Care Quality Commission

Aspire Healthcare Limited

Milton Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

This inspection took place on 5 and 6 November 2014 and was announced. A previous inspection was undertaken on 5 July 2013 and found there were no breaches of legal requirements.

Milton Lodge is registered to provide accommodation for up to 13 men who have a learning disability or mental health issues. People come to the service from a hospital environment where they have been cared for under the Mental Health Act 1983. At the time of the inspection there were 13 people using the service.

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

We saw there were procedures in place to keep people safe and staff understood what action to take if abuse

Summary of findings

was suspected. Staff were suitably trained and experienced for their role. They told us the quality of training was good. Staff were trained in safe working practices and more specific areas suitable for their role.

We saw there was enough staff on duty to meet people's needs. There were recruitment procedures in place and suitable checks were completed before staff started working at the service. There was a system in place to manage medicines safely.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The registered manager was aware of the Supreme Court judgement which had redefined the definition regarding what constituted a deprivation of liberty. We saw that mental capacity assessments were in place for each person and best interests meetings were held to ensure that all actions taken were in the best interests of people in line with legislation.

Staff knew people well and had a good understanding of their needs. They were respectful to people and were patient when supporting them. We saw staff enabled people to make decisions for themselves whenever possible.

People who used the service had an individual activities plan based on goals. People chose what activities they wished to engage in and when they liked to do them. People were supported to access the local community. There was a complaints procedure in place and people were provided with a copy in case they had any concerns about the service.

The registered manager monitored the quality of care. Surveys were carried out annually for people who lived at the service. Audits were also carried out for areas such as health and safety, infection control and fire safety.

Regular meetings were held with staff and these meetings were recorded. Staff felt supported in their role by the registered manager. However, we saw the registered provider did not always respond promptly to requests for repairs to be made and for equipment to be replaced.

Records including care plans and risk assessments were complete and kept securely. Records could only be changed by staff by hand which meant it was time consuming for staff when changes needed to be made.

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

Not all aspects of the service were safe.

People who lived at the service told us they felt safe there. Staff had received training in safeguarding vulnerable adults and knew how to recognise and report abuse.

We saw there was enough staff on duty to meet people's needs. There was a recruitment procedure in place to ensure people were safe to work at the service. There was a system in place to manage medicines safely.

We found there were issues with the decoration of the service and that some areas were in need of refurbishment.

Is the service effective?

Good

The service was effective.

Staff received suitable training for the role.

There was evidence that assessments had been undertaken in line with the Mental Capacity Act (2005) to determine if care or treatment was being provided in people's best interests.

People told us they were happy with the food and drink provided at the service. Staff were aware of people's dietary needs.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care provided to them. They said they were well supported at the service and that their needs were met. We observed that staff cared for people appropriately.

People were involved in planning their care and their views were listened to.

People were treated with respect and dignity by staff who were able to maintain their privacy.

Is the service responsive?

Good

The service was responsive.

People who used the service had individual care plans in place which recorded their needs. Detailed assessments were completed before people began to use the service and the service liaised closely with other agencies to provide support to people.

Activities were centred on the needs of the individual and there was a wide variety available.

Summary of findings

There was a complaints system in place and people were provided with details of how to complain.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

The registered manager undertook a range of audits to ensure the service was safe. She monitored the environment and records were kept of her findings.

Staff and people who used the service were positive about the manager and how approachable she was. Meetings were held with people who used the service and staff but these meetings were not frequent.

We saw the provider did not always respond promptly to requests for repairs or the replacement or equipment. Care records and risk assessments were detailed and kept securely. However, they were hand written which was time consuming and could lead to duplication in care plans.

Milton Lodge

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 was carried out on 5 and 6 November 2014. Due to the needs of people who used the service this inspection was announced. The inspection team consisted of an inspector and a specialist advisor who was a registered mental health nurse and who had experience of providing nursing care and support to people with a learning disability or mental health issues.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team and the local authority safeguarding adults team. They had no comments to make on the running of the service.

We spoke with eight people who used the service and three relatives. We also spoke to a consultant psychiatrist, a social worker from the community learning disabilities team who had responsibility for most people who used the service and who knew the service well. We talked to the provider, the registered manager, the deputy manager and five support workers at the service.

We reviewed a number of documents as part of the inspection including, four care plans, risk assessments, medicine administration records, four staff training records, safety checks and quality assurance documents such as surveys and records of meetings with people who used the service and staff.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at the service. Comments included, "It is safe. I can come and go as I like" and "Yes, I am safe. I have had no problems." We spoke to a consultant psychiatrist who knew the service well. She was positive about the service. She told us, "I have no reason to believe that people are not safe there. It is a good service."

We spoke with a number of health and social care professionals who did not raise any concerns about the service or about people's safety. We spoke with staff who told us they were aware of the provider's safeguarding policy. We checked records and saw that staff had received training in safeguarding vulnerable adults. Staff described to us what constituted an abuse and knew the correct procedure to follow if they suspected someone was at risk of abuse. Staff were aware that in the case of potential abuse they could report it to their management, the local authority safeguarding team, the Care Quality Commission (CQC) or the police.

We saw that the home had policy documents for safeguarding vulnerable adults and whistle blowing. The staff we spoke with told us they were aware of the company's whistle blowing policy, which explained to staff how they could raise any concerns they had relating to poor practice within the home. Staff told us they felt that any concerns raised through the whistle blowing process would be taken seriously. We checked records and saw the home had a log of any safeguarding incidents which detailed where people may be at risk of abuse. Any incidents recorded had been correctly reported to the local authority safeguarding team and the CQC.

During the course of the inspection we examined care records and looked at the issues relating to safety for people who used the service and members of staff. The registered manager and the deputy manager demonstrated that they understood the risks involved with the people who used the service. There was evidence in the care records of risk assessments which were evaluated and reviewed on a regular basis. For example, where one person required one to one support on a community visit a risk assessment was in place and described how staff should identify and respond to behaviour that may be seen as challenging.

The registered manager told us the staff team consisted of herself, a deputy manager and 17 support workers who all worked full-time at the service. We saw there was a low turnover of staff and that the staff team was stable. This provided stability for people who used the service and allowed time for people to develop relationships. At the time of our inspection there were seven members of staff on duty including the manager, the deputy manager and five support workers. We saw that past and future staff rotas had the correct amount of staff scheduled to work. We checked care plans and saw that staffing levels were measured by people's needs and dependency which had been assessed. This meant there was sufficient staff on duty to meet people's needs.

We saw there was an effective recruitment system in place. We saw checks were made before staff began work at the service. We checked staff records and saw an application form had been completed by all applicants. This included a previous work history. We looked at staff records and saw two references were requested for prospective new staff including one from a previous employer and that these were held on file. We saw enhanced checks with the Disclosure and Barring Service (formally the Criminal Records Bureau) had been completed and reference numbers were kept on each file. We were told no applicant would start work before all checks had been completed. Applicants provided proof of personal identification and proof of residence. We were told that where a person had been identified as having a previous conviction or caution each case would be reviewed independently and that if a person was employed who had a conviction; a risk assessment would be completed and recorded.

The service had a security system which was fully operational together with a fire alarm. We checked fire equipment including extinguishers and saw they were checked regularly. Regular tests of the fire system were completed and recorded. We saw it was a requirement that all staff had received training in fire safety. There were emergency procedures in place for the evacuation of the home and each persons evacuation needs had been assessed.

We saw safety checks had been completed for the fixed electrical system and for portable appliances such as

Requires Improvement

Is the service safe?

kettles and microwaves. A gas safety check had also been completed for the service. These checks had been completed by qualified professionals and safety certificates had been issued for the service.

The service had a system in place to manage medicines effectively. The medicine administration records (MAR's) were examined by us and were found to be in good order, there were no omissions of administration and prescribing was in accordance with National Institute of Clinical Excellence (NICE) guidelines and within British National Formulary (BNF) limits. There was no evidence of an over use of 'as required' medicines. These are medicines which are those given only to people when needed. We saw people who used the service had medicines delivered by a local pharmacy. Medicines were counted and recorded on MARs. We saw staff signed these records for all administration of medicines. We found that medicines were stored securely and were clearly marked with the name and date of birth of people who used the service clearly displayed. We examined the storage areas and found the medicines were kept safely in locked cabinets. We saw staff had received training in the administration of medicines.

The service was situated over three floors. There were 13 single bedrooms and people shared bathroom and toilet facilities. The service was safe and clean however we noted that some areas were in need of redecoration. We saw there was work that required completion including, the full renovation of the kitchen and laundry room. The service still had handrails attached to the walls from the original care home and that some of the flooring, although safe, was in need of replacement as it was old and worn. We spoke to the registered provider who told us the improvements had been identified and work was due to start. He told us he was to make further investment in the property and that this would commence in March 2015. People we spoke with were generally happy with the environment. Comments included, "I like it here. It's better than a hospital" and "It's like my home now." We considered that due to the condition of parts of the premises this requires improvement.

Good

Is the service effective?

Our findings

People we spoke with told us they felt the staff at the service were suitably trained and experienced to support them. Comments included, "The staff know what they are doing" and "They (staff) are good here." We talked with staff and asked them if they felt they had sufficient training for their role. Comments included, "I think the training is very good" and "The training is very good quality."

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards exist to ensure people are only deprived of their rights if it is within their best interests. We saw policies and procedures were in place for these safeguards. There were no (DoLS) in place at the service. Where people did not have the capacity to understand the choices available to them we saw the registered provider acted in accordance with legal requirements. If people lacked capacity we saw this had been assessed to see if a restriction of their liberty was required. We saw the registered manager and senior staff had received training in the Mental Capacity Act 2005 (MCA) and (DoLS). The staff demonstrated good knowledge of these areas and were able to describe how important it was to enable people to make decisions for themselves. We saw best interests meetings were held to ensure that all actions taken were in the best interests of people in line with legislation. This meant people's rights were respected and people were protected from abuse.

We checked staff records and saw that the registered manager monitored training at the home using a training matrix. We saw this was up to date and records showed that staff had received the required training. We saw that staff were able to develop professionally and received more specialised training aimed at their role. For example, health and nutrition and diabetes care. We spoke to staff who had been supported to complete a 12 week course on mental health awareness and learning disabilities. The registered manager told us when staff expressed an interest and if it was relevant to their role they would be supported to complete more specialised training.

Staff received supervision sessions every two months and an annual appraisal. Supervision sessions are used to check staff progress and provide guidance. A lack of supervision sessions and appraisal could mean the competency of some staff might not be assessed and support may not be provided if gaps in their knowledge or skills were identified. We saw copies of supervision documents where staff discussed matters relevant to them such as further training and competency.

People at the service often came from a hospital environment where they had received care and support under the Mental Health Act 1983. We saw that capacity had been assessed for people by healthcare professionals and some people were subject to a community treatment order. This is an order made by a clinician such as a psychiatrist who allows a person to continue to receive treatment within a community setting rather than in a hospital. We spoke with the registered manager about these orders and she demonstrated a good knowledge of the legal requirements of the MHA in this area.

People told us they liked the food provided at the service and that they helped to cook or prepare it. People were free to eat when they wished and there was a choice of what to eat at meal times. People were supported to access the kitchen and treated the area as their home. Records revealed staff had received training in food hygiene and infection control. People told us, "I like the food", The food is good" and "I like the food but we need more brown bread." We spoke to the registered manager about this who told us they were to order more brown bread in future.

Good

Is the service caring?

Our findings

People we spoke with were very positive about the care they received at the service. They told us, “I love it at Milton. The staff are caring” and “I feel at home here. I like it.” We spoke with a consultant psychiatrist from a local hospital who knew the service well. She said, “They are very proactive and attend to people’s needs. The staff there use their common sense and they know when to ask for help. They care for people well and their moral value is intact.”

We spent time with people who used the service and observed how they were cared for. We watched staff interactions with people. Staff were relaxed and understood people and their needs very well. Interaction was always positive as was the atmosphere at the home. For example, people who used the service always called staff by their first names and felt secure to have open and honest conversations in their presence. People spoke freely and without fear. People chose what they wanted to do and where they wanted to go. We saw people chose what they wanted for lunch. Staff were respectful and treated people with dignity. Staff supported people and were conscious that people made decisions for themselves.

We looked at people’s care plans and saw they included instructions on how staff should support people if they needed medical attention. They also included a hospital passport to take with them. This is a document which included information about the person, their needs and likes and dislikes. This meant hospitals would have information to help them understand what people’s needs were and how to support them.

People were involved in decisions about their care. For example, one person who used the service had been to see a specialist at a hospital and they had consented to that visit. People told us they were included in planning their care. Comments included, “They always ask me what I want” and “We have meetings and I tell them what I like. "People were provided with a service user guide that explained the services provided. The registered manager told us the staff team worked hard at making sure people were involved in their care and making decisions about that care. For example, we saw care plans recorded people’s choices during review meetings including what they like to eat. People’s wellbeing was monitored. Where people were at risk from malnutrition or dehydration. For example, when they had an infection. Staff recorded and monitored what food and fluid the person had.

People who lived at the service were independent and mobile. They told us staff treated them with respect and their privacy was maintained. Comments included, “The staff speak to me alone if I want to” and “I can go in the manager’s office and she shuts the door when I talk to her.” Staff demonstrated a good knowledge of how to preserve people’s dignity. They described how if they were supporting people with personal care they would ensure doors were closed and they would provide reassurance to people.

The service used an independent advocacy service to help support people with their decision making. We saw that when an advocate was appointed they were included in meetings alongside the service management and healthcare professionals. All people at the service were provided with the advocacy service details. This meant people’s health and wellbeing was monitored and maintained.

Good

Is the service responsive?

Our findings

People told us they were involved in making decisions about their care. Comments included, "We talk about things all the time" and "I go to meetings and we talk about things." Another person said, "I don't have any problems because we can talk to (staff name) and they sort it out. I see the doctor at the hospital and they ask how I am."

We looked at care records and saw they were detailed and person centred. The care plans were developed using information supplied from the people who used the service, their social worker from the community learning disabilities team and their consultant psychiatrist. We saw they were individual to the person and highlighted their specific needs. Care plans included information about people's life history. We spoke to staff about people who used the service and they were able to demonstrate a good knowledge of the people they cared for and their needs. For example, some people liked a strict routine and care was taken to ensure that their routine was carefully planned and organised. This meant people would not become distressed unnecessarily.

We saw that when someone moved to the service from hospital a member of the hospital staff delivered familiarity training to the staff at the service which enabled staff to build up a picture of people's needs and how to respond to them. We saw staff from the service also attended the hospital and shadowed hospital staff when caring for people who were to move to the service. This meant staff could learn how to care for people before they began to use the service and people became familiar with some staff which allowed for a more settled transfer to the service.

Care records were reviewed monthly by staff together with a specialist social worker from the NHS community learning disabilities team. We saw members from this team provided support and guidance to Milton Lodge staff and the people who used the service at these reviews.

Prompt referrals were then made to healthcare professionals such as general practitioners. We saw where one person was taking a medicine which could have side effects and their blood was taken regularly and monitored by their doctor. The results were then recorded in the care plan.

People took part in a wide range of activities. For example, people were encouraged and supported to make their own food and to do their laundry. People attended a variety of activities in the local community such as, gardening and a local allotment, music concerts, attending football matches, attending local community social clubs, fitness classes, arts and crafts and going to the cinema. The service also planned and held events including a Halloween party and a Christmas party was planned where people and their families and friends could attend.

We talked with people about the things they could do. Comments included, "It is better than the hospital. You can do what you want. The staff come with me and we have a good time" and "I like gardening at the ranch. It is good up there."

The registered provider had a complaints process in place. This was provided to people on arrival at the service and included the telephone numbers of organisations to contact and who to complain to including the local authority and the Care Quality Commission. We saw that there had been two complaints recorded in the last 12 months at the service. These complaints were recorded properly and responded to within a reasonable time. We asked people if they knew how to complain. One person said, "Yes I know how to complain. I would just go to (staff name) or the manager. I am not scared to complain." We spoke to the registered manager who told us she was active in dealing with issues promptly. This meant people understood how to complain and who to complain to if they should have a problem.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy with the management of the service and how it was run. Comments included, "You can go to her (the manager) with anything" and "The manager is good to me. I don't have a problem with her." We spoke to a consultant psychiatrist about the service. She told us, "The manager communicates with us well. I know her and she has been there for a while."

A registered manager was in post and was registered with the Care Quality Commission in line with legal requirements. She had worked for the company as a manager for 13 years.

We looked at the results of an annual survey which was sent out to people who used the service and their relatives in April 2014. There were 10 responses to the survey. Comments included, "I would like to thank you for helping me and making my life better" and "I would like to thank Milton Lodge. The staff are very nice to get on with." We looked at compliments sent to the service. One person said, "I would like to take this opportunity on behalf of myself and my family to say a huge thank you to the staff at Milton Lodge. You showed compassion and understanding during the hospital visits and your patience has no boundaries."

We saw meetings had been held with staff and that they had been recorded. The last meeting had been held on 2 September 2014 where staff had discussed changes to policies and procedures at the service. For example, health and safety. However the previous staff meeting had been held in March 2014. Meetings were held with people who used the service and the last meeting was held on 9 September 2014. We saw people had requested that they had fewer salads to eat as the weather got colder and that staff had acted on this. We saw relatives were invited to these meetings but did not always attend.

The staff worked closely with other agencies and stakeholders such as, the local NHS mental health trust and the local NHS hospital trust at Rake Lane, North Tyneside. We saw they had good communication with these services and regular meetings were held. Information was exchanged and stored with people's care plans.

Staff told us they were happy working at the service and had a good relationship with the registered manager. Staff told us, "The staff have a voice and the service users have a voice. We are here for the clients and are supported by the manager" and "We can go to the manager if we want to discuss anything and anything we say is treated with confidentiality."

During the course of the inspection we spoke with the registered manager and deputy manager of the service. They both felt supported in their role by the registered provider. However, we saw that the registered provider did not always respond promptly to their requests for repairs or the purchase of new equipment. For example, a crack in a work bench in the laundry had been reported but not repaired. We saw that requests for repairs were made to the registered providers office via an electronic reporting system.

We looked at the records kept for the service. Care plans were clear and well organised. We found records were up to date and complete. We reviewed records such as, care plans, risk assessments, safety records and audits for the service. However, we found that care plans and risk assessments were hand written. This was time consuming for staff when they needed to alter a document. We considered this requires improvement.

We saw audits of the service were completed for the home by the registered manager and included areas such as health and safety, infection control, fire safety and the safe handling of medication. We saw the registered manager was developing more detailed audits for infection control and health and safety for the service. Accidents and incidents at the service were recorded and monitored. We saw the registered provider had a disciplinary procedure in place for the investigation into poor practice or misconduct. The manager kept monthly records of accidents and injuries for the service.