Surbiton Care Homes Limited

Milverton Nursing Home

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 25 April 2016. At our previous inspection on 18 November 2015 the service was meeting the regulations inspected.

Milverton nursing home provides accommodation, personal and nursing care for up to 30 older people, some of whom have dementia. At the time of our inspection 27 people were using the service.

The service had a registered manager in post. 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.

Some aspects of the service required improvement. We saw that processes for recording incidents were not sufficiently robust. The incident reports did not capture the action taken to support the person at the time of the incident, and the response to the incident. Therefore the provider could not demonstrate they were learning from these and taking action to protect people from similar incidents recurring. The complaints process did not capture all complaints, and there was a risk that these concerns would not be learnt from.

A range of activities were provided at the service and there were opportunities to access the local community to stimulate people using the service and protect them from social isolation. People's views were gathered about what activities they would like delivered at the service. However, there was little opportunity for people who preferred to spend time in their room or did not want to engage in group activities to have one to one activities, and there was a risk that these people may become socially isolated.

People received the support they required with their personal care and health needs. Each person had a care plan which detailed what support they required and how that support should be delivered. The care plans also referred to risk management plans and preventative measures in place to reduce the risks to people's health and safety.

Staff were knowledgeable about the people they supported. This included being aware of their preferences, their interests and their life experiences. Staff used this information to provide people with the support they required and to build meaningful relationships with people.

People were involved in decisions about their care and the support they received. They were able to choose how they spent their time and were involved in decisions about daily life. Staff were aware of who was able to make decisions and who did not have the capacity to make complex decisions about their care. Where people did not have the capacity to consent to their care, staff adhered to the Mental Capacity Act 2005 and 'best interests' decisions were made on people's behalf.

People received their medicines as prescribed and there were sufficient stocks of medicines at the service.

Staff supported people to access healthcare professionals and ensure their health needs were addressed. Staff were knowledgeable about people's dietary requirements and people who required support at mealtimes received it.

There were sufficient staff on duty to meet people's needs. We observed staff being attentive to people and responding to requests for support promptly. Staff received the training and supervision they required to have the knowledge and skills to meet people's needs. Staff received refresher training to ensure they stayed up to date with good practice. Staff worked with other healthcare professionals to further develop their skills, particularly in regards to end of life care.

There was visible leadership and management at the service. Staff, people and relatives felt comfortable speaking with the management team and felt able to express their views and opinions. There were processes in place to obtain people and relatives feedback. Systems were also in place to review the quality of service delivery, and where improvements were identified these were addressed promptly.

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

Some aspects of the service were not safe. Incidents were recorded, however, there was a lack of information about the action taken in response to incidents to demonstrate the provider was learning from these.

Staff were aware of the risks to people's safety and preventative measures were taken to protect people from harm. Staff were aware of their responsibilities to safeguard people and of the reporting procedures if they had concerns a person was being harmed.

People received their medicines as prescribed, and appropriate stocks of medicines were kept at the service. Some people required medicines to be given when required. There was a lack of paperwork to instruct staff when to give these medicines, and instead staff used their clinical judgement.

Is the service effective?

Good

The service was effective. Staff received the training and supervision they required to ensure they had the knowledge and skills to support people.

Staff were aware of and adhered to the principles of the Mental Capacity Act 2005. For people who required it, Deprivation of Liberty Safeguards were used to ensure their safety.

People received the support they required at mealtimes. They received a choice at mealtimes and staff were aware of people's dietary requirements.

Staff supported people to access healthcare professionals, and received the support they required to manage their health needs.

Is the service caring?

Good

The service was caring. Staff had built positive relationships with people. Staff were knowledgeable about people's interests and personal preference. They supported people to make choices and be involved in decisions about their daily support.

Staff were respectful of people's privacy and supported them to maintain their dignity.

Staff worked with the local hospice and palliative care team to support people with their end of life care. Staff discussed with people and their relatives their end of life wishes and developed advance care plans.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. The complaints process did not capture all complaints, and there was a risk that some complaints would not be learnt from.

People received the support they required with their care needs. Care plans were detailed and kept up to date.

There were a range of activities delivered at the service and opportunities for people to access the local community. However, there was little opportunity for people who preferred to spend time in their rooms to have one to one activities.

Is the service well-led?

Good

The service was well-led. There were opportunities for people, relatives and staff to feedback about the service and make suggestions to improve service delivery.

There were clear leadership and management structures in place. Staff, people, and relatives said the management team were approachable and they felt comfortable speaking with them if they had any concerns.

There were processes in place to review the quality of the service. If improvements were required these were identify and acted upon promptly.

Milverton Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 April 2016 and was unannounced. The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people, six relatives and seven staff, including the registered manager. We reviewed four people's care records, 11 staff records and records relating to the management of the service. We looked at medicines management processes. Throughout the day we undertook general observations and used the short observation framework for inspection (SOFI) at lunchtime in the main lounge. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People, and their relatives, told us people were safe at the service. One person said, "I feel safe and comfortable." A relative told us, "I am confident that my [family member] is safe especially now as she has a ceiling hoist – it's much better."

Records were kept of incidents that occurred at the service. Staff told us that in response to incidents people's care needs were reviewed and care plans were updated when required. However, the action taken in response to an incident to ensure a person's safety was not recorded in the incident record. The registered manager told us they had not undertaken a review of the incidents that occurred to identify any patterns in the type of incident or the time they occurred. There was therefore a risk that the provider was not learning from incidents to prevent similar incidents from reoccurring. The registered manager said they had previously analysed the incidents that occurred and after our inspection they confirmed that they have reintroduced this process.

Staff were aware of their responsibilities to safeguard people from avoidable harm. Staff had received training in safeguarding adults and were able to describe signs of possible abuse. Staff told us they would report any signs of possible abuse to their management team and they were aware of the recording processes they were required to complete. The management team would liaise with the local authority safeguarding team as appropriate if they had concerns about a person's safety.

The staff identified risks to people's safety. Plans were developed to manage these risks. This included identifying and reducing the risk of people falling, developing pressure ulcers and becoming dehydrated or malnourished. Preventative measures were put in place including regularly repositioning people and using pressure relieving equipment to reduce the risk of pressure sores. Ensuring those that needed it were supported with walking frames and hoists, and ensuring people had access to regular food and drink. Staff undertook assessments to establish if it was suitable to have bed rails in place to reduce the risk of people falling from their beds. Where these were identified as being required, staff followed appropriate consent procedures for this type of restraint.

We observed there were sufficient staff on duty to meet people's needs. We observed staff checking on people regularly and responding to call bells promptly. The majority of staff we spoke with felt there were sufficient staff to enable them to undertake their duties and support people. The service had recently completed a recruitment drive and filled the vacancies they had in their staff team. We saw from staff records that safe recruitment processes had been followed and staff had relevant experience and qualifications, including national vocational qualifications in health and social care. Checks were undertaken to ensure staff were suitable to work with people, including checking their identification, obtaining references from previous employers and completing criminal records checks.

People received their medicines as prescribed. One person said, "I don't want to know what I'm taking – they give them to me and I take them. I trust them." Staff confirmed that ordering and delivery of medicines worked well and they received medicines as required. We saw that processes were in place to check the

stocks of medicines at the service, and the stock we checked was as expected. All medicines administered were recorded on a medicines administration record (MAR). The MARs we checked were completed correctly. Some people had medicines prescribed to be taken when required (PRN).This included pain relief medicines. At the time of our inspection nursing staff told us protocols were not in place to inform staff as to when to give these medicines and at what dose. Nursing staff told us they provided people with these medicines based on clinical judgement. However they said they would look into developing PRN protocols and introduce pain assessments to provide greater clarity for when these medicines should be administered. After the inspection the registered manager confirmed that PRN protocols were in place and they had reintroduced use of the Abbey Scale tool to assess pain. Some people were receiving controlled drugs. These were stored securely, and appropriate records were kept of the controlled drugs administered. There were processes in place to dispose of medicines safely. Staff arranged for medicine reviews with people's GPs, and any other prescribing clinician involved in their care, to ensure their medicines and the dose of medicines were appropriate for their changing needs.

Processes were in place to ensure a safe environment was provided and that staff knew how to protect a person's safety in an emergency, for example in the event of a fire. Fire alarms were tested and fire evacuation drills were practised. Each person had a personal evacuation plan in place so staff knew what support each person required. Tests were also undertaken on water safety, including legionella checks. Legionella is a bacterium that can exist in water systems if these are not maintained properly and which can be dangerous to people's health. On the day of our inspection, there were problems with the water supply to the home. The home was experiencing low water pressure due to a burst water pipe in the community which meant some people had insufficient water supply in their rooms. However, there were sufficient numbers of bathrooms with water to meet people's personal care needs. The registered manager confirmed that they had organised for work to be undertaken the evening of the inspection and the water problems had been addressed.

Good

Is the service effective?

Our findings

People received support from staff that had the skills and knowledge to undertake their roles. People liked the staff and two people described them as "lovely". Staff completed training that the provider felt was mandatory to their role, and they received regular refresher courses to ensure their knowledge and skills stayed up to date with current good practice guidance. This included training on equalities and diversity, safeguarding adults, person centred care, communication, moving and handling, nutrition and hydration and infection control. Staff also received additional training relevant to their role including completing the care certificate for staff new to care, and completing national vocational qualifications in health and social care. The care certificate is a nationally recognised tool to provide staff with the basic knowledge and skills to undertake their roles within a care setting.

Staff received regular supervision from their managers. These sessions gave staff the opportunity to review their roles, where their strengths lay and any additional support they required. Staff told us they found the supervision sessions useful and it gave them the chance to raise any concerns they had. They felt supported by their supervisor to manage and deal with those concerns. We saw from supervision records that staff's training needs were discussed as part of the process and ensured staff completed their mandatory training. Staff also received annual appraisals to review their performance.

The Mental Capacity Act 2005 (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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff adhered to their MCA code of practice. Staff were aware of who had the capacity to make decisions and which decisions they were able to make. We saw that this information was also captured in people's care records. For those who did not have the capacity to make decisions or a person legally appointed to make decisions on their behalf, 'best interests' decisions about their care and treatment were made by staff or the relevant healthcare professional with the involvement of the person's relatives.. We saw from people's care records that some people had lasting power of attorneys in place to make decisions on their behalf, and we saw that these people were involved as required in the person's care.

The staff were aware of their responsibilities to safeguard people who did not have the capacity to do so themselves. The registered manager had applied to the local authority for authorisation to deprive people of their liberty where they felt this was appropriate to maintain a person's safety. We saw that records were

kept of the authorisations in place and the registered manager had recorded when these were due to be reviewed.

We observed people enjoying their meals and the majority of people ate all the food provided. We heard from the chef and we observed that there were options provided at lunchtime for people to choose from. The chef told us they were in the process of reviewing the menu, with input from people and their relatives, to offer additional choices to people.

We observed that people who required support from staff at mealtimes received this. Staff supported people in a polite and patient manner. Staff were aware of people's nutritional needs and meals were provided in line with these, including provided those at risk of choking with soft diets. The chef was aware of people's dietary requirements and provided people that required it with high calorie meals. Where people were able to, staff enabled people to eat independently including providing them with adapted and appropriate cutlery and utensils.

Staff supported people to manage their health needs. Staff liaised with healthcare professionals as appropriate to ensure people's health was maintained. Each person was registered with a GP and staff organised for their GP to visit them if they were feeling unwell. Staff also organised for people to see a dentist, optician and chiropodist. One person said, "I've seen the optician and I like my new glasses." If people needed support from healthcare specialists, staff organised this for them. One person told us, "If I have a hospital appointment the staff arrange the transport and come with me." This included liaising with tissue viability nurses, speech and language therapists, physiotherapists and dieticians. We saw from people's care records that staff supported people in line with advice provided by these professionals to ensure people received the help their required.

Good

Is the service caring?

Our findings

People were supported by staff who knew them. One relative said, "[The staff] took time to listen and learn about our [family member] and were not just interested in their condition." They also told us they found staff to be "professional, discreet and engaged with [people]." A person told us they had built a good relationship with the staff. They said to us, "I feel that staff communicate with both of us [husband and wife]. They were wonderful in helping us celebrate our 50th wedding anniversary."

During our SOFI at lunchtime and throughout the day we observed that staff were attentive to people's needs. Staff regularly checked on people if they started coughing whilst having their food and offered to help people to cut up their food. Staff were polite to people and available to assist people as they needed.

Staff made sure people were comfortable. This included ensuring people were kept warm. We observed staff getting people additional clothes if they were cold, and people were provided with blankets if they wanted to sit outside.

The staff we spoke with were able to tell us about the people they were supporting. They were aware of people's life experiences, their interests and their hobbies. Staff told us this information enabled them to have meaningful conversations with people about topics they were interested in, and to speak with them about people's families and experiences. People's preferences were also identified in regards to the gender of the staff that supported them with their personal care. People were only supported by staff of the opposite gender with their prior agreement.

Staff involved people in decisions about their care and how they spent their time. We observed staff asking people what they wanted to do and actively engaging them in activities of their choice. Staff told us they involved people in day to day decisions for example, in regards to daily routines, what they wanted to wear and how they spent their time. We saw people's care records included information about what choices people were and were not able to make. They also included information about how to support people that were not able to verbalise their choices. For people who were unable to verbally express their choice, staff were aware of how people communicated their wishes.

Staff were respectful of people's privacy and dignity. Staff knocked before entering people's bedrooms and supported them with their personal care in the privacy of their room. Staff were conscious not to discuss people's care and support needs in communal areas, and relatives confirmed that discussions about their family member occurred in a private room where the conversation could not be overheard. We identified that some personal information about people's support needs was included on an information board which could be seen by visitors. We brought this to the attention of the registered manager and they moved the information straight away so it was kept confidential.

People were supported to have visitors and we saw many family members visiting on the day of our inspection. Staff told us many people had regular visitors and people were supported to maintain their relationships with friends and family. The service had restricted visiting times, particularly at mealtimes and

late in the evenings. We heard that some relatives were unhappy about this arrangement. We spoke with the registered manager about this and they made some exceptions to visiting times for example if a person was receiving palliative support. However, they felt having no visitors in the communal lounge at mealtimes was appropriate to ensure people received the support they required at mealtimes.

Since our previous inspection the staff had built links with the local hospice to further improve their practice in regards to providing end of life care. Some of the staff had spent days at the hospice to learn more about end of life care and receive in depth training. These staff were also completing diplomas in end of life care. The staff from the hospice had supporting staff to work with people and their families to develop advance care plans, outlining what support they wished to receive with their end of life care and to identify their preferences in regards to where they received care. For people who were receiving end of life care, staff worked with the hospice and the community palliative care team to ensure the care provided met the person's needs. The registered manager told us they were liaising with the local hospice to begin to prepare for the Gold Standards Framework (GSF) accreditation. GSF is a framework for improving the quality and coordination of end of life care.

Requires Improvement

Is the service responsive?

Our findings

There were opportunities for people, and relatives, to feedback about the service. The complaints process was displayed in the hallway. People and their relatives told us they felt able to speak with the staff if they had any concerns or wanted to make a complaint. The complaints records we saw showed that complaints had been acknowledged, investigated and responded to. However, one relative told us they had previously made a complaint but we did not see records relating to this. We spoke with the senior nurse on duty about this as the registered manager was not available. They said usually verbal complaints were listened to and responded to straight away, but there was not a process in place to record and learn from these concerns. They said they would discuss with the registered manager how these concerns could be captured so that any trends could be identified. After our inspection the registered manager provided information which showed discussions were held with relatives in response to their complaints and these were discussed amongst the senior staff team during the service's governance meetings. However, due to the concerns not being captured through the complaints process there was a risk that this information may be missed when reviewing topics and themes of complaints received, and therefore may not be learnt from when reviewing service improvement.

In the communal lounge we observed people engaging in activities. There were a range of activities delivered at the service and opportunities for people to access the community. The activity programme was developed with input from people and their relatives. One person told us, "I go on lots of outings – the pub, community film shows, gardens – I love them all." Another person said, "I suggested a place to visit & the outing was arranged – I'm listened to."

Whilst there was a programme of group activities and trips in the community, staff told us and we observed there was little opportunities for people to have one to one activities. This meant there was a risk that people who preferred to spend time in their room could feel socially isolated. Care staff told us they engaged people in short conversations when they were supporting them in their rooms but there was little opportunity to engage them in meaningful activity because they did not have the time to do so. We spoke to the senior nurse about this and they said they would liaise with the registered manager to review opportunities for one to one activities.

People told us the staff supported them with their personal care, and provided them with any help they required. Staff assessed people's needs to identify what support they required and what they were able to do independently. We saw that information was also gathered from people and their relatives about what was important to people, their life experiences, daily routines, communication and social preferences. This information was used to develop individually tailored care plans. The care plans we viewed were detailed and gave staff clear instructions about how to support people. Care plans were updated monthly or more frequently if people's care needs changed.

The care staff we spoke with told us the healthcare assistants were allocated to a team each day and this enabled them to be clear about their roles and responsibilities for the shift, and to identify who they were supporting that day. They said this enabled them to provide a personalised service as they were able to give

people the support, time and attention they required and undertake any monitoring activity people required, for example, in relation to repositioning charts, food and fluid intake and bowel movement monitoring. The daily monitoring charts we saw were completed in line with instructions in people's care plans.

The staff we spoke with were knowledgeable about the people they supported, particularly in regards to the people they were a key worker for. A key worker is a dedicated member of staff to lead on the care provided to the person and ensure they received the support they required. Staff were aware of what people were able to do for themselves and staff told us they encouraged people to maintain their independence.

Staff said that they had regular handover meetings at the beginning and end of each shift so that all staff were made aware of any changes in people's needs. Staff confirmed that handover arrangements enabled them to have updated information and they felt there was good communication within the team about people's needs.

Good

Is the service well-led?

Our findings

People received a service from a staff team that were supported and managed. People, and their relatives, were aware of who the registered manager was and told us they found them to be approachable.

People and their relatives told us they felt involved in the service and felt able to express their views and opinions. We heard from people and their relatives that their suggestions for improvements to the service had been listened to and acted upon. This included some suggestions they made about activities, and improving the lighting in the lounge to make it feel more homely. Meetings were held with people and their relatives, and satisfaction surveys were also completed, to obtain their feedback about the service. In addition a 'friends of Milverton' group was set up where relatives of people who currently were and previously had used the service were able to get together. This group provided support to the relatives and also gave another opportunity to gather the views and opinions of relatives. The feedback from all meetings fed into the staff meetings so that the concerns and suggestions made were heard by the staff team and acted upon.

There was clear leadership and management at the service. The majority of staff told us they felt comfortable approaching the lead nurse, the registered manager and the director to discuss concerns they might have. They said they were well supported by their managers and felt able to speak with them if they needed any support. Staff also said that the registered manager made herself available and regularly checked whether the staff needed any additional support or wanted to talk.

Staff told us there was good teamwork at the service. They said communication was good amongst the team and that colleagues worked together to provide people with the support they required. Staff said there were regular team meetings and these provided staff with the opportunity to raise any concerns, and to discuss as a team how they should support people. The meetings gave them the opportunity to voice their opinions and worked as a team to problem solve. However, we also heard from staff that the timings of staff shift patterns meant there was not dedicated time to undertake handover, and at times staff had to stay late to sufficiently hand over information. Staff felt their concerns regarding this arrangement were sufficiently listened and responded to.

Systems had been established and were used to review the quality of service delivery. This included auditing the quality of care plans and medicines management processes. We saw the records from the recent audits and saw that when improvements were required these were actioned promptly. Checks were also undertaken on wound care. This ensured that wound care was provided in line with the person's care plan and advice from the healthcare specialist involved in their treatment.

The registered manager and management team reviewed the equipment at the service to ensure it was in working order and appropriate for the people using them. This included auditing the pressure relieving equipment and checking air mattresses and cushions were at the correct setting for the person using it.

The registered manager was aware of their legal responsibilities in regards to their registration with the Care

Quality Commission. They adhered to these requirements and submitted statutory notifications of significant events that occurred at the service.