Albany Farm Care (Havant) Limited

Milton House

Inspection report

18 Fourth Avenue
Havant
Hampshire
PO9 2QX

Tel: 02392480789

Date of inspection visit:
22 September 2020

Date of publication:
17 November 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Milton House is a residential care home providing personal care to five people at the time of the inspection. The home can accommodate up to six people in one building and there are multiple communal areas. They predominantly support people living with a learning disability and autism.

People's experience of using this service and what we found
People were at risk of harm due to poor medicines management. We could not be sure people had received their medicines safely and as prescribed.

Infection prevention and control was not always effective and safe. Staff were not wearing PPE in line with government guidelines.

Governance systems had not identified the concerns we found during our inspection. We could therefore not be assured that quality assurance processes were effective.

Staff were recruited safely, and staffing levels met the individual needs of people, meaning people received the support they required in a timely way. Staff knew how to keep people safe from harm.

Staff demonstrated a commitment to providing person-centred care based on people's preferences and wishes. The staff team, including agency staff used regularly, knew people well and had built trusting relationships with them.

Staff had received appropriate training and support to enable them to carry out their role safely.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The registered manager and staff described how people living at the service were the focus of their work. The culture in the service was improving and staff were supported to place people at the centre of all decisions about their lives and the environment they live in.

Where communication was a barrier, on-going support was being developed to improve communication between staff and people, so that people's voice could be heard and acted upon.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 01 May 2018).

Why we inspected
We received concerns in relation to the culture of the service and the safety of people when applying deprivation of liberty safeguards. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Following this inspection, the provider took action to mitigate the risks and address the concerns found. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Milton House on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Milton House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors.

Service and service type
Milton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we had received about the service, including previous inspection reports, concerns and notifications. Notifications are information about specific important events the service is legally required to send to us. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our

inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, the nominated individual and deputy manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed three people who could not verbally communicate with us and spoke to two people, living at the service. We observed staff communicating with people, reviewed the safety of the environment and reviewed medicine processes.

After the inspection
We reviewed and analysed a range of records we had received from the service, including five people's care records and risk assessments. We looked at staff files in relation to recruitment and a variety of records relating to the management of the service, including quality assurance records, policies and procedures and additional supporting information provided by the management team.

We contacted and spoke with, three relatives and five staff members. We had contact with and spoke with four external professionals who support people living at the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicines were not always managed safely. We found that information on medicines administration records (MAR) was not always clear, which had led to two people receiving the incorrect dose of their prescribed medicine. Although we found no evidence of harm caused by these errors, this meant people were at risk, by not receiving their medicines as prescribed. In addition, we found information in a person's care plan about the amount of medicine they were prescribed, this information did not correspond with the prescribed dose recorded on the persons MAR chart. We discussed all these concerns with the registered manager, who took immediate action to address the errors with staff. Following our inspection, the registered manager and provider arranged additional medicines training for all staff.

● Information recorded on people's MAR charts did not clearly identify medicines that were prescribed, 'as and when required' [PRN], as opposed to a regular daily prescription. In addition, medicines had not always been signed for when administered. This meant we could not be assured people had received their medicines as prescribed. We discussed these concerns with the registered manager, who took immediate action to address these errors with the staff team.

● People did not always have PRN protocols within their medicines records that described to staff when PRN medicines should be given. Where PRN protocols were in place, these were not always clear and did not contain information such as timescales for when PRN medicines should be considered. For example, one person was prescribed PRN medicine to manage behaviours that could cause risks to themselves and others. Information describing how staff should support the person, for how long and at what point they should administer the PRN medicine, was not clear. This meant people could be at risk of being given PRN medicine to manage their behaviour, before all other supportive techniques had been attempted. We discussed this with the registered manager, and they took immediate action to update people's PRN guidance to include timescales, where required.

● Systems were not always in place to ensure the safe application of topical medicines, such as topical creams. We found that MAR charts had not been signed when topical medicines were applied. This meant we could not be assured that people were having these medicines applied as prescribed. We discussed this with the registered manager, who took immediate action to investigate these concerns and address with the staff team.

● In the medicine audit completed by the service in August 2020 it was identified that staff were not signing the MAR correctly and there were gaps where medicines had not been signed for at all, people did not have medicines risk assessments in place and there was no information about the potential side effects of medicines for people. These risks were identified on an action plan and shown as completed. However, we found the same repeated errors during our visit. Therefore, we could not be assured that medicines were being managed safely for people.

● Where people required their medicines to be given covertly, the principles of the Mental Capacity Act had been followed and agreement from external medical professionals sought.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was using personal protective equipment [PPE], effectively and safely. We observed that staff were wearing a variety of different cotton face coverings. The government guidelines state that care staff should wear moisture resistant medical face masks, in order to reduce risks and these should be changed when they become moist or dirty and disposed of safely. It was unclear if the cotton face coverings staff were observed to be wearing, were being disposed of at the end of each shift. We observed one cotton face mask left on a desk, which was clearly dirty. This meant we were not assured that the provider was promoting safety through the correct use of PPE. We discussed our concerns with the registered manager, who took immediate action to address this with the staff team. There was a supply of the surgical face masks already available in the service and by the end of our visit, all staff were observed to be wearing the correct type of mask.

● Staff were not washing their hands thoroughly to reduce risks. We observed that when staff washed their hands, they were not always doing this for the length of time described in government guidelines. For example, we observed one member of staff only washing their hands for 10 seconds and another for seven seconds, instead of the minimum 20 seconds, described in government guidance. Although this had been identified by the registered manager in an audit on infection control in August 2020, staff were still failing to wash their hands thoroughly. This meant we could not be assured that risks to people from Covid 19 were being safely managed. We discussed this with the registered manager, who confirmed staff had received training in how to safely put on and take off their PPE and in handwashing. They assured us this would be addressed again with the staff team.

● There was a designated area for putting on and taking off PPE at the entrance to the service and gloves and aprons were available to staff. However, the hand washing facilities were located at another area in the service, which meant staff could not wash their hands where they put on and took off their PPE. Nonetheless, hand gel was available, and we were told that staff used a nearby hand basin to wash their hands and put on another pair of gloves as soon as they arrived in the building.

The failure to ensure the correct management of infection control risks, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach.

● The provider had an up to date infection control policy, that included information about Covid 19 and the potential risks.

● People and staff were supported to follow shielding and social distancing rules.

● One person had been admitted to the service during the coronavirus pandemic and we were assured that this had been done safely and following government guidelines.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider had risk assessed visitors to the service. People were being supported to have contact with their families and friends through video messaging services or through pre-arranged visits in the garden. We discussed how visits could be facilitated during the winter months and the registered manager assured us this was being reviewed, whilst being mindful of the risks within the local area at any time.

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to protect people from the potential risk of abuse. There were processes in place for investigating any safeguarding incidents that had occurred and these had been reported appropriately to CQC and the local safeguarding team.

● Staff had received training in safeguarding, understood their responsibilities and told us they would report safeguarding concerns in line with the provider's safeguarding and whistleblower procedures. One staff told us, "I would report any concerns to the manager," and they confirmed they were confident the [registered] manager would, "Absolutely take action." Another said, "If I was concerned, I would report my concerns immediately to management or go higher if required. If I was not confident that concerns were taken seriously, I would whistle blow or report to the local authority safeguarding team."

● We had mixed feedback from people's relatives. One person's relative said, "No I don't think [persons' name] is safe, I am worried that the staff don't know what they are doing." While another told us "Yes, overall, I do feel they [people] are safe, the [registered] manager has worked hard to sort out the problems." A third said, "The staff have communicated really well with us to get to know [person's name], so I feel they know how to keep them safe."

Assessing risk, safety monitoring and management

● Risks to people's personal safety had been assessed and had good detail about individual people. However, where people had behaviours that could be a risk to themselves and others, care records describing what staff should do to support the person, did not always contain clear information such as timescales for any interventions. For example, people's behaviour support plans did not describe clearly, at which point staff should consider moving to the next stage of intervention such as using physical interventions, to keep people safe. We discussed this with the registered manager who told us they would review care records and provide the additional information.

● Risk assessments had been completed for people. For example, people had risk assessments for accessing the community, medicines and nutrition. However, as described above, risks around some medicines and PRN use required additional information. The registered manager completed this following our inspection visit.

● Environmental risks had been assessed and managed to keep people safe, but still enabled people to do things independently where they could, such as moving around independently and being supported to use the kitchen.

● Health and safety audits identified when work was required, and the provider ensured that work was planned and completed in a timely way, although the coronavirus pandemic had impacted on the timeliness of some identified work to remove items from the garden.

● Business continuity plans were in place to ensure that individuals were prioritised in terms of risk during crisis situations. This had been updated to reflect the coronavirus pandemic.

● Fire safety risks had been assessed. Each person had a personal emergency evacuation plan (PEEP). These identified what assistance each person would need to safely leave the building, in the event of an emergency.

Learning lessons when things go wrong

● Accidents and incidents were recorded and monitored by the registered manager and the positive behaviour lead for the service. The provider had oversight of this, and any themes or patterns were identified.

● When serious incidents had occurred, the provider took action to investigate and share any learning with the staff team. People's care records were updated following an incident to reflect learning. The registered manager assured people's care plans were continually updated to reflect the most current needs.

● Information was shared with staff through handovers between shifts, staff meetings and individual staff

supervisions.

Staffing and recruitment

● Staffing levels were based on the needs of the people living at the service. Where people had complex needs, the need for additional support had been assessed and was provided, which meant people received support in line with their individual needs. Staff had received training that equipped them for their role. One staff member said, "We can always ensure that people are safe, this is the priority."

● At the time of our inspection, the service were using a high level of agency staff, but the registered manager told us these were regular agency staff who had been supporting people at the service well and had built positive relationships with them, which we observed during our inspection visit.

● The registered manager had recruited new staff members, who were going through an induction period, so they would be able to strengthen the existing staff team.

● We observed staff spending time with people and supporting them to participate in activities that were meaningful to them. Staff had time to sit and talk with people and provided prompt assistance when needed. One staff member told us, "There's always plenty for residents to do and they get out every day. We are a really good and supportive team."

● Recruitment checks had been completed to ensure that new staff employed were suitable to work at the service. This included disclosure and barring service (DBS) checks, obtaining up to date references and investigating any gaps in employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance systems were in place to assess, monitor and improve the service. However, these were not always effective and had failed to identify some of the concerns we found during the inspection.
- Medicine audits completed in August 2020 and September 2020 had failed to identify all of the concerns we found. The providers' audit did not include checks on information about each person's medicines, the times they should be administered and if information was correct on people's MAR chart. We found multiple errors on MAR charts, when we reviewed them during our inspection. This meant we could not be assured that systems in place were effective to keep people safe. We discussed these concerns with the registered manager and provider who took immediate action to improve medicines records and risk management.
- Infection control processes were not always safe. The registered manager and provider had failed to recognise staff were not using the recommended face masks or washing their hands for long enough, in order to reduce the risks during the coronavirus pandemic.

The failure to operate effective systems to assess, monitor and improve the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other quality assurance systems in place were effective. The registered manager carried out regular audits which included, health and safety and people's care records. There was also a system of audits in place to ensure that safety checks were made. For example, in respect of water temperatures and fire safety.
- The provider had policies and procedures, which staff accessed electronically, and this supported them to provide people with the assistance they needed.
- There was a clear management and staffing structure and everyone was clear about their role and those of others. The registered manager was supported by the providers, who had responsibility for the oversight of the service. The registered manager said, "I feel supported and can ask advice at any time."
- The service had an 'emergency contingency plan' in place, which detailed various procedures to be implemented in the event of an emergency and had been updated to include information about the coronavirus pandemic.
- The provider notified CQC of all significant events.

Continuous learning and improving care

- The provider had quality assurance processes to monitor the service provided, although these had not

always been effective. The provider and the registered manager reviewed systems and governance and arranged for any actions identified to be carried out promptly.
● Spot checks, where they made checks on the service at different times of the day and over the weekends, were completed by the registered manager. These helped support good practice by the staff team.
● Accident and incident records were reviewed and analysed by the registered manager and the positive behaviour support lead, to identify any potential triggers for behaviours or risks that needed reviewing. For example, people's communication care plans were being expanded to support staff with improved positive reinforcement when working with people. This had reduced the recent occurrence of incidents.
● Where incidents or accidents had occurred, these were shared with staff during handovers, staff meetings and supervision.

Working in partnership with others
● The registered manager acknowledged staff had not always worked collaboratively with external agencies in the past. However, they were addressing this and were developing external professional relationships, to improve outcomes for people. They told us, "We want to work well with external professionals and get support from them, to ensure we are supporting people well."
● The service had well established links with the local community and key organisations, reflecting the needs and preferences of people in its care.
● GP services, social workers and community learning disability services were involved. The registered manager acknowledged that this had been more challenging during the coronavirus pandemic but was working to improve contact and use their expertise when needed, so they could work more collaboratively. An external professional told us, "The [registered] manager is working hard to improve the service and is engaging with us when needed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We discussed the vision and values of the service with the registered manager, who acknowledged that they had worked hard to improve the culture in the service and develop a cohesive staff team. They told us, "I've had to have lots of meetings with staff to share with them my vision for the home and get them to trust me so we can work together to improve things for the people living here." A staff member said, "The service is improved 100%, the [registered] manager is doing her best trying to catch up and take over doing things the way they should be done. Paperwork is much better and clear, and we know what is expected of us."
● Relatives had previously been welcome to visit at any time. However, due to the coronavirus pandemic there had been a period of time where no visitors were permitted to visit the service. During this time the registered manager told us they had supported people to maintain contact through video and telephone calls, but this had not always been a successful means of communication for all people. Relatives were now able to visit but there was a clear system that considered the current risks and required visits to be booked in advance and PPE to be worn, alongside social distancing. Most visits had taken place in the garden and we discussed how visits could be facilitated though the winter months. The registered manager assured us this was being reviewed and the risks considered, whilst meeting people's human rights. One relative told us, "It was very relaxed the last time I visited, it has been difficult through this pandemic, but the staff are good at letting us know what's going on."
● Staff meetings were held regularly. Meetings were used to provide information, such as planned improvements to the environment, training, introducing increased positive support approaches and activity ideas. One staff member told us, "I have worked in a number of care homes, but this is the home I have been the happiest in, I love my job; I love the guys [people] and the [registered] manager is fantastic, I can go to her about anything."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager had worked hard to develop a person-centred culture within the service. They recognised where improvements had been needed and had recruited new staff with a clear focus on positive reinforcement and person-centred care, to improve the culture at the service. People had good person-centred care plans that described their likes, wants and wishes as well as their specific needs and how staff should support them.

● People were supported to access their local community, although this had been impacted by restrictions through the coronavirus pandemic. We were told people visited local shops, cafes and beaches. For example, during our inspection we saw that people were involved in deciding if they wanted to go out and where they would go. Staffing levels supported individual community activities. The registered manager demonstrated a high level of passion to get things right, and this was shared with the staff team. A staff member told us, "Service users [people], are given so much choice and get lots of activities; swimming, to the beach, canoeing, out for lunch, it's wonderful."

● We received mixed views from relatives. Some relatives were positive about the daily management of the service and felt improvements had been made since the registered manager had been in post. One relative said, "The staff have been absolutely fantastic [in supporting person through a difficult time], the [registered] manager was thoughtful, compassionate and really listened." They added they were, "blown away with how well the service worked with [person's name] during this difficult time." However, we received other feedback that expressed the service was not well led and their views were not listened to, or their concerns acted upon. We reviewed these concerns and liaised with external professionals to consider them. Some of the concerns they raised have already been identified in this report.

● External professionals told us they felt there had been improvements since the new [registered] manager had been in post. One said, "I think they [registered manager] have the right values and want to make positive changes."

● The registered manager told us that staffing levels for people had been consistent. People living at the service had complex needs and often required direct support from one or two staff members, in order to carry out activities of daily living, or access leisure activities. Although the service had been using a high proportion of agency staff, records showed that agency staff worked alongside the regular staff. The registered manager told us they had been aware of the additional risks of using agency staff during the coronavirus pandemic and had worked with the agency to ensure they had consistency. This meant that the temporary staff knew people well and had developed positive relationships with them, which we observed during our inspection visit.

● The environment was warm and welcoming. The registered manager showed us a quiet room, where sensory equipment had been purchased to provide an environment that met people's complex sensory needs. However, this was not fully developed and would benefit from further specialist equipment to meet people's individual sensory needs. The registered manager described how they were planning for the communal lounge to be re-decorated and this would involve people choosing colours, whist considering sensory needs. For example, they were aware of colour schemes that can be beneficial to people with Autism.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. The registered manager was building a strong, open and honest staff team that understood their responsibilities for accurate reporting of incidents and accidents.

● The registered manager understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and events that were required. The previous rating were displayed within the

entrance to the home and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines, which was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The provider failed to ensure the correct management of infection control risks, which was a breach of 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the service, which was a breach of Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.