Milestones Trust

77 Gloucester Road North

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 11 April 2018 and was unannounced. The service was last inspected in April 2016 and was rated as 'Good'.

77 Gloucester Road North is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

77 Gloucester Road North accommodates six people in an adapted, detached house. At the time of the inspection there were six people living at the service. The registered manager and staff were working in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion so that people could live an ordinary life.

There was a part time registered manager working in the home. 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.

People were supported by staff who had received training in how to recognise signs of abuse. Staff were aware of what actions they would take if they suspected a person was at risk of harm. Staff would take concerns further until their concerns were resolved.

Staff were aware of the risks to people and planned the best way of supporting them whilst at the same time encouraging people's independence.

Safe systems of recruitment were in place. However care and support to people living in the home was provided by more casual staff than the permanent staff who knew the people well.

The medicine procedures were not always in place to ensure people received their medicines as prescribed by their GP.

Care records provided staff with the information required to effectively support people's care, health and social well-being. Staff were supported by the management team through regular supervisions, training and team meetings.

People were supported to visit their GP and other healthcare professionals, in order to maintain good health. People were involved in planning their weekly menus and some were encouraged to be involved in the preparation of their food.

Staff obtained people's consent prior to offering support. People were supported to have maximum choice

and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice and people's rights.

People receive support from staff who treated them with dignity and respect. People were comfortable in the presence of staff, who supported them in a friendly manner. People were provided with information in a format they understood.

Complaints raised were investigated and responded to and where appropriate, lessons were learned. Staff were confident that if people raised a concerns they would be listened to and action would be taken.

Staff were motivated and felt supported in their role and worked with the registered manager's vision for the service.

The provider and home staff carried out regular audits of the service.

People and staff were provided with the opportunity to give feedback on the service, which was then acted on. A variety of audits were in place to assist the registered manager in making improvement across the service.

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.

Staff knew how to recognise the signs of abuse and report any concerns.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

There was an appropriate system in place for the monitoring and management of accidents and incidents.

There was not always a sufficient number of staff with in depth knowledge deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were not always administered safely.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service remains well led.

77 Gloucester Road North

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 9 and 11 April 2018 and was undertaken by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider completed and returned the PIR in March 2018 and we considered this when we made judgements in this report. We also reviewed other information that we held about the service such as notifications, which are events, which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection, we spent time observing the people living in the home to help us understand the experience of people who could not talk to us. We spoke to three support workers and the registered manager.

We reviewed a range of documents and records including the care records of three people using the service, three medication administration records, two staff files, training records, accidents and incidents, arrangements for managing complaints, daily records, surveys and quality audits.

Requires Improvement

Is the service safe?

Our findings

On arrival we found the home secure because the front door could only be opened by staff, we were then asked to identify ourselves and to sign in.

Staff demonstrated they understood how to recognise different signs of abuse and were confident in the action they would take to keep people safe. Staff had completed their safeguarding training and were able to discuss the organisation's whistle-blowing policy with us.

Medicines were not always administered or managed safely. We looked at medicine administration records (MARs) and saw they were completed. Where one person was receiving their medicines without their knowledge (covertly) for example in their food; arrangements were in place to ensure this was carried out safely and their rights protected. The person receiving their medicines in this manner had them for their best interest which had been discussed by the staff, GP and a relative. A pharmacist had been contacted, to ensure there were no adverse effects to the person with the medicine being mixed with food. Another person was informed their medication was being added to their food but for one medicine this was being done without the pharmacist's advice on whether this arrangement was safe. The pharmacist's advice was required to ensure that the method of administration did not interfere with the effectiveness of the medicine which could place the person at risk.

Body maps were in place for people had been prescribed topical creams to guide staff where on the body the cream should be applied. However we found two creams which were not dated when they were opened. One of the opened creams was being given to a person without any record of it in the MAR sheet showing it had been agreed to be prescribed. We also found medication being given for heartburn, but could not read the name of the medicine properly because it had been covered over by a sticky label and there was no record for it in the person's MAR sheet.

Staff had completed medication training and had their competency assessed by the registered manager to ensure they had the skills and knowledge for medicine administration. Protocols for medicines given 'as required' (PRN) such as painkillers were in place to indicate when to administer these medicines. Medicines were stored in locked cupboards according to national guidance. Staff recorded and monitored the temperatures of the room to ensure medicines were maintained at a safe temperature. Processes were in place to ensure that medicines were disposed of safely and staff kept medicine stock control records.

People were not always being supported by staff who knew well. The staff duty rosters for the most recent two weeks showed there were more casual staff working in the home as bank or from an agency than permanent staff. We found that two shifts over the two week period had only bank or agency staff on without any permanent staff. Whilst inspecting the service we heard casual staff asking permanent staff for guidance. Although this helped to ensure people were being kept safe, it put more responsibility onto the permanent staff. Information sent to us by the provider before we inspected stated that two minor medication errors were caused by casual staff.

We looked at a person's care record where their main interest and activity was to go walking and found that over the last 14 days they had stayed in more often than they had gone out. We also noted that one person needed two staff to provide them with personal care and yet most afternoons there were only two staff on duty. At the same time, staff were expected to ensure two people in another area of the home were kept apart. We were unable to understand how this arrangement could be achieved on the afternoon shifts to minimise the risk to people. The manager explained that because of people's habits and life style it was not a problem. Our view was that people's safety in the afternoons was reliant on the assumption that people's behaviour did not change. We asked the registered manager to risk assess these arrangements. We noted that one person's care plan had not been reviewed for eight months, the registered manager explained this was due to staff sickness.

Staff we spoke with said they needed to take more responsibility for the safe running of the home because they could not share the responsibilities with the bank or agency staff. We also saw that in the daily handover book there were two entries which said that people "Probably appeared unsettled due to different staff" or "Bank staff who didn't know her."

We discussed our staffing observations with the registered manager who explained there had been staff sickness, staff vacancies and staff leaving. We were told the service was actively recruiting and they tended to use the same bank and agency staff on a regular basis.

The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable staff were employed by the provider. The service contained confirmation of these checks on their staff files.

Risk assessments had been completed to cover all aspects of a person's care. We found them informative and individualised for the person they were written. For example assessments provided guidance to staff on how to minimise the risk to people when they were in the kitchen, taking a shower or going out for walks.

Risks to the building and premises were assessed. This included fire safety, gas safety, portable appliance testing, Legionella prevention and checks on the passenger lift, hoists and slings for moving people. Where risks were identified, action was taken. For example the information sent in by the registered manager before our inspection identified the action they had taken to improve the safety of the passenger lift.

There was an easy read fire procedure on display for people to inform themselves of the action they would be expected to take in the event of a fire. Personal evacuation plans were available which detailed the support a person would require during the day and evening if they had to evacuate the building if there was a fire. The plans were on display but for one person there were no details on what action the emergency services would have to take as nothing had been filled in for them.

All areas of the service were clean, including communal areas, bathrooms and toilets. There were appropriate hand washing facilities within the premises. Staff were able to talk about the importance of infection control for the safety of people living in the service and themselves. We observed staff using aprons and gloves when required. Each person who staff had assessed as requiring a hoist for transfers had their own sling to prevent cross infection.

Accident and incident reports were completed when injuries occurred to people. We saw that reports were reviewed by the registered manager and notes were made to reflect any investigations or follow up actions.

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Assessments that had been completed were decision specific and had been used to reflect areas when the person was unable to make the decision themselves. We saw best interest meetings had been instigated with professionals when a decision was required which could have an impact on a person's wellbeing. We noted that family members and independent advocates were invited to contribute towards making decisions in people's best interests.

We observed that staff explained to people what was happening and obtained their consent before they provided day to day care and support. Staff members were knowledgeable about peoples' reduced capacity, and how to obtain consent from people with limited or restricted communication skills. We observed staff communicating with one person with simple verbal prompts and body language. The person refused the support being offered and we noted the staff respected the person's decision and returned several times to see if they had changed their mind. We also noted the good practice of different staff going to the person offering their support.

We saw that the most recent staff starting in the service had received induction training when their employment commenced and regular training and updates to help them keep their skills and practices current. We saw that staff had completed training in a range of topics relevant to their roles. This included core training such as safeguarding, moving and handling and the Mental Capacity Act 2005 (MCA). Staff had also been given training to the specific needs of people in the home for instance catheter care. Staff confirmed they were supported through attendance at team meetings and individual supervision. The records showed the registered manager arranged for staff to get regular supervision. All staff we spoke with told us they received support and they could approach senior staff to discuss concerns or to get advice and support.

People appeared to enjoy the food they were eating; we saw that one person really enjoyed eating a large bowl of porridge, which they finished quickly and then sat back and smiled at us. Staff told us people were supported to choose what they wanted to eat and if they changed their mind they could always have an alternative. People were included in suggesting the meals they wanted on the menus. We looked at meals served to people over a two week period and pointed out a lack and variety of vegetables. The registered manager agreed to review the menus and seek nutritional advice from a dietician to ensure people had a balanced diet.

We observed the lunchtime meal and saw that people were provided with varying levels of support to help them eat and drink. To avoid making people feel different at mealtimes the registered manager explained how the presentation of the food looked similar for everyone even if they had different dietary needs. Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. People were offered regular snacks and drinks throughout the day. One person had his fluid input and output

assessed daily but we found that it was not always being added up each day to ensure they had taken a sufficient amount to help keep them well.

People's health care needs had been considered. When people were required to attend health appointments they were supported by staff who were able to guide them through the process. For each person there was an individual approach to the different health professionals they required to support their wellbeing. For example, some people required wheel chair specialist advice and some, specific medical guidance for their health condition. We saw the relevant professionals had been consulted when required to provide the support and guidance people needed.

The living space had been designed to meet people' needs. Communal areas had been decorated to provide a homely and calm environment. However several walls in the home were marked or discoloured and awaiting renovation. People's rooms were decorated according to their preferences, including the wall colours and curtains.

Good

Is the service caring?

Our findings

Staff had developed positive and friendly relationships with people and it was clear that the permanent staff knew them well. We observed people were relaxed and comfortable when interacting with staff. We observed staff 'engaging' with people in a friendly way and it was obvious they were interested in what people had to say. People were offered choices and this helped them retain their independence and to remain in control in their lives.

People's individuality was respected. Care plans contained detailed information for staff to read about people's past history, likes and dislikes, their preferences as to how they wished to be cared for, their cultural and spiritual needs. There was information which explained what was most important to people and what would be their perfect day. We saw that the staff had taken into account the information when they were supporting and helping people to make choices for themselves. For example, in one person's care plan it stated that the person liked to go out for walks and enjoy the fresh air. We saw that the person was supported to go out for a walk when possible. Another person was regularly supported to go to the local church on Sundays and this included support from a voluntary worker.

We observed that staff used a variety of ways to communicate with people in the home. Staff told us they used simple words to prompt some of the people, for others it was basic hand sign language and for others pictures were used to help them make choices. There was a communications section in people's care records and lots of the documentation we viewed was pictorial with simple sentences alongside them.

Staff respected people's dignity and made sure they supported people in the way they wished whilst encouraging them to remain as independent a life as possible. During our inspection we noted staff were always respectful in the way they addressed people. We observed staff knocking on people's doors. Throughout the day we noted there was good communication between staff and the people who used the service and saw that staff offered people choices. For example we heard a member of staff member asking a person what they wanted to do and if they wanted to go and join a group activity.

Good

Is the service responsive?

Our findings

People in the home had a comprehensive care record which included their history, information from people who knew them well and guidance from a range of professionals. People's diversity was considered as was their preferred clothes style and individual aspects of care needs. There were references in the care records to aspects of people's care which had been discovered over time, for example the enjoyment of a style of music or ambition for the future. One person was supported in planning to go abroad for their first time.

Staff received a daily handover when they commenced their shift. There was a communication book and all information relating to people's needs was documented. One staff member said, "It's the information we need. That's where I look up any changes."

People received the opportunity to access their interests and hobbies. Each week an external entertainer visited the home to provide visual stimulation and musical participation for people in the home. People had been to hydrotherapy, one person regularly attended a day facility and another went out daily to the shops to collect their newspaper.

The service involved people with the chickens kept in their back garden and growing vegetables in the summertime. The manager explained how one person was actively involved in gardening whilst others were happy to sit and watch.

There was a complaints policy available which was written and pictorial to make it easier for people to understand. We saw a complaint had been made since the last inspection, which had been investigated and resolved by the registered manager.

At the time of this inspection the provider was not supporting people with end of life care, however one care record we viewed was very clear about the type of service the person wanted at their funeral, including the type of music.

Good

Is the service well-led?

Our findings

The registered manager knew the people well. They worked alongside staff to ensure they maintained their knowledge of the people they supported and ensured staff were working consistently and effectively with people. The registered manager shared their visions and values which included an expectation to get the best out of people by providing them with person centred care and being prepared to take risks.

There were quality assurance systems in place and a programme of audits, which were undertaken by both the registered manager and other members of staff. In addition, the provider monitored the service through audits and twice monthly visits to the home. The results from these audits were shared with staff to help improve the service for people living in the home. However during our inspection we found medication errors which had not been picked up by the various audits, so we recommend that the medicine audits are more robust when they carried out.

Staff told us the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions and they felt their opinions were valued. Staff meetings were held every month and staff had regular supervision.

People were approached to provide feedback through a variety of methods which included completion of an annual survey. These were distributed to people, family, staff and stakeholders to obtain feedback. Survey results were then analysed and the results used to produce an action plan.

The registered manager and staff had links with the local community. People living at the home are encouraged to maintain contact with friends and families. People's community involvement included getting to be known by the local shop staff and being known by the church nearby where they went for tea and cake.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.