet.

People were supported to maintain good health and to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

Staff acted in a caring, compassionate and respectful way.

Staff knew the people they were caring for well and were aware of their likes and dislikes.

People were able to access advocacy services where needed.

Is the service responsive?

Good

The service was responsive.

Care and support plans were personalised and were reviewed regularly.

People had opportunities to take part in activities if they wished to do so.

Complaints were investigated and responded to in a timely way.

Is the service well-led?

Good

The service was well-led.

Quality assurance systems were in place to monitor the care and support that people received and where required identify improvements.

Staff felt supported by the manager and could raise concerns and seek guidance.

The management team had a clear vision for the future and development of the service.

Milford Manor 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 checked 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 31 July, 1 August and 7 August 2017 and was unannounced.

The inspection was completed by one Inspector and an Expert by experience on the first day and one Inspector on the other days. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience's area of expertise was caring for an older person with early onset dementia.

Before the inspection we reviewed the information we held about the service. We read the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

Not many people were able to tell us what they thought about living at Milford Manor. We therefore used a number of different methods to help us understand the experiences of people who use the service. This included talking with two people and six visiting relatives about their views on the quality of the care and support being provided. During two days of our inspection, we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included eight care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the service manager, two deputy managers, an operations director, two care staff,

housekeeping staff, the chef and a maintenance person. We received feedback from five health and social care professionals who worked alongside the service.

Good

Is the service safe?

Our findings

People were not able to tell us if they felt safe living at the service. Speaking with relatives they said: "They are fantastic here, I feel my (husband) has safe care, they explain what they are going to do before they do it and there are always two helping to turn him. He can't get out of bed now but when he needed the hoist there were always two and they knew what they were doing", "I have never seen anything which makes me uncomfortable and I come here every day", "They go above and beyond the line of duty" and "Can't fault them at all.".

The staff we spoke with showed an understanding of identifying safeguarding concerns and told us they would be confident in reporting any concerns to protect people. Where safeguarding concerns had been raised, these were thoroughly investigated and learnt from. Feedback from a health and social care professional stated "We have a monthly MDT (multi-disciplinary) meeting with the home where we are able to discuss each resident who has perhaps changing needs. We look at any safeguarding alerts, and incidents or accidents.".

Staff supported people who could become anxious and exhibit behaviours which may challenge others. We saw where risks had been identified; behaviour support plans were in place stating strategies and guidance for staff to follow. However, one person frequently made attempts to leave the home by breaking the lock of an exit door. While staff were aware of this, there was no mention in the person's behaviour support plan on guidance for staff or options considered to minimise the risk. We raised this with the service manager during our inspection, who told us the information was recorded in the care plan, but they would update the behaviour support plan immediately. The operations director told us the care home liaison team visited weekly for a meeting with staff regarding each person to discuss any issues, along with staff support and training. Where people's needs had changed or behaviours escalated, updated plans were put in place. The GP visited twice a week to provide advice and discuss any concerns.

Staff told us they knew the people they were supporting and told us they did not use restraint, but used "Touch support" to verbally discourage people from the behaviour or they would leave and give the person space. A relative said "The staff seem to be aware of what her triggers are". Where a risk to the person or others had been identified, the service worked closely with the Care Home liaison service and the Mental Health team for support. For example staff told us a person would frequently throw themselves to the floor. We saw in this person's bedroom they had two crash mats on the floor to ensure they were comfortable and safe. A review by the Care Home liaison team, stated staff had managed the situation successfully by making changes to the environment, instead of continually moving the person off the floor.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. The service also used the CCTV in communal areas to review any incidents for learning opportunities to minimise the risk of these reoccurring. The CCTV was also used to review safeguarding cases. A social care professional said "I am also very pleased that Wessex Care have installed CCTV into their common areas, lounges , corridors etc which enables for example with safeguarding referrals to see what actually happened between residents.".

Two falls we reviewed did not evidence 72hr observations after the fall. However, the service was using a new electronic system for recording, called "Nourish", which staff were still getting to know. Instead of recording the 72hr observations section separately, this was recorded on the system's daily time line. The operations manager told us people received the correct observations in a timely manner. There was clear evidence where the 72hr observation section had been used correctly but there was acknowledged inconsistency. This had been actioned since our inspection.

During the first day of our inspection we found unpleasant odours within the home. The sluices were dirty and used commode pots were left uncleaned. We raised this with the management team who told us there had been a blockage overnight, which could have contributed to the smell. The blockage also meant staff were unable to use the sluice to clean the commodes. They said they would act on the dirty sluices immediately. During the second day of our inspection we checked the sluice, which had been cleaned. We found the rest of the home to be cleaned to an acceptable standard. The operations director told us where some people had behaviours related to their continence, staff were alert to this and there were cleaning systems and processes in place to address these issues. They said it was a constant challenge to keep Milford Manor clean and tidy, while supporting people with complex mental health needs and promoting their independence. We saw feedback from relatives rated the cleanliness of the service as high.

Peoples' medicines were managed and administered safely. A national pharmacy provided the majority of medicines in a monitored dosage system (MDS). This is a storage system designed to simplify the administration of solid, oral dose medicines. Medicines are dispensed into the MDS by a pharmacist, which reduces the risk of errors. Staff removed the medicines from the dosage system and give them to the person at the required time.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

People were supported by staff with the right skills and knowledge to meet their individual needs. The service used a "Rob Fawcett Consultancy" dependency tool to assess the level of staffing needed based on people's care needs. The dependency of people and allocation of hours and staffing numbers were discussed weekly at a manager's meeting. The operations director told us the tool did not dictate the staffing levels and they also used it flexibly depending on individual circumstances. For example they increased staffing levels to support a person on a one-to-one basis to ensure their safety, until this could be discussed with the local authority.

Some relatives felt staff were rushed off their feet. Comments included "Well they could always do with more, it does seem sometimes as though they are short-staffed. They are so busy, people here have very high needs" and "I think they are quite short staffed, I visit at different times, one Sunday evening I couldn't get out of the home, I was thinking where is everyone, I couldn't get hold of the staff. The operations director told us there was a nurse call system in place at the front door and in every room within Milford Manor. This was explained to relatives and professionals and this was discussed again at a recent relatives' meeting.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found a mental capacity assessment was in place to assess if a person had the mental capacity to make key decisions affecting their daily living needs and chosen lifestyle. However, for more significant decisions, such as having door gates in front of people's rooms, mental capacity assessments and best interest decisions were not in place. We saw door gate agreement forms and individual door gate care plans were in place, however these documents did not evidence the mental capacity assessment to consent and that best interest principles were adhered to. One form had been signed to consent to the gates by a person who did not have the legal powers to do so. The Mental Capacity Act 2005 Code of Practice, states that where a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers (health and welfare lasting powers of attorney or Deputyship) to do so. The operations director told us this had been corrected following our inspection. It was also not clearly recorded if other less restrictive options had been considered to achieve the same outcome. This had now been incorporated in the door gate documentation.

We recommend the service seek advice on the implementation of the MCA in relation to carrying out assessments of people's capacity to make decisions regarding the use of door gates.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where needed the provider had made applications for DoLS authorisations to the local authority's supervisory body. More urgent DoLS had been authorised, whilst others were awaiting a response. People had a DoLS care plan in place, and any conditions on authorisations were recorded within the plan. This was also discussed at the weekly reviews with care home liaison and the weekly visits from an advocacy service.

We viewed the training records for staff which confirmed staff received training on a range of subjects. Training completed by staff included: safeguarding, dementia, behaviour support and mental capacity. A staff member told us the people they supported had complex mental health needs with behaviours that could be challenging. It was therefore important they had the relevant training to prepare them to manage complex situations in a stressful environment. The operations director told us staff received comprehensive training in managing behaviours that could be seen as challenging, for example Advanced challenging behaviour with breakaway techniques. The Care home liaison team also provided training in dementia care and challenging behaviour.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff told us they felt supported by the registered manager, and other staff.

People appeared to enjoy the food. There were good choices and fruit, fluids and snacks were seen to be readily available during the day. One relative told us, "We are generally pleased with mum's care. She is definitely physically better since she came here as she eats properly and has regular meals. They weigh her once a week to check all is ok".

People's preferences including their dislikes and any allergies were recorded and visible in the kitchen. We observed on our visit that there was a menu available on display in the communal area for people to see and be reminded what the choices for breakfast, lunch and supper were. The menu was in picture and written format, which was specially designed for people living with dementia. The kitchen assistant told us they would go around and see people individually in the morning to get their choice for lunch. A person said, "The chef comes to see me in the morning to ask what I want for dinner, I like the food". When people changed their mind, the chef would make them an alternative. We saw people had a choice of where they wanted their meal, some preferred to sit in the dining room, others in the communal areas or in their rooms. Meal times were unrushed and we observed staff checking whether people were happy with their meals and were gently encouraging and supportive.

One person was prescribed thickeners. We found an increased risk to this person due to conflicting information available and the knowledge of the staff. Some staff told us they would use one spoonful, other staff told us they would use two spoonful's of the thickener. This meant we could not be sure that the person was receiving their fluids at the right consistency. We raised this with the service manager, who updated the records immediately and created a sign, to remind staff of the recommendations. The issue was resolved during our inspection.

People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. The care plans that we reviewed all demonstrated evidence that people were supported to access health services when needed, for example their GP, Community nurses, and a chiropodist.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. Relatives spoke positively about staff approach in caring for their family member, at times in very difficult circumstances due to people's mental health needs. Relatives told us they also felt supported. One relative said, "If my family member has had a bad day they will ring me when I get home to check that I'm ok. They are so caring they can't do enough for us". Feedback from another relative stated, "My mother has a history of being difficult to help. Staff been endlessly patient. I have seen only good practice during my visits". A visiting health and social care professional told us, "Staff give patience, time and are very person centred."

People received care and support from staff who had got to know them well. Feedback from a visiting professional stated "I have confidence in their [staff] abilities, values and attitudes that they bring to their work at Milford Manor. They show that they have a good knowledge of their resident's care needs both physical and emotional. ".

The relationships between staff and people receiving support demonstrated dignity and respect at all times. We observed staff closing bedroom doors before giving personal care and knocking on doors, before entering. We observed staff explaining to people what they were about to do and gained permission before providing any support. A relative said, "Staff always ask permission from [husband] before they are going to do anything, they then chat to him while they are doing it, they let me know what's going on." Staff maintained eye contact while talking to people, whether they were standing or sitting.

The home was spacious and allowed people to spend time on their own if they wished. We saw people had access to quiet lounges, if they wanted to be on their own or to have time with visitors away from others. Visitors to the home felt welcomed. A relative said, "The staff are very welcoming, every time I come they offer me a drink and bring a tray with some biscuits, they invite me to Sunday lunch as they know I'm on my own. I always bring our dog." Staff treated people as individuals. We observed staff seated and chatting to people at times throughout the day. For example, we observed a domestic staff talking to a person who was in bed, while they were cleaning his room. The staff member did not just do the cleaning, but was engaging with the person in general chat. We saw people had access to the garden. One person said, "One good thing about being here is that I can walk around the garden".

People's records included information about their personal circumstances and how they wished to be supported. For example in one person's records, it stated they did not like to wear socks and slippers. In another person's records, it stated, "When I am sleepy after my supper, I don't like using the standing aid, but please help me to stand first." This meant people's likes and dislikes were taken into account when providing support. A relative told us, "The staff leave music on that my husband likes in his room, he can't get out of bed now but they leave the music on because they know it was important in his life."

Staff knew people's individual communication skills, abilities and preferences. Speaking with staff they were able to tell us about what was important to people. For example one person who could become agitated and confused, liked to talk about his past and his life in the Army. Another person preferred their own

company and enjoyed sitting by the stairs. People's views were sought through care reviews where possible and feedback forms were sent out to residents and relatives four times a year. In addition feedback cards, which could be sent to an independent website, were attached to invitations to the relatives' meetings. These cards were also available in the front entrance.

Staff told us they wanted to create a homely atmosphere for people, instead of it being institutionalized. Staff did not wear uniforms and told us this ensured there wasn't a division between them and people using the service. Night staff wore their pyjamas, which is known to orientate people living with dementia, to bedtime.

People were able to access advocacy services where needed. For example where people didn't have relatives or a representative, the service sought an advocate to represent and visit the person. The operations director told us they were also looking for a befriender for a person who had no family or friends visiting.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. We saw a compliment from a relative whose family member passed away at Milford Manor. The operations director told us the person had support from community nurses three times a day and staff were supportive of the person and their relatives. The relatives stayed in an empty room for six days and could be with the person as they wished. The compliment seen, stated: "Dad couldn't have been in a better care home. Your care and kindness have been exceptional. You should be very proud of the way you care for your residents".

Good

Is the service responsive?

Our findings

People's needs were assessed prior to them moving into the service and care and support plans developed using this information. We looked at the care files for four of the people living at the home. Care plans detailed people's preferences, likes, dislikes and routines. These provided staff with clear and detailed information to guide them on how to ensure people's care needs were met in their preferred way. A visiting professional said "I am confident that the service is meeting people's needs in a very challenging environment.".

The operations director told us many people were admitted to the home from a local community mental health hospital. The service had developed good links with the hospital, which meant that there was a smooth transfer between services. For example the service would meet with the person and the care home liaison professional allocated to that person in hospital, before the person moved to the home. After the person had been discharged from hospital, the person kept the same professional, which meant continuity in their care and support. A visiting professional said "In terms of being available to assess potential new residents, there is always a very speedy and professional response to our request.".

People's needs were reviewed regularly and as required. People and their relatives were invited to attend a six monthly review, however where relatives were not able to attend, their views were sought by telephone. People also had an annual review with a social worker, either from the adult social care team or the mental health team, which relatives were invited to

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. The service had regular multi-disciplinary meetings, involving the Head of Mental Health, a mental health social worker and care home liaison team. This was an opportunity to review and monitor any change in people's mental health needs and discuss any safeguarding concerns.

Staff supported people to take part in activities, either in a group or on a one-to-one basis, for example singing for the brain, reminiscence using iPad technology, circle dance therapy, art therapy and weekly visits to a local community farm. We observed that activities were flexible. Staff told us they very much relied on how people were feeling at the time and would change the activity accordingly. For example we saw that people did not want to take part in a flower arranging activity, so staff suggested having afternoon tea in the garden, which people happily agreed to. Where people chose not to take part in an activity, we saw they were able to move around the home freely. A person told us, "I like to sit in the conservatory because it's so light and I like listening to the radio, sometimes I will do some activities. I get my hair done and that's nice. Someone comes here and they will wash my hair in the shower, then I will sit in front of the mirror while she does my hair, like a salon." The operations director told us they had recently been in contact with a local nursery to set up intergenerational work. The nursery intended to set up one day a week at one of the Wessex care homes, which might not be Milford Manor but it meant the residents could visit.

The operations director told us social activity provision in this environment could be challenging. They said

it had to be responsive, for example 'working in the moment'. Set structured timed activities were often less effective unless carried out by specially qualified and experienced individuals like 'Alive'. The operations director said they had invested heavily in external specialists supporting weekly group type activities or therapy. They had also focused individual interaction activity training with all the in-house staff, so that whatever their role they can participate in a meaningful social activity as and when needed.

People's and their relatives' concerns and complaints were encouraged, investigated and responded to in good time. Relatives told us they knew how to complain if they needed to. Speaking with relatives they said: "The staff know my husband's needs very well, I have no complaints. If I had a concern I would know who to go to, every so often I have had meetings with management. I feel part of decisions" and "I have never felt the need to complain but I do know who I could go to, I feel confident they would listen to any concerns I had. They have the right people here, it's hard work, sometimes they get rushed off their feet. If I could improve anything it would be for them to have extra help when they are busy.".

Good

Is the service well-led?

Our findings

The service had two registered managers 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. The registered managers were not able to be present during our inspection, however was happy to speak with us via conference or Skype facilities. Instead a service manager was available during the first two days of our inspection and the operations director for the last day.

The operations director told us the service was continually developing and had a strong philosophy of promoting people's choice and independence. A visiting professional said "The home have been trying to develop their care philosophy about seeing the person first rather than the diagnosis.". The provider was in the process of a five year development plan, which would also see the refurbishment and updating of Milford Manor.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Internal audits had been completed, for example weight audits, medicines, falls and skin integrity/pressure sores. Shortfalls identified were recorded and we saw that actions were put in place to address shortfalls.

The operations director told us their biggest achievement had been providing a service to people, which not many care homes would do. They had recognised there was a need to care for very vulnerable, unwell people. Milford Manor Care Home was one of five care homes in Wiltshire, providing support to older people with complex mental health needs. The operations director told us they were hoping to develop close links with other managers, who supported people with behaviours that could be challenging to others. They were hoping to share experiences and learn how to support each other. The service also worked closely with a local community mental health hospital. A visiting health and social care professional spoke positively about the management team. They said "X [operations director] is very good. Can't praise her enough. She is always learning." and "I find the manager and the deputy very approachable".

Staff told us they felt supported by the management team. Comments included, "Management is open and accessible" and "They are open here, things get resolved quickly". Staff had regular staff meetings and opportunities to discuss any training needs, concerns regarding people using the service or any updates on policies and procedures.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. The operations director told us it had not been possible to have "residents'" meetings due to the nature of people's mental health needs, however they were slowly getting a group of residents together, who would be able to take part and make their views known. We saw evidence that relatives' meetings took place and relatives were able to raise any concerns. Part of the relatives' meetings were used as a support group for relatives. They also had opportunities to feedback any concerns or

compliments about the service, through completing care home review slips.

Staff were supported to question the practice of other staff members. Staff had access to the company's whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities