Leonard Cheshire Disability

Mickley Hall - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Mickley Hall Nursing Home on 31May and the 5 June 2017.The inspection was unannounced on the first day. The service provided accommodation, nursing and personal care for up to 40 people living with a range of physical and mental disabilities. On the days of our inspection visits there were 34 people using the service.

Our last inspection took place in August 2015. We identified concerns relating to inadequate levels of safety. This was a breach of Regulation 12 (Safe Care and Treatment) Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was mainly in relation to how medicines were managed. We also identified areas of concern in how the service was managed. This was This was a breach of Regulation 17 (Good Governance) Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Following this inspection we asked the provider to send us an action plan detailing how they would address these issues. The provider complied and sent us their action plan telling us about the improvements they intended to make. During this inspection we looked at whether or not those improvements had been met. We found mostly improvements had been made regarding well led and the administration of medicines.

The service had been without a registered manager for over 18 months. However a manager had recently been appointed. We were assured they would apply to be registered with CQC at the earliest possible convenience. 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 found that while the service mostly met the breach of regulation 12, there were still issues with the administration of medicines. People with complex needs were left unattended in the dining area for long periods of time.

Some documentation relating to people was left unattended in an unsecure room which meant people's confidentiality could have been compromised.

People's dignity was not always promoted as some staff used the dining room as their own facility. This was also used by staff from another service. Some staff spoke over people's heads and other staff ignored people and did not use common courtesy to them. People received care from staff who were appropriately trained and confident to meet their individual needs. They were supported to access health, social and medical care, as required.

People's needs were assessed and their care plans provided staff with guidance about how they wanted their individual needs to be met. Care plans we looked at were centred on the individual and contained the necessary risk assessments and details of what was important to people. These were regularly reviewed and

amended to ensure they reflected people's changing support needs and wishes.

Policies and procedures were in place to help ensure people's safety. Staff told us they had completed training in safe working practices. Generally we saw staff supported people with patience, consideration and kindness and their privacy and dignity was respected. However we saw instances where people's dignity was not always supported. There were not enough facilities to offer people daily baths or showers.

People were protected from the risk of harm or abuse by thorough recruitment procedures. Appropriate pre-employment checks had been made to help protect people and ensure the suitability of staff who was employed.

Staff felt supported and there were systems in place to ensure this. The service had a system in place to review, care planning, care delivery, risk and ensuring people who lived at Mickley Hall were supported to pursue their hobbies and interests.

People were supported to fulfil their spiritual and religious needs.

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

Medicines were not always administered as prescribed and some people were left unattended for long periods of time. There was sufficient staff on duty to safely meet people's identified care and support needs, although they were not always effectively deployed to meet people's needs. People were protected by thorough recruitment practices, which helped ensure their safety. Staff were aware of how to recognise and report abuse.

Is the service effective?

Good

The service was effective

Staff were confident and competent in their roles. They had training in relation to the Mental Capacity Act (MCA) and most staff had an understanding of Deprivation of Liberty Safeguards (DoLS). The service maintained close links to a number of visiting professionals and people were able to access external health care services.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always supported. Some staff spoke over people's head while ignoring them. Staff used people's facilities for their own use. However most staff conducted direct interactions with people in a kind manner. There were not enough facilities to offer people a daily shower.

People and their relatives spoke positively about the kind, understanding and compassionate attitude of care staff. People were involved in making decisions about their care; they were asked about their choices and individual preferences and these were reflected in the personalised care and support they received.

Is the service responsive?

Good

The service was responsive

Staff had a good understanding of people's identified care and support needs. People were supported to pursue their hobbies and interests.

A complaints procedure was in place and people and their relatives felt confident any concerns or issues raised would be addressed. The service received many complements.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post.

The quality of service provided was monitored but audits relating to the running of the service were not always effective. The culture of the service was generally open and inclusive. Staff felt supported.

Mickley Hall - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

The inspection took place on 31 May and 6 June 2017 and was unannounced on the first day. On the 31 May the inspection visit was conducted by one inspector and a Specialist Advisor. On the 6 June 2017 the inspection team consisted of one inspection manager and one inspector.

We looked at other information we held about the service, including notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law.

We observed care practice and saw how people using the service were supported. We spoke with five people who used the service, five relatives, four members of staff, the regional manager, the acting manager and the newly appointed manager.

Not all of the people living at the service were able to fully express their views about their care. 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 looked at documentation, relating to people's care including three people's care and support plans, their health records, risk assessments and daily notes. We also looked at four staff files and records relating

to the management of the service. They included audits such as medicine administration and maintenance of the environment, staff rotas, training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At the last inspection carried out in August 2015 we found, people could not be assured that the systems in place would ensure they had their medicines administered as prescribed. This was a breach of Regulation12. An action plan received on the 25 November 2016 stated these issues would be resolved by 29 February 2016. This included, 'Our revised medication policy was reviewed and launched on 1 July 2015 and has been re- issued to all nurses' and ensuring there were monthly audits in place.

We found improvements in storage, recording and administration of medicines had been made at this inspection visit. Medicines were stored in a safe manner in a room that allowed staff space to work and prepare for medicine rounds. However, we found incidents of potential unsafe practice where the welfare of people was not always considered. For example, we found one person had been given their medication crushed (seven tablets) and added to a drink and given to them in one go. Records showed the person should have been offered their medicines before crushing them. If they refused to take them then it was considered in their best interest to have them administered covertly. The person was not offered the opportunity to knowingly take their medicines. Administration the medicines covertly should have been done by administering the medicines singly and not all at once.

The nurse administering medicines did not take care to ensure the person was not put at risk by doing this. Another example was when a different nurse had to be prompted to ensure a person had eaten before being given their medicines. We saw a further example of poor practice where a person was given two inhalers directly after each other; best practice would have allowed some time (at least 5 minutes) between each inhaler. This meant people were not always offered their medicines as prescribed, staff were unaware of the consequences of administering medicines in the manner described.

At the last inspection care had not been taken to ensure the medicine trolley contained the necessary medicines. There were delays while the staff member returned to the medicines room to get the correct medicines. This was highlighted at the last inspection and continued at this inspection. We saw this again on this inspection visit. One nurse had to leave the trolley locked but unattended while medicines were sought that were not on the trolley. Another nurse had a member of staff observing them and this member of staff had to get medicines from the medication room. This meant that unnecessary delays in getting medicines to people. We spoke to the management team about these issues and they resolved to address it as a matter of urgency.

All the people we spoke with said they felt safe. One person said, "Yes I do feel safe all the time." Another said, "It's a safe area as well as a safe home. I'm glad I live here." Relatives said, "We leave here knowing [relative] is very safe. Their safety is never an issue." Another said, "[Relative] has been here for years, safety has never been an issue." Another said, "I will voice my opinion if I'm not happy."

Most risk to people was recognised and managed in a manner that balanced choice and independence with risk. All the care plans we looked at gave detailed accounts of the risk posed to people and how to mitigate that risk. For example if a person was at risk of choking it was clearly assessed and control measures

detailed and put in place. If a person was at risk of falling out of bed there was a risk assessment for bed sides and crash mats. There was a system in place to review accidents and incidents. People, where appropriate, had an annual review of falls risk or sooner, if there was a problem. People who had a recurring pattern of falling were referred to health care professionals for guidance. We saw this advice was followed.

However while there were sufficient staff to keep people safe and to respond to calls for assistance. On the first day of our inspection visit there were eight people left unattended in the dining room. We did not see any immediate risk to people, however people living at Mickley Hall have complex needs and not all would be able to summon assistance should they have needed it. Therefore it was important to have staff supervision on hand to respond to people if they showed any signs of distress through facial expressions or coughing. Without a staff member in place people were left at risk.

One person had a fresh dressing on a wound. We got different answers from nursing and supporting staff on how and when this happened. This was a concern as the safety and welfare of people could be compromised if staff were unaware of a wound.

Staff knew how to keep people safe from abuse. They were trained in how to recognise abuse. All the staff we spoke with could identify the different types of abuse. They were aware of their duty of care to people and knew how to respond should they need to. Staff had access to relevant phone numbers to report their concerns should they need to.

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

We reviewed staff employment records and found checks had been undertaken before prospective staff worked at the service. Records showed pre-employment checks had been carried out. These included obtaining references, proof of identity and undertaking criminal record checks with the Disclosure and Barring Service (DBS). We also saw the provider had carried out checks on nursing staffs' annual registration and membership with the Nursing and Midwifery Council (NMC) to assure themselves nursing staff had retained their registration status. This meant people and their relatives could be confident staff had been screened as to their suitability to care for the people they supported.

Good

Is the service effective?

Our findings

Generally staff understood the requirements of the MCA and the importance of acting in people's best interests. Records we looked at showed mental capacity assessments had been completed and people's best interests had been established. However, we noted one area where guidance relating to the Act was not understood or followed. One person was established as not having capacity. However their records showed their wishes not to have a full capacity meeting was respected. This confused approached to establishing capacity showed a lack of understanding of the Act and could cause decisions to be made that were not in the person's best interest.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The manager and most of the staff we spoke with understood the circumstances which may require them to make an application to deprive a person of their liberty and were familiar with the processes involved. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. (DoLS). Appropriate applications had been made where these were required.

Staff said they felt confident and well supported in their role and received all necessary training. This was supported by training records we saw. The service cares for people who have complex needs and the staff training reflected this. Training included caring for people with various conditions such as Parkinsons, Dementia and Huntingtons. Staff we spoke with were able to tell us about people's conditions and how they managed them. People we spoke with said staff were good at caring for them; one person said, "Yes they know how to care for me." One relative said, "Yes, they seem to know exactly how to care for [relative]." A staff member said, "You have to know people well to understand what you can do for them. [Person's name] you need to allow [name] plenty of time to answer and then you can have a conversation." Another staff member was able to tell us what snacks people liked. This showed staff understood how people's conditions effected them and what was important to them.

Staff said they received supervision and there was a plan in place to ensure staff were offered supervision on a regular basis. Supervision included an observed practice session. Staff said they found this very useful. One staff member said, "It gives you confidence you are doing things right."

People's Individual care plans we looked at demonstrated that, whenever necessary, referrals had been made to appropriate health professionals. People said they could always see the GP if they needed to. One person told us, "I can always talk to someone if I am worried about my health." This was supported by a relative we spoke with who told us, "A doctor comes round regularly and I'm sure they will come at other times if needed, I've got no concerns about that." Health care professionals we spoke with confirmed this.

We were told the staff always followed directions given and they were called appropriately to attend to people.

Individual care plans we looked at contained records of all visits made by healthcare professionals. Staff confirmed that, should someone's health condition deteriorate, they would immediately inform the deputy manager or person in charge. As well as the GP's visits to the service, we saw, where appropriate, people were supported to attend health appointments outside the service. This meant people had access to healthcare professionals, as necessary and the service responded appropriately to any changes in people's individual health needs. We spoke with health care professionals who supported this. The service has a physio therapist and people, where appropriate, had regular access to this service. The service worked closely with a local hospice to offer optimum support to people at the end of their life.

We saw staff understood and supported people who required a specialist diet. Care plans we looked at showed where it was necessary, people had been referred to health care professionals such as Speech and Language Therapists (SALT) for support and guidance.

People's nutritional needs were assessed and identified whether they were at risk of poor nutrition and dehydration. Where a risk was identified, food and fluid charts were used to record and monitor how much people ate and drank. Drinks were regularly offered and served throughout the day.

Requires Improvement

Is the service caring?

Our findings

All people and relatives were very positive about the caring nature of staff. We were told, "Oh yes the girls are lovely." Another said, "All the staff from the top down are kind and lovely." One relative said, "Yes they are very caring." Another said, "You would have to travel a long way to find more caring staff."

Most people told us their dignity was promoted at all times. One person said, "Yes staff promote my dignity." Another, said "They [staff] care for me nicely, they always close the curtains and make sure I'm private before the start." A third person said, "They [staff] always go the extra mile."

Our findings did not always support this.as we mixed findings in relation to the promotion of people's dignity. Generally, we saw most staff were aware of issues surrounding people's dignity. However, we saw incidents where people's dignity was not promoted. For example staff ignored people and they spoke to each other over people's heads. Staff routinely entered the dining room without speaking to people, smiling or making eye contact with them. They focused on the task in hand and appeared unaware they were in people's home and the need to acknowledge this. For example we saw a staff member, who was engaged with someone, was interrupted in this interaction by another staff member who requested they assisted them shower a person. We saw this was done without the staff member excusing themselves or apologising to the person whose conversation they had interrupted. This showed staff were not always respectful to people and put the task they were completing before people's feelings.

We saw a person being moved in their wheelchair from the bathroom covered in towels while being taken to their room. Although they were fully covered, it was an unnecessary lapse in promoting dignity. This was discussed with the manager who provided reassurance that this was done in line with the person's wishes.

We saw some staff assisted people to eat without engaging with the person they were assisting. We saw a staff member pick up a fried egg with their bare hands and put it on a person's plate and then assisted them to eat it. This meant the staff member did not understand how to ensure people's dignity was promoted at all times.

The serving of lunch appeared haphazard and did not appear to put the needs of people before staff. For example some staff used people's dining room as their own facility. Staff gathered at a corner table in the dining room and ate their own meals. They did this without engaging with the people whose dining room it was. We saw staff eating their lunch, while some people had not yet been served their lunch. We saw a person joining staff at 'their' table and saw the person made efforts to make conversation staff responded to them but did not assist the engagement.

Other staff who did not work for the service used people's dining room as a personal facility and interrupted staff who were assisting people to eat lunch for almost three minutes while they spoke to a staff member. They never acknowledged the person whose meal they interrupted or apologised for the interruption.

People were not routinely offered a daily shower or bath. We were told this was mainly due to the lack of

facilities throughout the building. We were told this was being addressed in the next three months. One person said they found their independence curtailed by the way they were cared for. For example they needed their personal care delivered in a specific manner. They said staff did not do this and resulted in them been incapacitated throughout their personal care delivery. They said they found this difficult. We spoke to the acting manager about this and they said they were not aware of it and would investigate it further.

We did see some good engagement. We saw staff laugh and joke with people and saw there was a good relationship between some staff and people. We saw other staff interacted well with people who needed assistance to eat. We saw they asked the person what they wanted next on their fork and in some cases told the person what was on the fork. We saw they waited for the person to swallow their food and offered a drink appropriately.

One person showed us a garden bench the service had assisted them to put in to remember their mother. They said they were very proud of this and said it helped when they were sad and missing their mother.

Good

Is the service responsive?

Our findings

People and relatives were happy with the quality of the care people received. One person said, "Yes, I am very happy with the care." A second said, "I have a nice life here, I go out a lot and am always busy." A relative said, "[Relative] is well cared for, staff understand his condition, we are very happy with [relative's] care. Another said, "I can walk away knowing [relative] is in good hands. A third said, "We as a family are totally involved in [relative's] care planning."

All people living at Mickley Hall had an assessment of need prior to being admitted to the service. These needs were reviewed on a regular basis.

The service provider was clear they would only admit people whose needs and wishes they could meet. Care planning was ongoing and personalised. It was detailed and up to date. People we spoke with and their relatives were involved in care planning. We saw personalised care planning. For example, there was detailed information for staff on how to respond to people should their condition change; we saw where appropriate, this was done with the full involvement of relatives.

Assisted technology was used effectively to assist people to be more involved in their care planning and pursue independence and to have a more active social life. Health care professionals supported this and said the service was much better in this aspect of care than it had been and was improving all the time. In addition to this the service had an IT room where people were given access to the internet and other facilities to keep them connected to family and their friends. We saw this was in constant use and we were told it was very important to people. One person said, "I really like being in here and listening to music." This showed people had choice about how they lived and that staff facilitated their wishes.

People who lived at Mickley Hall had the opportunity to have an active social life. There was a team of volunteers to assist people in pursuing their hobbies and interests. For example one person wanted to visit a local radio station and staff assisted them to do this and also to pursue their favourite music artists including going to concerts.

Most people had the opportunity to go on holiday. Two had been planned for the year so far. One person said they were, "Really looking forward to it and I know what to expect, I was there before."

The provider ensured young people in particular had a good quality social life outside. For example they had the opportunity to pursue hobbies and interests such as going to music concerts.

Staff ensured people who had more complex needs and wished to stay in their rooms were comfortable and had access to their music or whatever they wished to do. This included being staff respecting the wish to be quiet and restful.

People's diverse needs were considered. We saw there was a Christian service conducted while we were

there. Staff understood and met the needs people who had other spiritual and religious needs such as Muslims. Staff understood how this impacted on the delivery of care and carried out people's wishes which meant staff understood what was important to people.

There was a breakfast club for people who were able to make their own breakfast with some assistance from staff. We were told this was very popular. We spoke with people who had used it to prepare their favourite breakfast, which included a chilli omelette. They said it was, "Great to be able to eat what they wanted".

Relatives told us they were encouraged to be part of their relative's life at the home. Visitors were welcomed and all the visitors we spoke with said they were made welcome at all times. They said "This is the best place; we looked at others and saw this was by far the best for [relative]."

There were regular meetings for people and relatives. We noted a poor attendance from people with only one person regularly attending. However, we did not see this as a problem as we saw people chatting easily with the acting manager and we were assured if there was a problem the management team were always on hand to respond.

The provider had a complaints system in place. We saw complaints were responded to in line with the providers' procedures; we saw there were no complaints outstanding. The service received many complements about the service they provide

Professionals who placed people in the service were very happy with the quality of care and the opportunities offered to people, whose complex needs were recognised and met. They went on to say they were informed of changes and said this was an improvement on the service over the past two years.

This approach to care ensured people had optimum care because the service worked closely with people, their relatives and representatives worked together to achieve this.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in August 2015 we found that the provider did not have a robust quality assurance process in place, this was a breach of Regulation 17 HSCA (RA) Regulations 2014 Good Governance, in so far as we found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided. The action plan received on 25 November 2015 stated they would be compliant with the breach by March 2016.

At this inspection we found the breach was mostly met. We found a number of people's private records kept in an unlocked room and had an open window. We were told that these were being sorted out before being stored appropriately. We were told that records had been stored inappropriately and this was the end of a piece of work that had taken since the last inspection in 2015 to complete. Despite being outside the date of the action plan, however we were assured by this given the extent of the problem raised at the last inspection.

The service does not have a registered manager. The previous manager left the service almost two years ago and had not been replaced until the week of the first inspection visit. We were told their registration would be commenced as a matter of urgency. We saw evidence the provider had made efforts to fill this vacancy but had not found a suitable manager until recently. There was an acting manager in post until this appointment. However the service remained without a registered manager. This means a rating of requires improvement is applied.

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.

There were systems in place to review records, care planning, delivery of care and to ensure people were safe. Part of this system was a monthly walk around by the acting manager where they looked at how the service was reviewed in relation to cleanliness and responsiveness of staff. However, the areas we had concerns about were not identified or addresses these included, not always ensured staff promoted people's dignity and respected boundaries in relation to staff using people's facilities. People did not always have their medicine as prescribed and ensuring all staff were aware of Deprivation of Liberty Safeguards. This meant that the quality assurance system was not always fit for purpose.

Incidents and accidents were reviewed. This review was used to establish what measures had been put in place to prevent, where possible, further incidents while still ensuring people had optimum independence.

The provider had systems in place to ensure care planning was inclusive. People and their relatives were included in care planning. This ensured people's needs and wishes were recognised and met. Care planning included ensuring people's hobbies and interests were identified and people had the opportunity to pursue them.

The deployment of staff did not always meet the needs of people. For example the service was broken down into five different areas. Each area had had two staff to assist approximately seven people to get up washed and dressed and prepared for the day ahead. Therefore care staff were engaged in personal care from the start of their shift to approximately 11.30. During this time there were no dedicated staff deployed to care for people, who all agreed had very complex needs, in the communal areas. There were sufficient staff but deployment was not always in the best interests or safety of people. For example two staff were deployed to the breakfast club to care for two or three people while up to eight people with complex needs were left unattended in the dining room. This meant, people's needs were not always met in a timely and effective manner.

Staff were trained to meet the complex needs and wishes of people. People and their relatives were involved in the care planning and delivery of the care of their relative. All relatives we spoke with were happy with the management of the service and how they were communicated with. One person said. "[Acting manager's name] was always on hand and always ready to listen." All of the people we spoke with were complementary about the acting manager and all commented on how the service had improved under their management. Two health care professionals said they were now confident that their directions in relation to people would be followed. They said this had improved hugely in the past two years.

The provider was aware of the need for people to have interesting and varied lives and we saw people living in the service had opportunities to pursue hobbies outside the service.

Staff felt supported and felt the service had improved under the management of the acting manager. This view was supported by people, health care professionals and relatives. One staff member said, "It's marvellous working here, I enjoy it." Another said, "It's been lovely here since [acting manager] has been here, [acting manager] has transformed the place into something extraordinary."