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Millbrook House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 & 17May 2017 and was unannounced.

Millbrook House is a nursing home which provides care for older people with mental health care needs. It can provide care for up to 42 people and it is located in Southport.

A registered manager was 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.

We found the environment was in need to attention which made it difficult to keep hygienic to maintain standards of infection control. This was particularly evident for the toilet facilities on the ground floor which were not clean.

This is a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The provider had systems and process in place to monitor and drive forward improvements. This included a number of audits (checks) for various aspects of the service. We found on this inspection that the existing auditing system was not robust as this had not picked up on the deficits we identified around monitoring standards of infection control and other developmental issues we discussed on the inspection.

This is a breach of Regulation 17 (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

With regards to promoting a dementia friendly environment there were some appropriate wall coverings, themed décor and pictures in corridors and doors were painted in different colours to aid orientation. Some toilets and bathrooms had signage but this was not consistent in the home. There was a need for some further development to enhance the environment, particularly on the ground floor to improve accessibility, safety and orientation. We found toilet doors were locked during the inspection which meant they were not accessible for people. This was rectified during the inspection.

We have made a recommendation around the provider considering current guidance and best practice around promoting a dementia friendly environment to support people living with dementia.

The home had a consistent staff team though the numbers of staff on duty during the first day of the inspection were not in accordance with the staffing rota due to staff sickness. Staff rotas we viewed showed that in general staffing levels were consistent and staff were deployed in sufficient numbers to support people.

People were offered a varied social programme, based on individual preference. We saw social activities were meaningful and well planned at different times of the day. People told us they enjoyed what was arranged, particularly the music and cookery sessions.

External contracts were in place and internal health and safety checks and audits were completed to help maintain the safety of the building and its equipment.

Care files held thorough risk assessments to mitigate hazards to people's safety and welfare.

People had a plan of care which set out their health and social care needs. Plans of care contained person centred information, which helped to provide a holistic approach to care.

We observed staff treated people appropriately, supportively and with an understanding of their needs. We saw people were relaxed in the presence of the staff.

Recruitment procedures were robust and the required checks had been completed. Thus ensuring staff were 'fit' to work with vulnerable people.

Medicines were administered safely to people and the registered manager completed medicine audits to ensure the safe management of medicines.

Staff were aware of what constituted abuse and told us the procedure they would follow should they need to report an untoward incident. Training records confirmed staff had undertaken safeguarding training.

We saw staff were responsive to each person's changing needs and care reviews took place. Staff supported people with external appointments with different health professionals at the appropriate time.

Staff received training and support and had a good understanding of how to support people with dementia.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed and an assessment of the person's mental capacity was made.

When necessary, referrals had been made to support people on a Deprivation of Liberty (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the registered manager of the home.

The provision of meals at the home was via an external supplier. Snacks and foods such as, sandwiches, cakes and biscuits were prepared at the home; breakfasts were also prepared on site. People told us they enjoyed the meals.

Relatives told us they felt supported and encouraged to maintain relationships with those who lived at Millbrook House.

A complaints' procedure was in place and people and their relatives felt confident in raising concerns with the registered manager.

Staff and people said the home was well managed and the registered manager was supportive,

approachable and led a motivated staff team.

The registered manager had a good understanding of their role and responsibilities in relation to what was expected from them as a registered manager with us, the Care Quality Commission (CQC). The registered manager had notified us any notifiable incidents in the home.

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.

We found the environment was in need to attention which made it difficult to keep hygienic and maintain standards of infection control

The home had a consistent staff team to support people in the home.

People told us that they felt safe living at the home.

Suitable systems and processes were in place to ensure the premises and equipment were maintained and safe to use.

People were protected against the risks associated with medicines because arrangements to manage medicines were consistently followed.

People's care needs had been risk assessed and control measures were in place to help keep people safe.

Staff had been checked when they were recruited to make they were suitable to work with vulnerable adults.

Staff we spoke with were knew how to recognise and respond to abuse correctly.

Is the service effective?

Requires Improvement

The service was not always effective

We have made a recommendation around the provider considering current guidance and best practice around promoting a dementia friendly environment to support people living with dementia.

Consent was gained from people in accordance with the Mental Capacity Act (2005).

Applications to deprive people of their liberty had been made appropriately.

People were served meals that were nutritionally balanced taking into account choice and preference.

People said staff had the right skills to support them.

Staff were regularly supervised and trained in a range of relevant subjects to support people safely.

People's health was monitored by the staff and health care professionals. Referrals were made at the appropriate time.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received. They said the staff were polite and caring.

We observed people's dignity and privacy being respected by staff during the inspection and interactions were warm and genuine.

People and relative told us they were involved with their care.

Is the service responsive?

Good

The service was responsive.

People joined in with a varied social activity programme. This was arranged appropriately and in accordance with what people wanted.

People knew how to raise any concerns. Complaints were recorded and acted on in accordance with the home's complaints' procedure.

Care plans contained a significant level of person-centred detail. This helped staff to get to know them well

Systems were in place to gather people's and relatives' views regarding the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems and processes were in place to monitor the service. We found on this inspection that the existing auditing system was not robust as this had not picked up on the deficits we identified

around monitoring standards of infection control.

The service had a manager who was registered with the (CQC) Care Quality Commission.

The registered manager was long standing and provided efficient and effective leadership of the home.

People, relative and staff spoke positively regarding the overall management of the home.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home and the rating from the last inspection was displayed within the home for people to view.

Millbrook House

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 16 & 17 May 2017 and was unannounced. The inspection team included two adult social care inspectors 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with four people living at the home and three relatives. We also spoke with the provider, regional manager, registered manager, three nurses, chef, housekeeper, activities organiser, maintenance person and three members of the care team. 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 the care files of seven people receiving support from the service, two staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

We looked at the standard of infection control in the home. On the first day of the inspection we noted a strong malodour on entering the reception area and also a malodour in the beach room (used for relaxation and social activities). We found inappropriate furnishings in the beach room which would have made it difficult to keep clean. When looking round the home we also found a very strong malodour in a bedroom. The malodour in these areas was brought to the registered manager's attention during the inspection.

We found the environment was in need to attention to the standard of décor in some areas which made it difficult to keep clean and hygienic to maintain standards of infection control. This was particularly evident for the toilet facilities on the ground floor. Paint/wallpaper was flaking, there was poor plaster work with exposed filler around a pipe, sinks and floors were stained, one radiator appeared rusty and there was no toilet roll holder in one toilet.

The toilets on the ground floor had liquid soap dispensers and paper towel dispensers which were mounted on the walls to reduce the risk of accidental contamination. These however were empty. There were no soap and paper hand towels in two toilets on the ground floor. Hand help soap dispensers and paper towels were available in some bathrooms and other toilets though we saw paper towels were stacked on a radiator or window sill, for example; these were difficult for people to reach and did not promote good standards of infection control. A waste bin in one toilet did not have a lid.

Cleaning rotas/schedules were current and signed off on completion each day though these did not make reference to the standard of environment in these areas and the difficulty keeping them clean.The registered manager informed us the service had not as yet been formally audited by senior managers around infection control and the environment using the organisation's audit tool. There was also no appointed lead in the home for infection control.

This is a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

At the time of the inspection the registered manager took swift action to remedy the malodours. On the second day of the inspection there was no odour noted on entering the home.

Following the inspection the registered manager informed us that work had commenced to improve the standard of the beach room (which was being turned into a family/meeting room) and the toilet facilities; old sinks and toilets removed. New soap dispensers and paper towel dispensers were ordered during the inspection and fitted the following day.

We asked people and their relatives if they felt safe. People and relatives said did feel safe and free from bullying or harassment. People living in the home said they knew who to speak to if they did not feel safe and they felt confident about doing so. With regards to staffing arrangements people and relatives told us the staff numbers were adequate, with one person reporting, "There are lots of staff around, you see them."

We looked at the arrangements in place for making sure the environment was safe. On arrival at the home people could only enter the home by pressing a door bell as the reception door was kept locked. Key pads were in operation for various parts of the home and corridors and communal areas (lounges and dining room and corridors) were kept free from trip hazards. Visitors to the home were asked to sign in and were provided with an identification badge. These measures help to ensure people's safety.

A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire.

External contracts were in place to ensure services such as, gas, electric, water and lifting equipment were safely maintained. We viewed the certificates for these checks and they were in date. A variety of internal checks were also completed, such as portable appliance testing and hot water temperatures.

Care files held thorough risk assessments to mitigate hazards to people's safety and welfare. This included a risk assessment for the use of bed rails, for falls and for nutritional needs. Control measures were in place to minimise the risk of malnutrition. These assessments had been reviewed regularly to ensure any change in people's needs was identified to help staff support people safely. People and their relatives told us they attended meetings around how risks were managed and they felt involved in these decisions.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at the recruitment records for two newly recruited staff and asked the registered manager for evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and an additional check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We saw appropriate checks had been made. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We looked at how the home was staffed and how staff were deployed to ensure people's safety. We saw that staff were positioned at various points throughout the home to support and monitor people to promote their welfare and safety. Staff were vigilant in their approach providing appropriate level of assistance to people in accordance with individual need. Staff told us, because of people's health conditions, some people may have periods of aggression and therefore people needed to be closely observed. The practice of stationing staff at key points allowed people to move around the building freely while staff supported people and monitored their behaviours and interactions. It was evident staff knew people well and were familiar with people's needs and how best to communicate. A staff member told us, "I know the residents and am aware of how to help them, everyone is different and it is important to remember that." Another staff member said, "There are regular staff – not an issue."

During the inspection the registered manager was on duty with two nurses, seven carers, a chef, kitchen assistant, laundry assistant, activities organiser, two domestic staff, housekeeper and maintenance person. There should have been eight care staff however this number had dropped due to sickness. On the late shift to support people over the tea time period the home usually had nine care staff. This was to offer more support to people at tea time when people's levels of confusion could increase. Again due to unforeseen circumstances this number dropped by one; the registered manager arranged for staff support from an agency. On the second day of the inspection the numbers were in accordance with the staffing rota. At night the home was staffed by one nurse and four carers. Staff rotas we viewed showed that these levels were generally consistent and staff were deployed in sufficient numbers to support people.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock checks and other records for people living in the home. The home had recently had a change of pharmacy provider and staff were receiving medicines training to support the change of MARs. The registered manager told us the pharmacy provider offered more formal qualifications in medicine management and this was going to be accessed by the nursing staff. The training given helped to ensure staff had the skills and knowledge to administer medicines safely. Staff told us they felt confident in using the new MARs.

Medicines were stored in locked trolleys which were kept in a locked clinical room. The temperature of the room and the medicine fridge were monitored and recorded daily and we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Controlled medicines were stored in a separate locked room in a locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

MAR charts we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. We saw staff administering medicines from the medicine trolleys in the clinical room as they felt this was a safer option than from taking the medicine trolleys to the communal areas. Staff had signed the MAR charts to say they had administered the medicines. This helped to ensure medicines were given safely as prescribed. People told us they received their medicines on time.

Quantities of medicines received into the home must be checked to provide an accurate stock check. We found quantities of medicines received had been checked and recorded. We checked the stock balance of a number of medicines (including a controlled medicine) and they were accurate.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. Guidance regarding administration of people's medicines recorded within people's care plans; this included the administration of PRN medicines.

The staff were aware of how to record the use of 'thickening' powder to thicken people's drinks although no one was prescribed them at the time of the inspection. 'Thickening' powders are used for people who may have swallowing difficulties to accept fluids and reduce the risk of choking.

For people who needed topical preparations such as creams, these were recorded when applied. A body map was in place to show the areas of the body where the cream was to be applied. Nutritional supplements were given as prescribed in accordance with people's nutritional requirements.

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were aware how to raise concerns and were familiar with the safeguarding process in relation to their role. A staff member said, "I would speak up and say something, I know about the reporting of incidents. Everything is always reported."

Staff had access to policies and supporting documentation on the appropriate actions to take in the event of any safeguarding concerns being raised. Details of the local safeguarding team and other information in relation to protecting people and their rights was displayed. Incidents that had been deemed as safeguarding were recorded along with any actions taken to improve practice.

We found that accidents were recorded and appropriate actions were taken to ensure people's health and

safety. Accidents and incidents were analysed as part of the audit system so that any emerging themes were identified and acted on.

Requires Improvement

Is the service effective?

Our findings

With regards to promoting a dementia friendly environment there were some appropriate wall coverings, themed décor and pictures in corridors and doors were painted in different colours (but no names) to aid orientation. Some toilets and bathrooms had signage but this was not consistent in the home. There was a need for some further development to enhance the environment, particularly on the ground floor to improve accessibility, safety and orientation. For example, clear signs at eye level and prominent colour contrast to add clarity to the environment.

On the first day of the inspection the toilets on the ground floor were locked which meant they were not accessible for people. This did not promote people's rights to independence and privacy which is of particular concern for people who have dementia and may be unable to express themselves should they be unable to freely use this facility. We discussed this with the staff who informed us that usually the toilet doors were kept unlocked and only locked when the floors were cleaned. We raised this with the registered manager who made sure the doors were unlocked. On the second day of the inspection we found one toilet door locked; others were unlocked.

We recommend the provider considers current guidance and best practice around promoting a dementia friendly environment to support people living with dementia.

People and relatives told us the staff provided good care and support and were well trained in caring for people with dementia. Relatives reported, "Vast improvement in my (family member's) behaviour since (family member) arrived two years ago" and "Staff are very vigilant, they are very responsive in difficult situations." People said if they wanted to speak with a member of staff or needed help the staff were always available and they had the assistance needed. When talking about care a person told us how the staff had helped them with their diet to lose weight and as a result they were more 'mobile' and 'active'.

Our observations showed staff were attentive to people's needs. This included making sure people were given regular drinks and offering assistance with different aspects of personal care. For example, support with walking and washing and dressing. We saw a person being assisted from a day chair into a wheel chair. This transfer was performed safely by the staff with the use of a hoist.

For people who became agitated staff were reassuring and supported the person appropriately. Staff spent time with people on a 'one to one' basis but also were aware of the need to provide 'space' and 'quiet' time in accordance with people's assessed need. A staff member said, "Our residents need time to themselves and we can tell when they need this."

During our inspection we reviewed the care of seven people living at the home. When we looked at people's care notes we saw references to referrals and support for people from a range of health care professionals. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. Care staff told us they understood the importance of reporting any changes with people's health to the nursing staff who would ensure any necessary referrals were made. We spoke with a nurse on duty who

told us care staff were vigilant and liaised well if they observed any health issues.

One person we reviewed had experienced changing care needs because of on-going health issues. We saw they had been referred to a variety of health care professionals including the person's GP who had visited to review on regular occasions. Another person had recently been seen by the GP because they required a medical review after some weight loss. We saw there had been a referral to the dietician and a care plan was in place to support the person. We saw there had been an increase in the person's weight as a result. Good records and a supporting care plan helped ensure good support and monitoring. We also saw input from the falls team, speech and language therapy team, chiropody service and community mental health practioners. This close working with external health professionals helped to ensure effective outcomes for people in respect of their health.

Due to living with dementia, people were not able to give us any in-depth discussion regarding how they felt about staff and whether they were competent and had the skills to carry out care. We made some observations using the SOFI tool in the main day room for 40 minutes and also made other general observations. We saw staff interacting appropriately with people who seemed relaxed in staff presence. One staff member took time to connect with a person who was observed to be withdrawn by reading a book with them to a positive effect. This showed staff had an understanding of the importance of, and skills to communicate effectively.

We were told the provider had set up an academy with training managers to oversee the training requirements for staff employed at the Dovehaven homes. The Dovehaven academy set out short term and long term objectives for the staff in respect of assessing staff's training needs for subjects they consider mandatory and staff were enrolled on formal qualifications in care. The academy supporting Dovehaven Nursing Home consisted of a manager with three assessors for QCF [Qualifications and Credit Framework) and eight hours of administration support. The academy linked in with an external training company to complete overall management of training needs for the provider.

We looked at the induction process for new staff employed at the home. The registered manager explained the induction process which included a standard checklist of information carried out over the first few days of employment, a handbook for new staff, some shadowing of experienced staff and attendance at mandatory training such as moving and handling, safeguarding of vulnerable adults, fire safety and general health and safety. Staff we spoke with confirmed these arrangements for induction.

We asked about how the induction met the standards of the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. The standards cover areas such as, infection prevention and control, safeguarding adults, working in a person centred way and duty of care. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting employment.

The registered manager was able to tell us about how the Care Certificate had been introduced and which staff were currently completing this at the home. Work had recently been completed to commence a three day classroom based induction which covered [mapped over to] the standards in the Care Certificate. Any standards not covered in the three day programme would be covered outside of this with workbooks and further training over 12-15 weeks, including the Dovehaven group existing standard induction. We saw staff training files for staff currently undertaking the Care Certificate.

We discussed with the registered manager other formal qualifications in care which staff had achieved or were enrolled on. We saw that staff were undertaking accredited qualification made up of units such as, NVQ

(National Vocational Qualification) or Diploma under the QCF (Qualifications and Credit Framework). With regards to formal qualifications in care the manager told us eight out of 15 out of 22 care staff had obtained a NVQ in care (68%). This was confirmed by records we saw.

The training matrix sent to us following the inspection evidenced a series of on-going updates and training to support staff. Staff received supervision and appraisal and attended meetings. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff we spoke with said they were informed about matters that affected the service and that they received a good standard of mandatory and dementia training.

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). 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 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).

Staff had applied for a number of people to be supported on a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were being monitored by the registered manager of the home. At the time of the inspection 20 people had been assessed by the Local Authority and were on a standard authorisation to deprive them of their liberty. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this. We also saw examples of authorisations in people's care files.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. In one example a person had bed rails in place to help ensure their safety but who lacked capacity to consent to these. We saw there had been an assessment made of the persons use of bedrails which included reference to the persons mental capacity regarding this decision and care had been taken to include any relatives in the decision making process. The staff had made a 'best interest' decision following this process for the bedrails to be placed. Although there were notes showing how the person lacked capacity in this instance the assessment would have been enhanced and made clearer if the two stage mental capacity assessment tool had been used also. We discussed with the registered manager and area manager how this assessment tool, although evidenced in some decisions, could be used in more situations to aid the assessment and best interest process.

Similarly staff showed us how a person had been assessed on 'covert' administration for medicines (medicines given without the persons consent or knowledge in their 'best interest'). Again reference was made to capacity issues but this would have been clearer using the standard assessment tool. Following the inspection the registered manager informed us that the two stage mental capacity was being completed for people.

Other examples included care files which showed where people had consented to their plan of care. We saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates (family members).

The provision of meals at the home was via an external supplier. The meals were frozen, heated and plated before serving. Snacks and foods such as sandwiches, cakes and biscuits, and breakfasts were prepared at

the home. People were offered a good choice at breakfast which included a full English breakfast.

For people who required pureed meals because of swallowing difficulties the external supplier served the meals in recognisable shapes to retain shape and colour. This helped ensure the meals looked appetising and to support people living with dementia to more easily recognise the foods they were eating.

We joined people for lunch and found there were menus of the day placed on each dining table to show what options were available. This added to the ambience of the dining area and people's eating experiences. Staff told us how they helped people to choose the meal they wanted and that they could choose an alternative if they did not like the prepared meals. People could choose where they wished to have their meals and adapted cutlery and crockery was available to support people as needed.

We spoke with the chef who was aware of people's dietary needs and requirements and known food allergies. This information was recorded in the kitchen and in people's care files. There was a choice of hot meals served at lunch and at tea time with plenty of hot and cold drinks and snacks at various other times.

We saw staff offering people lots of drinks, encouraging and support with their meals. This support was given at a pace to suit the individual. We saw relatives visiting over lunch and they were able to assist their family member with their meal if so they so wished. One person we spoke with told us they did not like the food but others were complementary and everyone appeared to eat well and enjoy their meal at lunch and tea time. There was plenty of fresh fruit and this was served to people as a healthy option.

Good

Is the service caring?

Our findings

People we spoke with told us the staff spoke with them in a friendly and polite manner. A person told us, The staff are always polite, not an issue." Relatives informed us that staff listened and treated their family member with kindness and compassion and were respectful during their visits. A relative informed us that the home had been very caring especially if they had any worries. With regards to care a relative said, "They (staff) are certainly on the ball.

We found the staff very welcoming to everyone. We spent time observing care at the home and saw staff treated people patiently and with both respect and courtesy. We did however note that during the first day of the inspection a number of people (female residents) appeared a little unkempt, for example, in need of their hair brushing. We also noted that at least eight people were not wearing footwear. We were informed by the staff that 'they kick them off' or 'they don't wear them'. We did not see any attempt by the staff to encourage the use of appropriate foot wear. We raised this with the registered manager who said they would discuss this with the staff. On the second day of the inspection more people were wearing footwear and there was 'better' attention to personal care. For one person we asked that their reading glasses be cleaned as they were dirty. This was brought to the registered manager's attention and acted on.

People were sat in the lounge, dining room, conservatory and film room at different times of the day and staff checked to make sure they were happy and comfortable where they were sitting. Staff used appropriate humour and there was plenty of engagement, chatter and laughter, particularly around the music session.

Staff displayed a calm and reassuring manner especially when faced with a behaviour that might be challenging and would need more specific intervention and support to assure people's welfare and that of others. If people became vocal and agitated it was evident that staff knew people well and their approach and understanding of people's needs helped to de-escalate any potential situation. For a person who constantly required reassurance the staff sat next to them and displayed genuine concern and interest in what the person was saying. They did everything they could to reassure them and offered them a cup of tea.

The staff we spoke with were able to tell us about the care and support they gave to people and how they were kept up to date of people's care and treatment at staff handovers and various other meetings. Our observations showed staff had built up positive and meaningful relationships with people living in the home and their relatives. A staff member told us how much they enjoyed working with people with dementia. They went on to tell us how people were encouraged to be independent and we saw how this was recorded in people's plan of care.

In respect of promoting standards of privacy staff knocked on people's doors before entering their bedroom and used the preferred term of address. For people who had left food on their plate over lunch, staff checked to make sure they had finished and had enough to eat before removing the plate.

Due to the nature of the service people could not always use a call bell for assistance hence the need for a staff presence in the communal areas and regular checks of people who stayed in their room due to poor

health or their own choice. We saw staff completing checks throughout the day to ensure people's safety and wellbeing.

People living at the home communicated in different ways and staff approach was very much based around this. We saw that staff knew how to communicate efficiently with people, using a more tactile approach when they felt this would be beneficial. People responded well to this and held staff's hands.

We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

People had access to advocacy support if needed. Details of the local advocacy service was advertised in the home for people to refer to. Two people had the support of an advocate at the time of the inspection.

We observed relatives/visitors visiting throughout both days of the inspection. Relatives told us they felt supported and encouraged to maintain their important relationships with those who lived at Millbrook House. Relatives told us they were kept well informed about decisions and had been involved with care planning and care reviews. We saw there were no restrictions in visiting, encouraging relationships to be maintained. A relative confirmed this and said they and their family member were given privacy for their visits.

The provision of end of life care included future care planning. This was recorded in people's care files and interest parties had been involved in decisions made in accordance with people's wishes. The registered manager informed us the staff were undertaking a recognised comprehensive end of life care training programme. This was to provide staff with a formal qualification in end of life care to enhance their knowledge and skills in the delivery of compassionate care.

Good

Is the service responsive?

Our findings

People and relatives told us that they knew how to complain but hadn't needed to do so. They told us they had been given the opportunity to feed back at meetings and completed questionnaires though were not actively involved in the running of the home. With regards to complaints a person said, "Wonderful, I've never had to complain". Likewise another person reported that if they had a complaint they would, 'shout up'.

A complaints' policy was available and this was displayed for people to refer to along with a copy of this document in the home's brochure in people's rooms. There was a complaints' log available to evidence how complaints had been investigated and whether they had been resolved. We reviewed four complaints which had been logged, investigated and actions recorded.

People had a plan of care to address particular care needs and preferences specific to each individual. These were written taking into account the pre admission assessment which was completed prior to the person moving into the home. This assessment ensured staff were aware of people's needs and that they could be met effectively from the day they moved in. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, physical health, mobility, communication, sight hearing, skin integrity, personal care, nutrition, continence, social care and sleep.

People's plan of care also contained information about the individual from a social aspect, including previous interests, work and leisure pursuits. Information was also recorded around preferences and choices for daily living; this meant care files contained important information about the person as an individual and what was important and mattered to them.

We looked at how people and their relatives were involved with their family member's care plan. We received a mixed response regarding this though we saw discussions held with relatives recorded around changes in care or input from health professionals. We discussed with the registered manager the need to better evidence people's input (where possible) or relative input in key decisions. The registered manager said they would act on this. Care reviews took place and care documents were updated to reflect any change in care or treatment.

For people whose position needed to be changed or their fluid and diet intake monitored, records were in place to evidence this care. These along with the daily statement of care provided a good over view of people's current care and support in accordance with their planed care.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. We discussed this around monitoring people's health, their communication, diet and behaviours. A staff member said, "We know the residents so well, we know if something is not right."

Staff had a good understanding of people's preferred routine. We saw a person informing a member of staff

that they enjoyed their bacon and egg at 10.30am. This identified a degree of flexibility regarding meal times as this allowed the person to have a lie in and to catch up on sleep. Breakfast was served at this time. Staff told us about another person who had wanted to stay in bed till the afternoon and that they would ask them later if they wanted to get up as it was their choice.

An activities organiser was employed five days a week and there was a wide range of social activities going on each day. Trips out from the home were also arranged. A relative informed us that in terms of areas where staff did well, the activities and trips were very effective in keeping their family member stimulated. This we observed during the inspection. Other relatives also confirmed they were happy with the social arrangements. One person was worried about not being able to attend church on a Sunday. This request was passed on to the registered manager who said they would look into this.

During the inspection people played musical instruments, listened to music, joined in with singing, made jam tarts, took part in reading and a racket and balloon session. Eight people joined in with this which appeared to be fun and inter active. For one person who loved music we saw they were encouraged to play their own music instrument and to reminisce about their past contribution to music. This appeared to be very much enjoyed by those involved.

Social activities were planned at different times of the day, the more active sessions being arranged early morning when people had more energy and wanted to be active; consideration was also given to the length of each session. People's enjoyment and participation was recorded.

The home had a picture house room for film shows. The registered manager showed us some good development around dementia practice. This included a room which had been decorated and equipped as a baby nursery. The registered manager told us about the benefits of 'doll therapy' which promotes comfort, a connection with the past and stimulation for people with dementia. The home had a library room, a snooker room with a chess board and darts board and a room designated for 'quiet' time. The registered manager told us this was often used at night when people were unable to sleep. The room had comfortable arm chairs, blankets and a television.

We looked at processes in place to gather feedback from people and listen to their views. This included the provision of satisfaction surveys. We were shown some relative surveys from February 2017. We saw a number of positive comments about the home though there were some comments around improvement. The registered manager was unsure if they had been followed up on when the information had been collated at senior management level. They said they would look into this.

A relative meeting was held in January 2017 and four relatives attended. A coffee morning had been arranged later this month for relatives to meet. The purpose was also for relatives to 'talk about their journey' when caring for someone with dementia and to bring forward ideas for the development of the home. The registered manager told us that usually people they supported chose not to take part in the meetings.

Requires Improvement

Is the service well-led?

Our findings

We looked at the governance arrangements to monitor standards and drive forward improvements. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with an effective and safe service.

An audit calendar was in place which identified areas of the service to be audited on a monthly or six monthly basis and the registered manager and members of the senior management team responsible for their completion. We found arrangements for monitoring standards were not always robust to ensure the service was run in the best interest of people who lived there. The existing auditing system had not picked up on the deficits we identified around monitoring standards of infection control to help assure a safe and clean environment for people.

Following the inspection we were provided with a copy of the organisation's SCREW audit for Millbrook House, (so called in respect of the five questions we ask; is the service 'safe', 'caring', 'responsive', 'effective 'and 'well led'?). The audit was completed in February 2017 by the compliance manager and the scores overview recorded 76% compliance. The audit included management, dignity and respect, person centred care, safe care, safeguarding, nutrition and hydration, premises and equipment, complaints, governance, duty of candour and staffing. We saw a number of actions had been completed or were in the process of completion; this audit had however not highlighted any concerns in respect of infection control standards.

Following the inspection the registered manager devised a specific audit for the toilet facilities. They contacted us to advise that the completed audit had identified the same concerns which we raised during the inspection. The 'Dovehaven six month Infection Control: Quality Assurance Tool' had not been completed prior to the inspection. This audit was completed by a member of the senior management team following our visit. This audit assessed training, policies and risk assessments, use of personal protective clothing (PPE), training, the general environment, sharps, waste and laundry. The scoring for the environment rated this area as 'inadequate' ('priority high').

We also saw the people would benefit from further improvements within the environment to create a more dementia friendly home. This was raised at the inspection in February/March 2016. We saw work had been completed in some areas of the home however it was particularly evident on the ground floor that people would benefit from clearer signage and colour schemes to aid orientation. We raised this again with the provider during the inspection.

With regards to the environment the snoezelen was not used being used to its full potential; the lights in this room were also broken. This is a room which provides a controlled multisensory environment which can be used for people with dementia. The registered manager told us that this room needed to be upgraded so that it could be used for its intended purpose.

The registered manager told us that plans had been in place for some time regarding the provision of a small kitchen/cafe area though there was not start date for this. The purpose of this room being to

encourage life skills and social interaction for people living in the home.

This is a breach of Regulation 17 (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Following on from our inspection we have been informed of the work now being undertaken to upgrade the toilet facilities and standards around the control of infection. The provider also confirmed that work would commence work around the kitchen/café in the dining area and for this work to be completed within the next six weeks. The registered manager and provider acted promptly in response to our findings to improve the environment.

A registered manager was in post for the home and they were present on both days of the inspection. People, their relatives and staff had a positive view of the registered manager and their leadership qualities. We were told the registered manager was approachable, supportive, organised and led a motivated staff team. A relative said, "The manager goes above and beyond what (they) should do." Staff reported, (name of manager) is as good manager – very sociable and easy to approach", "Really good, always there to talk to", Good management" and "Just great."

We saw a clear management structure had been developed. The registered manager was supported by a regional manager, compliance manager and the provider. Support for staff training was provided by Dovehaven academy with the use of a training officer to help oversee the training programme.

The registered manager had completed a review of audits for April and May 2017, which identified common themes around improvements for the environment/infection control. This included areas that needed painting, the need to deep clean chairs and to undertake high and low surface cleaning. These had not all been completed at the time of the inspection but we have since heard that the work has commenced.

The registered manager showed us a number of other audits which had been completed to monitor standards in the home. This included medicines, accidents/incidents, care plans, bed rails, catheter care, topical creams, diet and nutrition and DoLS. These provided a good over view of how the service was operating with emphasis on monitoring clinical practice.

Staff told us they benefited from a good staff team. They told us they attended staff meetings and spoke positively about the supervision they received. A staff member said, "We have staff meetings, very useful." Talking with staff confirmed that they felt confident raising concerns. Staff were aware of the home's whistle blowing policy and told us they would use it should the need arise.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Millbrook House.

From April 2015 it is a legal requirement for providers to display their CQC rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Millbrook House was displayed for people to see.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found the environment was in need to attention which made it difficult to keep hygienic to maintain standards of infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found arrangements for monitoring standards were not always robust to ensure the service was run in the best interest of people who lived at the home.