Leonard Cheshire Disability

Mickley Hall - Care Home with Nursing Physical Disabilities

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

This unannounced inspection was carried out on the 20 & 21 August 2015.

Mickley Hall provides accommodation and nursing care for up to 40 people living with physical and learning disabilities. At the time of the inspection there 37 people living there.

The service had 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.

Summary of findings

There were enough staff to ensure people's safety, however people's needs were not always met in a timely manner.People told us they often had to waitto have their needs attended to.

Medicines were not always administered, recorded or managed appropriately. The storage of medicines were chaotic and staff could not always be sure people had received their medicines as prescribed.

Whistleblowing information was available to staff and they knew how to use it. Staff were aware of how to report and respond to allegations of abuse which meant people were better protected from the risk of abuse.

Staff had been appropriately trained to carry out their role, however they were not always supervised and supported. The registered manager understood their role in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had their nutritional needs recognised and supported. People were assisted to eat in a manner that supported their dignity.

People were supported to access health and social care professionals on a regular basis. They were supported in relationships with their family members and friends. However, people's hobbies and interests were not always well supported and people wanted more access to the community.

People or their relatives were involved in the decisions about their care. Care plans provided information on how to assist and support them in meeting their needs but the provider was not sure whether these were up to date and so was reviewing all care plans.

Staff were knowledgeable about people's needs. They were mostly caring, kind and compassionate. However, we observed some occasions when staff did not treat people with respect or promote their dignity.

The management of the service was chaotic and the registered manager and the deputy manager did not work as a team. This left staff without clear direction and guidance. People's records were not always kept in a confidential manner.

The service did not always have effective systems in place to assess, review and evaluate the quality of service provision. The provider was aware of some of the issues within the service and had taken action to start to make improvements. However, at the time of our inspection the improvements were not yet evident.

We found two breaches of the Health and Social Care Act and you can see what actions we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not always safe.

Systems in place to give people their medicines were not always managed safely.

People and their relatives told us that the home was safe. Staff were recruited safely.

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Safeguarding and whistleblowing guidance enabled the staff to raise concerns when people were at risk of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always feel supported and they did not have regular supervision. Staff received appropriate training opportunities.

Principles of the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS) were known and understood.

People were supported to eat sufficient and nutritious food and drink and had timely access to appropriate health care support.

Is the service caring?

Requires improvement

The service was not always caring.

People's wishes and choices were not always respected.

We observed some positive and respectful interactions between the staff and people who used the service but on other occasions people did not have their dignity promoted.

The staff we spoke with demonstrated that they knew the people they supported well and that they understood their needs.

Relatives were encouraged to visit whenever they wanted

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs had been assessed but people did not always feel their needs were being met by the staff team. People were not always supported to follow their interests or hobbies.

There was no clear evidence that care plans were up to date and contained clear information to assist staff to care for people.

Summary of findings

There was a complaints process in place for people to use.

Is the service well-led?

Requires improvement

The service was not always well led.

There was no effective management structure in the home and staff were without direction and support. The staff were not always well motivated and felt that their views were not always listened to.

The quality systems in place did not always recognise and respond to areas for improvement.

Mickley Hall - Care Home with Nursing Physical Disabilities

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.

The inspection took place on 25 August 2015 and was unannounced. It was conducted by two inspectors and one specialist advisor, who was a nurse with a background in physical and learning disabilities,.

We reviewed the inspection history of the service and the information we held including notifications received from the provider. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

We spoke with five people who used the service, two relatives, one healthcare professional, four care staff, one nurse, the deputy manager, the registered manager and the regional manager. We also had contact with the Local Authorities who had placed people in the service.

We reviewed four people's care records and medication records. We looked at records relating to the recruitment of staff, their support and records relating to how the safety and quality of the service was monitored.

Requires improvement

Is the service safe?

Our findings

There was no thorough process in place to ensure people had their medicines as prescribed. Medicines were stored in a haphazard manner in a messy overcrowded room making it difficult for staff to access the medicines and equipment they needed to care for people. Medicine fridges were not locked this meant that people's medicines were not stored securely and people who wer not authorised to do so had access to them. Medication Administration Records (MAR) were not secure and were kept loose leafed. This meant that they could be mislaid and as these were the only copies available, staff would have no way of knowing what medicines people were prescribed.

Staff had added additional medicines to the MAR charts without a second signature to verify that the correct medicine and dosage as prescribed by the GP had been added. Staff who administered medicines took a very long time to complete the process. One the day of the inspection it took staff from just after breakfast (9.00am) until lunchtime (12.30pm) to administer morning medication. All people's medicines were recorded as been given at the same time. This meant that the time recorded was not the time the medicines were given. This could mean that there was not enough time between rounds to meet the requirements of the prescribed medicines such as medicines that needed a specific amount of time between doses.

Care had not been taken to ensure the medicine trolley contained the necessary medicines. There were delays while the staff member returned to the room to get the correct medicines.

Medicines were not always signed for at the time when they were given. We saw that staff sign for medicines that we were told had been administered the previous day. The staff member had not given the medicines the previous day. Therefore they could not be sure they had been taken by the person. This is important because medicines should be administered and recorded as prescribed to ensure the person can maintain their health.

We observed gaps in the MAR charts and staff were unable to explain whether these medicines had been administered or not. This meant that staff could not be sure people were getting their medicines as prescribed. The provider was aware of this and had requested the support of their prescribing pharmacist to complete a full review of medicines. They had also recognised the need for a larger medicines storage area and had started to extend the area.

People's medicines were not managed in a safe way which ensured people were receiving their medicines as prescribed. This was a breach of **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.**

One person said, "I do like it here, it's much safer than anywhere else I have been." Staff we spoke with told us that they had received training on keeping people safe and were able to demonstrate that they had a good understanding of how to keep people safe. The safeguarding training included caring for people who have a physical disability. All the staff we spoke with knew the procedures to follow if they suspected abuse had occurred. They assured us that they would follow up on concerns they had until they were sure the issues had been dealt with. We noted that the registered manager had reported relevant incidents of concern to the local authority and to the Care Quality Commission. This meant that measures were in place to ensure people were better protected from the risk of abuse.

People had individualised risk assessments. Each assessment identified the risk to them, the steps in place to minimise the risk and the steps staff should take should an incident occur. However, the provider could not assure us the risk assessments were up to date and represented current risks to people. They had brought in additional resources to review all risk assessments with people so they could be sure appropriate and up to date risk assessments were in place. Some staff had not read the risk assessments and did not always understand the risk to each individual. This meant the staff member may not recognise when people were at risk.

There were sufficient numbers of staff on duty. However, staff said that the deployment of staffing was not always efficient. For example, nurses spent a long time administering medicines, which took them away from being able to perform other nursing duties and supervise the care staff. The provider had recognised this and a full review of staffing at the service was underway.

The provider protected people by having a thorough procedure in place for the recruitment of staff. Discussions

Requires improvement

Is the service safe?

with staff and a review of records showed identity and security checks had been carried out on staff before they stared working in the home. This included establishing a full work history of the staff member and verifying the information given on pervious employment. Disclosure and Barring Service (DBS) certificates had been obtained for all staff prior to starting to work in the home. This ensured that only people who were suited to work with vulnerable people were appointed. Staff confirmed that they did not take up employment until the appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service (DBS) certificates had been obtained. Checks had been carried out to ensure nursing staff were suitably qualified and had an up to date registration with the Nursing and Midwifery Council.

People were protected from risk in the environment because the provider had carried out assessments to identify and address any risks posed to people by the environment. These included checks of hot water and fire systems. Staff told us that there were formal emergency plans with contact number available for emergencies to do with the building, such as a gas or water leak. There was information as to where to find the necessary taps to switch the supplies of gas, electricity or water off.

Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Requires improvement

Is the service effective?

Our findings

People we spoke with told us that staff were trained to meet their needs. One person said, "They actually understand young people with disabilities." Another said, "I've not hit them with anything they can't do for me yet."

Staff also told us that they used to received regular supervision and had felt supported in their roles. However in the last six months this had slipped and now they did not feel they had a good relationship with the senior staff. One member of staff said they no longer felt supported and felt they could not ask for support as the last time they had approached the registered manager they were, "Shouted at." The provider recognised the staff needed more constant support and had provided additional resources to address this. Records showed that supervision meetings with staff had been held on a regular basis but had recently slipped. Staff said that they did not have an annual appraisal meeting at which developmental opportunities were discussed. The registered manager agreed that this no longer happened. This meant that staff were not always supported to enable them to provide care to a good standard.

Staff told us that there was a mandatory training programme in place and that they had the training they required for their roles. One staff member told us that their training was, "Good" and another said, "Yes the training is very good and we can ask for anything we need, although we do not always get it if it's not going to improve our role." They told us this was provided in a number of ways, by e-learning, distance learning books and face to face training and this was supported by records we checked. One member of staff told us they were completing additional training about how to care for people who were living with dementia. Another said that they had been given training in what to do if someone was choking. Specialist staff, such as physiotherapists, were trained in how to care for people living with multiple scoliosis. Nursing staff had updated training in wound care and assisting people who needed their nutrition delivered via a tube in their stomach..

Training for new staff included a two to three week induction period where new staff shadowed experienced staff to gain knowledge. They were also given time to read care plans prior to working alone with people. A review of training records showed that staff had the appropriate training to meet the needs of the people. This meant that staff were equipped to care for people and to understand their health care needs.

The people we spoke with told us that when there were changes to the care that was to be provided they were consulted and their consent gained. They said, "Every time they do a care plan update I come in and sign it off." People told us that staff always asked for their consent before delivering any care. One person told us, "They never do anything without asking." Staff told us of ways in which they gained consent from people before providing care. One told us, "Sometimes I just want to hang around and that's ok". A staff member said "Even though I know them really well I wouldn't dream of providing care without their full permission."

The staff told us that where people were not able to consent to an aspect of their own care, the principles of the Mental Capacity Act 2005 (MCA) were followed. This meant that people had an assessment of their capacity to consent, and where necessary, a best interest decision was made. We saw evidence that three people had been assessed under the MCA and that best interest decisions had been made in accordance with the act. We saw that one person had the support of an Independent Mental Capacity Advocate for a best interest decision. This meant that people's legal rights were protected. The registered manager was aware of the procedure to follow in the event of a person being deprived of their liberty. We were told that three people who used the services were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is a way of legally protecting people from harm by depriving them of their liberty. This was in line with the requirements of the Mental Capacity Act 2005 (MCA).

People told us that they had plenty of choice of good, nutritious food that they liked. The food was served in a self-service style and people we spoke with liked this. One person told us, "The food is usually very good, though sometimes the vegetables are a bit mushy." Another said, "I like that I can eat when I want to." A third person said, "There is a choice and you just choose the one you want." We observed lunch and we saw that people showed signs that they were enjoying their food. Those people who needed assistance with eating were assisted in a manner that promoted their dignity and ensured they were offered enough to eat. We saw people had access to snacks and

Requires improvement

Is the service effective?

drinks of their choice throughout the day. People were consulted on menu planning to ensure they got the food they liked. People who were assisted to eat via a 'peg feed' had this done in a manner that promoted their health. People who had difficulty in eating were referred to appropriate health care professionals such as dieticians. There was a selection of healthy food available. This ensured that the people had a good diet and were in control of how and when they ate.

People told us that they were assisted to access other healthcare professionals to maintain their health and well-being. The service provided a physiotherapist to assist people who had physical disabilities to maintain their mobility. Records confirmed that people had been assisted to see a variety of healthcare professionals and other professionals to promote their well-being, including their GP, district nurse, optician and chiropodist. When visits had been made to people by healthcare professionals the reason for these and the actions taken had been recorded to enable the staff to monitor the person's health more closely. People told us and records showed that referrals had been made to relevant healthcare professionals, such as occupational therapists and the local mental health team. This ensured the people had appropriate access to health care professionals to ensure the mental and physical health was promoted.

Requires improvement

Is the service caring?

Our findings

People did not always have their care delivered in a manner that promoted their dignity. For example, we saw nursing staff conduct aspects of personal care in a communal area. We also saw that nursing staff delivered care without speaking to people or without consulting them on how they wanted their care delivered. This detracted from the person's dignity and sense of well-being.

We saw other examples where staff had not ensured people's dignity, provided support to ensure people were comfortable or acted respectfully towards them. Some people were dressed in dirty and stained clothing without being allowed the opportunity to change their clothing. One person's wheelchair lap belt was stained and dirty and staff had not taken action to ensure it was cleaned. One person's glasses were not put on properly and this meant they could not see properly. This was not corrected until we asked staff to do this. Another person had blood stains on their clothing and again this was not addressed until we asked for the person to be attended to. We saw staff ignore people who said 'good morning' to them and observed that people did not like this. This approach to care detracted from people's dignity. However, most care staff treated people with respect.

One person said it's, "Wonderful, like a family here." Another person said that they felt respected in the home and that they, "Always had done, here is really good like this, Leonard Cheshire ethos is to be as independent as possible". They said most of the time they were able to cope on their own but when they needed assistance it was there. Most staff were very caring and said "We become a family here."

Staff knew different people's preferences and care needs. They were able to tell us how they supported people with a range of different needs who lived at the home. We observed most staff interacting with people throughout the day in a friendly and polite manner.

People were included in decisions about their care. One person told us that, "I can talk to any of the staff about my support. They are easy to talk to." Staff told us that they were careful to support people's dignity. For example, one staff member said they were careful to wash someone carefully to ensure only the part of their body being washed was exposed. This showed and awareness and respect for people's privacy.

People were involved in how they spent their day. They had choice about when to get up and go to bed, what to wear, what to eat and what activities they wanted to do. There were arrangements in place to ensure that people had access to their families and friends and the local community. For example, the provider had transport available to take people out and about. All people spoken with wanted more access to the local community. People were supported to visit family and friends. This ensured that the people were not isolated in the home and were able to continue friendships that were important to them.

People told us that their relatives were free to visit them at any time. One relative told us that the home had, "open door visiting."

Requires improvement

Is the service responsive?

Our findings

People told us their needs were not always responded to in a timely manner. One person said they had to wait too long to be attended to and were starting to lose confidence in the staff's' ability to meet their needs. Another person said that staff sometimes, "Shout back at me." We spoke to the registered manager and the provider who were going to investigate these concerns as a matter of urgency. Several people said that it took staff too long to respond to their needs. For example, we were told staff started to do things like assist them to use the toilet and then forgot to come back. People found this very distressing.

All the people living at the home had an assessment of their needs and wishes. Care plans had clear personal information in them. This had been gathered with people. Evidence seen showed that choice was provided and honoured over times of getting up and going to bed. People were able to have their meals at different times. One person was able to say that they go out to places of their choice. A volunteer at the home confirmed people made choices about where they would like to go.

However, the provider told us that they could not be sure all care plans were up to date and reflective of people's current needs and wishes. Therefore they had started to review all care plans and had brought in additional resources to achieve this. This included ensuring end of life care was documented and that people's health care passports were up to date.

We received a variety of responses from people about how they were cared for and people had differing views about their experiences. Some were negative in parts and some were very positive and said of staff, "They're really responsive". Another person said, "There is good communication between staff and residents" and, "If you want some information passing on, someone will pass it on", they, "Definitely come back". They also said that their favourite thing to do was having conversations. They said that they felt that sometimes staff, "Had not listened to what I've said" and, "I don't like talking to agency staff."

Where possible people were assisted to pursue their hobbies and interests outside the service. For example, one person liked to go to concerts and did this on a 'fairly regular' basis. However this was very important to them and they wanted more assistance to attend more concerts. Most people liked to spend time away from the home with friends and family and were supported to do this. Another person had 'IT' connected in their bedroom. They were really pleased with this but felt they had to wait too long for this (two years.) However, they said they were very happy it was now working as it gave them something to do all the time.

However, all they people we spoke with said there weren't enough staff who could drive the provider's vehicle as they, "Would like to go out to places more". All said, "More transport please". They said that they used to be able to say this to the registered manager but felt the [registered manager] didn't have time to talk to people now.

There was an activity room in the home which contained a variety of crafts and other materials however this was not in use. People and staff said it was usually open once a week. People said they wanted access to this more often and did not understand why it was restricted.

The provider had systems in place to ensure people felt listened to and they were encouraged to share their experiences. The home had many ways of consulting people on how the home was run, these included residents and relatives meetings where issues were raised. However, people told us these had now slipped and were not as productive as they used to be as many of their issues and requests had not been responded to.

People were aware that they could complain if they were unhappy with the care delivered. There was a complaints process in place and we saw that this was followed when a complaint was made. However, the people who told us they were unhappy with the service did not feel empowered to complain or to discuss their care delivery. The registered manager was aware that the systems had slipped and were not as effective as before. They said that this was partly due to them having to cover many nursing shifts when nurses were not available. The provider had recognised the issues we raised and was taking action to address them. These included providing extra experienced staff to support the management team.

Requires improvement

Is the service well-led?

Our findings

There was no consistent approach to quality assurance to ensure effective development and improvement of the service. The registered manager and the deputy manager did not work as a team to identify and meet people's needs and wishes. Staff were not managed and deployed effectively. The provider had not identified these problems in a timely manner although had now recognised these issues.

There were no effective processes in place for staff to follow to ensure they were meeting people's needs as effectively as possible. For example the administration of medicines was haphazard, lengthy to administer and errors in record keeping had not been identified.

People's confidentiality was not protected as their records were not stored in a manner that protected their confidentiality. Records were stored in unlocked offices, on desk tops. There was no effective management in the daily running of the service. This resulted in some people's care needs not been met and staff without direction.

There was no clear vision for the service and because of this staffs' morale was low and sick leave was high. This lead to the use of agency staff who could not work unescorted therefore reducing the effectiveness of the permanent staff team.

Systems for improving the service through auditing and monitoring were not effective and it was unclear in some areas as to what actions had been taken. For example, whilst there was a complaints system in place, it had not been used effectively to improve the provision of their care.

There were quality assurance audits in place. However, these had failed to recognise and respond to the shortfalls in the quality of service provision. For example, that the service was not responsive and people's needs were not met in a timely manner.

Once the provider became aware of the shortfalls in the service they responded by committing additional resources into the service. This included the introduction of an experienced manager and senior nursing staff to address the issues at the home. However, the effects of this had not been evident at the time of our inspection.

Systems to assess, monitor and improve the quality of service were not effective. This was a breach of **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People could not be assured that the systems in place would ensure they had their medicines administered as prescribed.**