# Approach Community Homes Limited

# Milton House

## Inspection report

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Tel: 01234602741

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Milton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 13 people in one adapted building. At the time of our inspection nine people were living at the home.

We checked to see if the care service had been developed and designed in line with the values that underpin 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. The registered manager was committed to developing the person-centred culture of the service. However, they were not familiar with this guidance.

At our previous inspection in June 2017 we rated the service as 'requires improvement'. At this inspection we found the service continued to be rated 'requires improvement'. This was because, although the service had made improvements since the last inspection some work was still required in relation to end of life care, how records were kept and how quality was monitored.

This unannounced inspection took place on 24 May 2018.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe living at the service, with the staff and with the support the staff gave them. People were protected as far as possible from abuse and avoidable harm by staff who were trained and competent to recognise and report abuse.

Medicines were administered safely and people were supported to access health and social care services when required.

The provider had effective recruitment processes in place and there were sufficient staff to support people safely.

Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff gained people's consent before they provided any care or support to them.

People had enough to eat and drink and menus appeared to offer a balanced diet. People's choice,

preferences and involvement in preparing meals were promoted, although some people chose to not participate.

People were supported to have choice and control of their lives and there were risk assessments in place that gave guidance to staff on how risks to people could be minimised without compromising their independence.

Staff supervision was provided regularly and training to enable staff to support people well was all up to date.

Staff were kind and respectful to people and we saw some positive interactions during the inspection. People were supported to pursue their interests.

Care plans took account of people's individual needs, preferences, and choices and were reviewed regularly although end of life planning was not included. A system was developed immediately following the inspection to address this for the future.

A system to log complaints and outcomes was not in place so it was not possible to review whether or not they were managed effectively, or how they were used to make improvements to the service.

The provider had clear values to underpin the service that were known and understood by staff. The registered manager promoted a person-centred culture within the service.

The provider had a quality monitoring processes in place to monitor the standard of care but this was not sufficiently detailed to demonstrate that a full overview was carried out. Following the inspection, the registered manager sent us information to show that an improved system was being developed by the provider.

## 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.

Risk Assessments were detailed and identified risks that were specific to individual people.

People were protected from the risk of infection and medicines were managed safely.

People were protected from abuse because staff understood the signs to look for and the process for reporting concerns.

There were enough staff deployed to keep people safe and effective staff recruitment reduced the risk of unsuitable staff being employed.

There was evidence that the provider learned from when things went wrong and made improvements to the service.

### Is the service effective?

**Good**

The service was effective.

The requirements of the Mental Capacity Act were met.

People had enough to eat and drink.

Staff received training to provide them with the skills and knowledge to support people who used the service.

### Is the service caring?

**Good**

The service was caring.

People were involved in planning their care and support.

People were supported by caring staff who knew each person well.

Staff respected people's privacy and dignity.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Support plans were person centred but would have benefitted from greater detail.

People were encouraged and supported to find meaningful activities to be involved in.

End of life plans had not been completed.

Complaints were managed informally but no record was kept to demonstrate correct management or learning from complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Systems to monitor the quality of the service were not robust and did not effectively support improvements to the service.

There was a person-centred culture within the service.

The provider had a clearly understood set of values that underpinned the service.

People, relatives, staff and other professionals were encouraged to share their views about the service.

The service worked in partnership with other professionals to meet people's needs.

# Milton House

**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 unannounced inspection took 24 May 2018 and was carried out by one inspector.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about.

We used information the provider sent us in the Provider Information Return in April 2017. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we observed how the staff interacted with people who lived at Milton House. We spoke with three people who lived there, two staff and the registered manager. We observed the interactions between staff and other people who used the service who were not able to tell us about their experience. We looked at three people's care records as well as other records and systems relating to the management of the service. These included systems relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Good

# Is the service safe?

## Our findings

People told us they felt safe at Milton House. One person said, "Yes staff help me be safe." Some people were not able to tell us if they felt safe and so we observed their interactions with staff to help us understand. We saw that people appeared comfortable and at ease in the presence of staff which suggested that they felt safe.

Staff had received training in safeguarding people and when asked, demonstrated a good understanding of different types of abuse and the signs they should look for which may indicate that someone could be at risk of possible harm.

The provider had an up to date safeguarding policy that gave guidance to staff on how to identify and report concerns about people's safety. Information about safeguarding was on display in the home and it included contact details for the relevant agencies for staff to refer to when needed. Staff could tell us about external organisations they could report concerns to.

There were personalised risk assessments for each person to give guidance to staff on any specific areas where people were more at risk such as mobility and falling, choking, making hot drinks, going out in the community, and behaviour. The assessments maintained a balance between minimising risks to people and promoting their independence and choice. They had been reviewed and updated regularly or when people's needs had changed so that people received the care they required.

There were enough staff available to keep people safe and meet their needs in a timely manner. The registered manager told us that the staff rota was organised to make sure that activities, appointments, outings and home visits could take place if people needed staff support. The provider had a recruitment process in place to support the safe recruitment of staff. This included carrying out pre-employment checks such as references and a criminal records check, which had to be satisfactory before the new member of staff could start work. This helped to ensure that only staff suitable to work at this service were employed.

The service was clean and well maintained. Staff had a robust system in place to ensure that the premises remained clean and that people were protected from the risk of infection. Some people participated in cleaning tasks and were supported by staff to keep their own rooms clean. Infection control audits were carried out as part of the registered manager's day to day oversight of the service. Staff had sufficient understanding of good practice in relation to infection control, and were seen to follow current guidance during our inspection. Waste and laundry were managed appropriately, and staff were seen to wash their hands before and after providing support to people and carrying out tasks such as cooking meals.

The service had introduced an electronic medicines system to support the safe management of medicines. The system significantly reduced the chance of errors because it provided clear prompts to staff when it was time for medicines to be administered, and did not allow staff to administer medicines at the wrong times and flagged up quickly when a medicine was late. Ordering and checking stocks was also facilitated by the system. Errors were unlikely but in the event that one occurred, it could be easily identified, enabling the

registered manager to take swift action to address them. The system could generate daily reports and audits to give the registered manager an over view of medicines administered. This was particularly useful for the monitoring of 'as required' (PRN) medicines, to enable the registered manager to look at patterns of use. Staff had all been trained to understand the system, which the manager showed us on the day of the inspection. An intuitive system, which was easy to use, it protected people from the risk of poor medicine management practice.

We saw that the provider and the registered manager learned from when things went wrong and took swift action to ensure the service improved as a result. For example, we saw that if incidents or accidents occurred, these were recorded, and the registered manager reviewed these records to identify trends and patterns. Following this, changes to care plans or risk assessments were made as necessary to ensure the person's needs were met and the risk of reoccurrence was reduced.

Good

# Is the service effective?

## Our findings

From the care and support records we looked at, we saw that people's needs and preferences were assessed prior to them coming to live at the service in line with current good practice guidance. The assessments identified people's needs in relation to issues such as eating and drinking, mobility, communication, personal care, and any specific health conditions. From this process, a care plan was developed to identify each individual need and what support was required from staff. We saw that care plans were regularly reviewed and updated when people's needs changed. Staff told us that they kept up to date with changes in people's needs by talking to them, reading the care plans, the staff communications book and through daily hand over meetings when coming on shift.

We found the service was developing their use of technology to support people's needs to be met effectively. For example, the introduction of the electronic medicines system reduced the likelihood of errors being made that could have an impact on people's wellbeing. One person told us that they used an electronic tablet to access the internet which expanded their opportunities and enabled them to access resources that appealed to them, watch videos and information that could support their independence.

The provision of training relevant to the needs of people living at the service had been completed by all staff and people received effective care from knowledgeable staff. Staff confirmed that they were satisfied with the training provided to them and said it supported them to be good at their jobs. The provider had an induction process for newly appointed staff and staff we spoke with confirmed this had been useful in supporting them to familiarise themselves with their role and the needs of the people using the service.

The provider had a policy in relation to the provision of formal supervision within the service. We saw from records, and staff told us, that supervision was regular and met their expectations. Staff confirmed that supervision was of a high standard, supporting them to do their job well and to identify and address their own development and training needs. The registered manager also carried out annual performance reviews with each member of staff.

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.

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. We found that where it was assessed as appropriate, DoLS applications had been made to the supervisory body in line with legislative

requirements. We saw from records that, where a person was believed to lack capacity to make a specific decision, capacity assessments were completed and best interest decisions were made by the relevant professionals and family members or representatives. We saw that staff routinely asked people for their consent before providing support.

Staff had good knowledge of people's preferences and demonstrated a flexible approach to meeting people's needs at mealtimes. People had enough to eat and drink and we saw that they were able to make choices about meals they wished to have. Although a menu was planned, we saw that staff checked with each person whether they wanted that particular meal or would prefer something different before cooking commenced. One person told us, "Yes, I eat the food I like. I don't do the cooking, not yet, maybe I will later." We saw that people had access to snacks and drinks whenever they wanted them. Staff told us that people were encouraged to eat a balanced diet and we saw that fresh fruit and vegetables were included on the menus. The registered manager told us that there were processes in place to manage any concerns about people's dietary needs and records confirmed that referrals were made to dietitians when this was required.

We looked at whether people's needs were being met by the adaptation, design and decoration of the premises. People living at the home said they found it comfortable and communal areas were pleasantly decorated. The registered manager confirmed that the provider was responsive to requests to maintain the property, and there was a rolling programme of redecoration to ensure the upkeep of the house. There was a choice of communal space which enabled people to have privacy elsewhere than just in their bedrooms. People's bedrooms were personalised to their own taste.

People were supported to access additional health and social care services, such as GPs, dietitians, chiropodist and dentists so that their health needs were appropriately met. Staff told us they had positive relationships with the various healthcare professionals involved in people's care and were confident to make referrals as necessary. Records also indicated that staff responded quickly to people's health needs and they sought advice from other health and social care professionals when the need arose. Advice from other healthcare professionals relating to the care and support being provided by the service was incorporated into each person's care plan.

Good

# Is the service caring?

## Our findings

People we spoke with said that the staff were caring. One person said, "I like [Name] and [Name]. They make jokes and they make me laugh." We saw that people appeared to be at ease in the company of staff and there was plenty of laughter and banter enjoyed by all. Staff demonstrated a caring attitude and appeared to know each person well. For example, one person who used the service communicated by using gestures and signs that were individual to them. We saw a member of staff took time to hold a conversation with the person, using the same gestures. The person was clearly pleased to have this understanding with the member of staff, and it demonstrated that the member of staff valued the person and what they were communicating.

Each person had a keyworker who had responsibility for supporting them to be involved and make decisions about their care and support. People we spoke with were positive about their keyworkers. One person said, "I get on well with [Keyworker]. We like the same things and we do things together. I can talk to [Keyworker] if I am worried and I can say if there's things I want to do."
The manager told us that the aims of the service were to provide a real home environment for people, and to promote people's independence with a view to them living independently in the future, if this is what they wanted. She confirmed that some people who had previously lived at the service had developed their life skills and were now living independently or in supported housing. For some people living at the service, the move to a residential home from a larger institution or from living all their life with their family had been a huge life changing event. Staff understood this, and recognised the need to work with people at their own pace, considering each person's individual circumstances, and supporting them to make choices about what independence looked like for them.

Staff were aware of the importance of maintaining people's privacy and dignity when assisting them with personal care and spoke of measures such as keeping people as covered as possible, and closing doors and curtains. People told us that staff usually knocked on their bedroom doors before entering.

Staff supported people to maintain contact with their friends and family. Family members and friends were welcome to visit. Advocacy services were available if someone wanted an independent person to support them to share their views.

Requires Improvement

# Is the service responsive?

## Our findings

People had been involved in the development of a care plan which identified their needs and preferences and how staff were to support them to meet them. The plans covered people's needs in relation to various activities of life, such as eating, sleeping, communication and personal care. We found that the support plans we reviewed contained some information to support staff to understand people's individual preferences. However, this could be developed further to ensure the plans were as person centred as possible. For example, some care plans, developed to support people to manage their behaviour, lacked information on the specific triggers for the behaviour and what was helpful to the person to avoid escalation. In addition, although the care plans identified people's support needs, there was little information to show that people were supported to make plans or to have goals or aspirations for the future. The registered manager told us that work was ongoing to improve care plans and that she would address our findings as a priority. Care plans were reviewed regularly to ensure they took account of any changes in people's needs.

Since the last inspection in June 2017, the registered manager and staff had developed some aspects of some care plans to present information in an accessible way. This was done to enable people to understand the contents of the documents. This had not been completed for all care plans at the time of this inspection, but was a positive step towards embracing a person-centred approach to care planning.

People were supported to take part in activities that were meaningful to them and to maintain their interests. On the day of the inspection, several people had attended a day centre. We saw that other people were supported to participate in activities such as going to church, going shopping, socialising with friends, playing pool, playing the organ, and going to the cinema. One person attended a horticultural centre. The registered manager told us that they were looking to support another person to find voluntary work in a local charity shop, but this had not happened yet.

People were supported by staff to participate in daily living tasks, such as cleaning, tidying up, laundry, cooking and shopping. Staff were flexible in their approach towards this and shared these tasks with people depending on how much the person was able to do, and in some instances, wanted to do, for themselves.

People told us they could talk to their keyworker or the manager if they had any concerns. One person said, "I can talk to [registered manager]. She is good." Although the provider had a complaints policy there was not an accessible format version to support people who used the service to understand it. The registered manager confirmed that she would develop this following the inspection. Although a comments book was in place, the registered manager had no formal log with which to document complaints and the action taken to address them. The registered manager explained that complaints were managed through an 'open door' policy, which meant that concerns were dealt with informally and resolved before the need to make a formal complaint arose. However, the lack of a formal recording system meant that there was no evidence to show how complaints were managed or how learning from them was used to make improvements to the service.

At the time of this inspection, care plans did not include information about people's wishes in relation to

end of life care. End of life plans ensure people's personal wishes, religious and cultural beliefs and the needs of their family are known and understood to enable them to have a dignified and pain free death. Following the inspection, the registered manager sent us an end of life planning document that she had developed to identify people's wishes over the coming weeks. The plan was detailed and included sections to describe how and where the person wished to be cared for, who they wanted involved, as well as their religious and cultural beliefs and what arrangements they wanted for their funeral. It was written in an accessible format to support people to be meaningfully involved in this process.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection in June 2017, we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 and of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. This was because there was a lack of systems in place to monitor the quality of the service, and the provider had also failed to notify us of Deprivation of Liberty(DoLS) authorisations as required. At this inspection, we found that some improvements had been made and the service was no longer in breach. The provider had sent notifications as appropriate following the last inspection. However, some further work was required to ensure that the system used to monitor quality was robust and could provide a thorough overview of the quality of the service.

The registered manager carried out regular checks on the quality of various aspects of the service such as care planning, training, and infection control. Areas for improvement were noted as were actions taken to address them.

Following the last inspection, the provider reintroduced provider monitoring visits that had previously been discontinued. The registered manager showed us a list of actions produced by the provider following these visits to inform the manager about what improvements to the service were required. However, there was no framework to these visits and no indication of whether or not a full audit had been carried out, or what areas were looked at. As such, there was no way to tell whether or not specific aspects of the service had been reviewed at the visit and found to have no issues, hence they were not on the list of actions. In contrast, they may have not been on the list of actions because they had not been looked at. We were therefore not confident that there was a robust system in place to monitor the quality of the service. Following this inspection, the registered manager shared a new quality monitoring system that was under development in response to our findings. Although the system was not yet in place, this showed that the registered manager and the provider were responsive to feedback and used it proactively to make improvements to the service.

There was evidence that the registered manager and the provider needed to refresh their knowledge of current regulatory requirements and good practice guidance. We found that the registered manager and the provider had not kept up to date with changes to the Care Quality Commission inspection process introduced in November 2017. For example, it is now an expectation that services will include End of Life Planning within their care planning system which the manager was not aware of at the time of our inspection. The manager was also unfamiliar with the 'registering the right support' guidance which offers direction to providers about person centred care, and about the provision of services that only support a small number of people. There is an expectation that services that support larger groups of people consider how they can support person centred practice and/or reduce the number of people using the service over time. At the time of the inspection there were nine people living at the service out of a possible 13. The registered manager was not aware if there were plans to permanently reduce the numbers of people living there.

During the inspection we observed people who used the service interacting with the registered manager. It was clear that she had a visible presence in the home and that people felt comfortable to speak with her.

One person said, "[Registered Manager's name]! That's who I like!" Staff also told us that the manager was approachable to them and to the people who lived at the service. One member of staff said, "[Registered Manager's name] helps me to work things out. She doesn't just give me answers but talks it through so that I can learn for myself." Another member of staff said that the registered manager supported them to develop their role and they felt she valued the contribution of individual staff members.

The registered manager promoted an open and person-centred culture within the service and ensured staff understood this by emphasising the importance of placing people at the heart of care in supervisions and team meetings. We found that staff embraced this and took pride in working in an empowering way with people. One member of staff said, "It's not about how you can make sure you have a good day at work, it's about doing things right."

There were regular staff meetings and resident's meetings to support people and staff to express their views. People also had very regular contact with their key workers who supported them to make decisions and share their views about the service they received. The provider carried out annual satisfaction surveys and we saw the results on the day of the inspection. However, no action plan had been developed in response to comments made to improve the quality of care.

The registered manager told us, and records confirmed, that the home worked in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure there was provision of joined-up care. Where required, staff also shared information with relevant people and agencies for the benefit of the people living there.