Integrated Nursing Homes Limited

Millbridge

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 inspection took place on 10 March 2015 and was unannounced. Millbridge is a residential care home providing nursing and personal care and support for up to 53 older people, some of whom may live with dementia.

The home has not had a registered manager since September 2013, although there had been a manager in post since April 2014. 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 told us they felt safe and that staff supported them in a way that they liked. Staff were aware of safeguarding people from abuse and how to report issues of concern.

Summary of findings

Individual risks to people were not always assessed adequately by staff and there was not enough information about how to reduce risks around different areas of the home.

There were enough staff available at most times to meet people's needs. However, staff members were not able to spend time with people or meet their social needs.

All of the required recruitment checks had been obtained for all new staff to ensure they were suitable to work with people.

Medicines were safely stored and administered, and staff members who gave out medicines had been trained. Not all medicines were safely given out.

Staff members received other training, in a format that provided them with the opportunity to ask questions and practice new skills. Staff felt supported although they did not all receive supervision from the manager, which did not provide time for personal development.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was not meeting the requirements of DoLS. Inadequate action had been taken to comply with a condition of one DoLS or to ensure authorisation was obtained for other people.

Staff members understood the MCA and presumed people had the capacity to make decisions first. However, where someone lacked capacity, there were no written records to guide staff about who else could make the decision or how to support the person to be able to make the decision.

People enjoyed their meals and were given choices about what they ate. Drinks were readily available to ensure people were hydrated. Not all staff members assisted people appropriately.

Staff members mostly worked together with health professionals in the community to ensure suitable health provision was in place for people. Not all recommendations to refer to health care professionals were followed.

Most staff were caring, kind, respectful and courteous, although not all staff members communicated with people well. Staff members knew people well, what they liked and how they wanted to be treated. People's privacy and dignity was respected.

People's needs were responded to well and care tasks were carried out thoroughly by staff. Care plans, however, did not all contain enough information to support individual people with their needs. People's social needs were not met and they did not have the opportunity to go outside when they wanted.

A complaints procedure was available and appropriate action was taken when complaints were made, although records of these were not available.

The manager was supportive and approachable, and people or their relatives could speak with her at any time.

The home did not properly monitor care and other records to assess the risks to people and ensure that these were reduced as much as possible.

We have made a recommendation about adequate staffing levels.

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.

People were supported by enough skilled staff to meet their physical needs and to keep them safe. Staff recruitment checks had been obtained before new staff started work to ensure they were suitable to work with people.

Risks to people had not always been properly assessed and inadequate assessment of risks around the home had been made.

Medicine records were properly kept and medicines were safely stored, although not all medicines were safely given out.

Is the service effective?

Requires improvement

The service was not always effective.

Staff members received enough training to do the job required.

The manager had not acted on recent updated guidance of the Deprivation of Liberty Safeguards or a condition on one person's DoLS. Mental capacity assessments had not been completed for people who could not make decisions for themselves.

The home worked with health care professionals to ensure people's health care needs for people were met.

People were given a choice about what they ate and drinks were readily available to prevent people becoming dehydrated. Staff members did not always help people in the most appropriate way.

Is the service caring?

Requires improvement

The service was caring.

People's privacy and dignity was respected.

People liked the staff members caring for them and staff members knew people's individual preferences.

Not all staff members communicated with people well.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not have their individual care needs properly planned for, although staff responded quickly when people's needs changed. People had little to occupy them during the day and they were not able to go outside when they wanted.

Summary of findings

People were given the opportunity to complain and those complaints were acted upon appropriately.

Is the service well-led?

Requires improvement

The service was not always well led.

Audits to monitor the quality of the service provided were completed and identified the areas that required improvement, but actions had not been identified to address shortfalls. People were not given the opportunity to give their views about the quality of the service they received.

Staff members and the manager worked with each other, health care professionals, visitors and people living at the home to ensure there was a high morale within the home.

There was no registered manager although the manager had been in post for nearly a year.

Millbridge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 March 2015 and was an unannounced inspection.

The inspection was carried out by two inspectors.

Before we visited the home we checked the information that we held about the service and the service provider. For example, notifications that the provider is legally required to send us and information of concern that we had received.

During our inspection we spoke with six people who lived at the home and one visitor. We also spoke with six staff, including care and nursing staff, housekeeping staff, and the area manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We completed general observations and reviewed records. These included five people's care records, three staff recruitment records, staff training records, six medicine records and audit and quality monitoring processes.

Requires improvement

Is the service safe?

Our findings

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as; malnutrition, behaviour, medicine management, and moving and handling. Our conversations with staff demonstrated that they were aware of assessments and the guidance required to reduce risks. Most assessments provided guidance for staff to follow to ensure that people remained safe. However, we also saw that nutritional risk assessments had not always been completed accurately and did not correctly depict the risk to people. Not all risk assessments had been reviewed and updated with new information. For example, information about one person being able to go outside had not been updated and they continued to be restricted to inside the home for much of the time. One person's continence assessment contained information about the person that was inconsistent with their other care records. This resulted in an inaccurate assessment of the person's abilities. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us that there were usually enough care staff available but not always. They said an extra staff member had been employed and this had been of great benefit as the number of agency staff being used had reduced. There were dedicated housekeeping and kitchen staff, as well as other ancillary staff, such as a gardener and maintenance person. However, the provider was still trying to recruit an activities coordinator.

We were told that usual care staffing numbers for the 34 people living at the home at the time of our inspection were nine staff during the day and five staff at night, including nursing staff. On the day of our inspection there were eight staff working across both buildings, which included one agency staff member who had never worked at the home before. Staff told us that 10 people (almost a third of people living at the home) needed two staff members to assist them with care and transfers. We saw that people received care and their physical care needs were met.

The home was made up of two separate buildings; the main house and the coach house. Although the coach house had been purpose built, the main house was an old three storey property with rooms located in all parts of the building. Although there was a calm atmosphere throughout the home, we observed that staff were not always easily visible and there were long periods when people did not see anyone. Two people told us that they would have liked to go outside but were unable to do this without a staff member. We talked with one person in a communal area for over 20 minutes, but no staff member entered the room. In another area of the home, after everyone who had wanted to get up was up, we again saw that staff members did not spend time with people in communal areas.

We concluded that there were adequate staffing numbers to meet people's care needs, but this did not allow them to spend time with people or to enable people to participate in activities that they wished to enjoy.

People told us that they felt safe in the home. They said staff looked after them and that they had no complaints.

Staff members we spoke with understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the manager responsible for safeguarding referrals, which staff members were all aware of. There were written instructions to guide staff and they knew where these were kept. Staff members had received training in safeguarding people and records we examined confirmed this.

Information we hold about the home indicated that referrals were made to the local authority safeguarding team and staff took the appropriate action to reduce the risk of further incidents occurring. We were confident therefore that staff would be able to recognise and report safeguarding concerns correctly.

Servicing and maintenance checks for equipment and systems around the home were carried out. We saw that fire safety and other equipment had been checked and serviced within the last 12 months, and regular checks were carried out on hot water temperatures in bathroom and washing facilities.

The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff they employed were of good character.

Requires improvement

Is the service safe?

We found that the arrangements for the management of people's medicines were safe. They were stored safely and securely in locked trolleys or in a locked room. The temperature that medicines were stored at was recorded each day to make sure that it was at an acceptable level to keep the medicines fit for use.

Arrangements were in place to record when medicines were received, given to people and disposed of. The records kept regarding the administration of medicines were in good order and the number of medicines recorded on these records tallied with the number of medicines available. They provided an account of medicines used and demonstrated that people were given their medicines as intended by the person who had prescribed them.

Staff members had received medicines training. We observed two members of staff giving out medicines. This was mostly completed correctly and in line with current guidance, which was in place to make sure that people are given their medicines safely. However, not all staff members ensured that people took their medicines and one medicine was left on a shared table at lunchtime. This meant that there was a risk that the person may not take their medicine or that another person may take it by mistake.

We recommend that the service consider current guidance about adequate staffing levels to ensure people are able to meet their social needs and staff are available at all times.

Requires improvement

Is the service effective?

Our findings

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The staff told us that they had recently received training in DoLS and this had given them a greater understanding of the safeguards. However, not all staff members were able to properly describe the safeguards and how these should be applied. Entry doors to the main units and all external doors were locked and people did not have free access outside the home without a staff member. Staff told us that this was because there was a river running close to the home, which could be accessed from the grounds. At our last inspection only two DoLS applications had been made and staff members were not aware of any further applications, despite people living at the home whose liberty was restricted.

We discussed with staff the condition on one person's DoLS authorisation that a secure garden area be developed so that the person could safely go outside when they wanted to. Staff did not know when work would start on securing this area. The timeframe for meeting this condition had almost ended, and included an extension of four months after the local authority DoLS officer found that the original timeframe had not been met. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members' understanding of their role in supporting people to continue to make their own decisions was good following recent training that they had received in the Mental Capacity Act. Our observations however, showed that not all staff members allowed people to make their own decisions.

We saw that care records for some people noted that they lacked capacity in some areas, such as managing their own medicines, when to seek medical advice or to receive personal care. Mental capacity assessments had not been completed to determine which decisions people were not able to make for themselves. Neither were there best interest decisions to show the least restrictive course of action or who should make particular decisions on behalf of the person. Where there was an entry in care records about a person's capacity we noted that there was inadequate information to support the decisions that needed to be made by staff on people's behalf. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a varied ability by staff members to provide appropriate assistance to people when they helped them to eat. We saw that some staff members adapted their support to each person, whether that required them to prompt the person, supervise or to physically assist them. These staff members were attentive, spoke with people appropriately and allowed the person to eat at their own pace. We saw that people were able to eat and drink where and how they wished and they were able to choose which course they ate first. However, we also saw that some staff members carried on conversations with other people or did not speak with people to let them know what food was on the fork/spoon while helping people to eat. One person told us that they had a particular dislike of part of the dessert they had been given, although the staff member did not change this and the person ate around the part they did not like.

The amount of food being consumed by people was recorded to ensure they received as much food as they needed to maintain or increase their low weights. However not all identified weight loss was recorded accurately, and this resulted in an inaccurate risk level being determined. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information within people's care records about their individual health needs and what staff needed to do to support people to maintain good health. People saw specialist healthcare professionals, such as occupational therapists, opticians, GPs and district nurses when they needed to. Staff members told us that they were able to easily access the local GP and district nursing service. We noted that advice provided by health care professionals had usually been sought and acted on. However, in one person's records advice had not been acted on and in another person's records advice from a health care professional had not been sought, although it was a recommended course of action in one of the person's risk assessments. This meant that although appropriate

Requires improvement

Is the service effective?

actions had been taken, such as providing people with nutritional supplements, staff members could not be sure that the most up to date advice and guidance had been made available.

Staff told us they were supported well with training and development. One staff member talked to us about their induction and told us they felt confident in what was expected prior to working on their own. Another staff member described the training they had recently received on end of life care, which included training about using specialist equipment. Other staff told us about the dementia courses they had attended. Staff members also had the opportunity to gain a national qualification, such as a National Vocational Qualification or a Diploma, at level two or three in health and social care. We observed staff members in their work and found that they were tactful, patient and effective in reducing people's anxiety or behaviour that may upset others and in delivering care.

Staff told us that they felt supported in their work and they could talk to the manager at any time whenever they felt they needed support. However, they also told us that they did not all receive supervision meetings with the manager in which they could raise any issues they had and where their performance was discussed. One staff member told us that they had not received supervision in three years. Although another new staff member told us that they had received supervision since they had started working at the home.

People were provided with a choice of nutritious food, and they told us they enjoyed the meals offered. One person had requested soup as an alternative to their main meal and this was made available to them. They said that this was, "Very nice". Another person told us, "I have a choice with what meals I prefer and the food is good". We saw that people enjoyed the food that they ate. A menu was available on tables and we observed that this provided people with conversation about what to eat. However, we also observed that not all of the items on the menu were available.

Records showed that where staff had been concerned about people who had lost weight, they had been referred for specialist advice. Some people had been provided with a more specialised diet, such as a puree diet as a result of this advice.

Requires improvement

Is the service caring?

Our findings

We saw during the lunchtime meal in one part of the home that people sat in almost complete silence; there was little conversation or any other noise in the room. Some staff members spoke with people and involved them in decisions about their meals and drinks, other staff members did not speak at all. One staff member gave three people a drink, not once speaking with them or involving them in the decision, even though all three people were able to communicate and there were three choices of drink on offer. We also saw a staff member changing one person's position without speaking with them or letting them know what they were going to do.

Visitors told us that they were involved in their relative's care. We saw that people's records detailed when they had been contacted by staff at the home and the context of those conversations. We also saw that when people were not able to be involved in their own care decisions, that their relatives were able to do this on their behalf by attending reviews of people's care and contributing to their care plans. However, we saw that information about people being involved in their care was poorly recorded. Best interest decisions were not available to guide staff in ensuring people continued to be involved in their care and make as many of their own decisions as possible. We saw that although it was important for people to be able to go outside, no action had been taken to make sure they could do this safely. We also saw that some staff members did not always give people the opportunity to consent to the care they received.

All of the people we spoke with were happy with the staff who cared for them and one person said, "They all look after us well". Two other people told us that, "Staff are nice to me. I like the staff over here" and "I have a good time. The staff look after me well. I like the chats we have". They told us that the staff were kind, caring and compassionate, and that staff did as much as possible in caring for them. One person's visitor told us that they had no complaint about the way their relative was supported by staff.

During our inspection we heard and observed laughter and most people looked happy and contented. They were relaxed with the staff who were supporting them. Staff engaged in conversations with people and we saw that the majority of the time they were treated as individuals.

Staff were polite and respectful when they talked to people, we witnessed quiet encouraging words when a person was moving from the lounge to their bedroom. Staff made eye contact with people and crouched down to speak to them at their level so as not to intimidate them.

At times we observed staff communicating with people well, at other times this was not done so well. Staff members understood the requests of people who found it difficult to verbally communicate. When asked, staff members demonstrated a good knowledge about how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these. We observed one staff member help a person who was unable to easily communicate verbally with their lunch. They listened to the person and responded when required to what the person had said, to the person's satisfaction, even though we found it difficult to understand what the person was saying.

We observed staff respecting people's dignity and privacy. They were seen quietly asking people whether they were comfortable, needed a drink or required personal care. They also ensured that curtains were pulled and doors were closed when providing personal care and knocked on people's doors before entering their rooms. We saw dignity preserved when a person's clothing was caught inappropriately. People were assisted to their own rooms before personal care was offered to ensure their privacy and dignity was respected.

There was variable information in relation to people's individual life history, likes, dislikes and preferences in care records, although staff were able to demonstrate a good knowledge of people's individual preferences. One person told us of their food preferences and said that staff members ensured they were given one of their particular likes if they asked for it.

Requires improvement

Is the service responsive?

Our findings

Care plans were in place for most people to give staff guidance on how to support people with their identified needs such as personal care, medicines' management, communication, nutrition and with mobility needs. However, the information provided was variable in its level of detail about what was important to people, their daily routine and what activities they enjoyed. Some plans contained more detail and provided clear guidance for staff in how the individual needs for each person should be met. Other records were disorganised and did not provide easy access to any guidance they contained. Reviews of plans had not always been carried out, which meant that changes to people's care had not been recorded.

Although we saw that charts and records associated with care, such as repositioning and food intake charts, had been started, we noted that not all charts had been fully completed. Food charts showed the food or meal provided, but often not how much had been eaten or how much had been on the plate initially. This meant that the amount of each food group (vegetable, protein or carbohydrate) eaten could not be ascertained. The amount that people had drunk was not always recorded. We saw that people's drinks were topped up during meal times and meals were removed without any record kept for those people whose intake was monitored. This meant that accurate records were not being kept of the care provided to people living at the home. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff were responsive to people's physical care needs. They were available when needed and we saw that people did not have to wait for attention during the day, although we had concerns about whether there were enough staff available to spend time with people. For those people who were not able to get out of bed, we saw that they received care from staff members at appropriate intervals to reduce the risk of pressure ulcers developing.

We saw that people sitting in communal areas were left on their own for long periods with nothing but the television to watch. Few people were watching the programmes when we spent time in the communal areas; in one part of the home, only one person was watching, in another five of the eight people in the room had gone to sleep. One person told us that they found the home, "Quiet, boring and nothing to do", while another person said, "There is nothing to do except read or do my crossword". Two people told us how much they wanted to go outside but could not. One person knew about another care home close by where they had friends living and wished to visit them but had no-one to take them. Another person commented that, "I wish the staff had time to take me out. I would love to go in the grounds but I am told it is not safe".

Staff members told us that external entertainers visited the home every fortnight and if they had time they would provide games, such as skittles. We did not see this on the day of our inspection. We found that people's social needs were not being met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were happy with the support they received, although a visitor commented that they had made a complaint about the care provided to their relative. This had been addressed and the visitor felt that the care and support the person received had improved.

A complaints policy and procedure was available in the main foyer and contained details of external agencies that people could also contact if they wished to make a complaint. Staff confirmed that action had been taken to address two recent complaints received by the home. However, no information was available to show how these complaints had been investigated, the outcome or actions that had been taken. We concluded that although complaints had been addressed, there was a lack of recording of investigations, outcomes and actions taken to ensure similar issues did not continue to arise.

Staff told us that they encouraged people to keep in touch with family and other individuals who were important to them. Records were kept that confirmed this and we saw that people regularly saw friends and relatives. We saw in one person's records that their family had been kept up to date with their condition.

Requires improvement

Is the service well-led?

Our findings

The manager completed audits of care records, maintenance and domestic areas. We saw that audits completed between July and December 2014 identified issues, but that actions to address these issues had not been developed. For example, health care professionals had not always been contacted when appropriate. Information about the specific actions required, who was responsible for this and how it would be monitored to ensure the action had been taken was not available. We found during our inspection that although health care professionals had been contacted most of the time, we identified one instance where this had not been the case.

The regional manager told us that the provider planned to introduce more systemic monitoring but that this was not in place at the time of our inspection.

No formal questionnaires had been sent to people or their relatives for two or three years. A report of questionnaire results from 2011 and 2012 was available and on display in the home, however a more recent report had not been developed regarding people's views of the home. This did not ensure that people's views about the quality of the service they received were obtained and did not allow any development or improvement of the home.

Analysis of other records, such as accident and incident records or complaints, had also not taken place. Only one complaint had been logged, and this only after being received via the local authority safeguarding team. We saw in staff meeting minutes that outcomes had been fed back to staff so that they could change and improve their practice. While we could see that the manager had intended to carry out further work at some point, there had been no action to address this, which meant that possible trends and themes across the home had not been identified. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had been in post since April 2014, although an application to become the registered manager had not been submitted. We were told that the manager was not available for this inspection or for the following two weeks. Staff at the home were supported by the area manager.

Staff spoke of the support provided by the whole staff team. They told us they worked well as a team and they supported each other. They told us the manager was very approachable and that they could rely on any of the staff team for support or advice.

Staff said that they were kept informed about matters that affected the home through team meetings and talking to the manager regularly. They told us about staff meetings they attended and that the manager fed back information to staff who did not attend the meetings. This ensured that staff knew what was expected of them and felt supported. Staff told us that their morale was very good and demonstrated that they understood their roles and responsibilities.

Several staff members told us that the manager had an open door policy, was visible around the home and was very approachable. They told us that they had been made to feel appreciated. Staff were aware of the management structure within the provider's organisation and who they could contact if they needed to discuss any issues.

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 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected against the risks associated with inadequate assessment of care needs or care planning to meet individual needs and ensure welfare and safety. People's individual needs were not always met.**

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 **People who use services were not protected against the risks of inappropriate or unsafe care because adequate systems were not in place to assess and monitor the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who use services were not protected against the risks of unauthorised deprivation of liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People who use services were not protected against the risks that they could not make their own decisions because mental capacity assessments had not been completed and best interest decisions made in line with Section 4 of the Mental Capacity Act 2005.**

This section is primarily information for the provider

Action we have told the provider to take

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 People who use services were not protected against the risks of unsafe or inappropriate care arising from a lack of information about them because accurate records had not always been kept about care given to each person.