CareQuality Commission

Anchor Trust

Millbeck

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 31 May 2016. The inspection was unannounced which meant the staff and registered provider did not know we would be visiting.

Millbeck is a purpose built care home for up to 30 older people operated by Anchor Trust. The home is located in the centre of Norton, in close proximity to shops, public transport and other amenities. Bedrooms are located on the ground and first floor and all have en-suite facilities.

The service had a registered manager. 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. The registered manager was on maternity leave at the time of inspection. A regional support manager was supporting the deputy manager during the registered manager's absence.

Staff we spoke with knew how to administer medicines safely and the records we saw showed that medicines were being administered and checked regularly.

However improvements were needed in guidance for medicines prescribed 'when required', topical medicines administration and handwritten medication administration records (MAR). We have recommended that the registered provider makes improvements to ensure the safe management of medicines.

Accidents and incidents were monitored each month to see if any trends were identified.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected. Where appropriate, the service worked collaboratively with other professionals to act in the best interests of people who could not make decisions for themselves. At the time of inspection there was one person subject to a DoLS authorisation. We saw evidence of consent within care files.

People were supported to maintain their health through access to food and drinks. Appropriate tools were used to monitor people's weight and nutritional health. People spoke positively about the food provided.

There was evidence of activities provision and people who used the service were happy with what was available.

Staff we spoke with understood the principles and processes of safeguarding. Staff knew how to identify abuse and act to report it to the appropriate authority. Staff said they would be confident to whistle blow [raise concerns about the service, staff practices or provider] if the need ever arose.

The registered provider followed safe processes to help ensure staff were suitable to work with people living in the service. There were sufficient staff to provide the support needed and staff knew people's needs well. Staff had regular supervisions and appraisals to monitor their performance. Staff received regular training in the areas needed to support people effectively.

People and their relatives spoke positively about the care they received. Throughout the inspection we saw people being treated with dignity and respect. Staff were seen to be very respectful of people and supported people in a dignified and discreet manner.

No one at the service was using an advocate at the time of the inspection. Information on advocacy was available. Procedures were in place to provide people with end of life care.

We found care plans to be person centred. Person centred planning [PCP] provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person.

The service worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met.

The service had an up to date complaints policy. Complaints were properly recorded and fully investigated. However outcomes did not always include the complainants response.

The registered provider carried out regular checks to monitor and improve the quality of the service.

Staff felt supported by the managers, who they described as professional and approachable.

Feedback was sought on a regular basis from people and their relatives on how to improve the service.

Staff and people who used the service and their relatives had regular meetings.

The manager's understood their roles and responsibilities, and felt supported by the registered provider.

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.

Systems were in place for the management of medicines so that people received their medicines safely. However we could not evidence creams were being applied as per prescription and protocols for when required medicines were not always in place.

Staffing levels were regularly reviewed and staff stated that staffing levels had improved.

Risks to people were identified however risk assessments were brief and needed more detail.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

Is the service effective?

Good

The service was effective.

Staff were supported through a regular system of supervision and appraisal, and received regular training.

Policies and practice were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected.

People were supported to maintain a healthy diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People and their relatives spoke positively about the care they received. We saw examples of positive, kind and dignified care throughout the inspection.

The service supported people to access advocacy services.
Procedures were in place to provide people with end of life care.

Is the service responsive?

Good

The service was responsive.

Care plans provided information on person-centred care.

There was evidence of activities provision and people were happy with what was on offer.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Good

The service was well-led.

Quality assurance checks were undertaken on a regular basis.

Staff felt supported by management.

Feedback was sought from people and their relatives on how to improve the service.

The regional support manager and deputy manager understood their roles and responsibilities.

Care Quality Commission

Millbeck

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 31 May 2016 and was unannounced. This meant the registered provider did not know we would be visiting

The inspection team consisted of one adult social care inspector.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was not asked to complete a 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 seven people who lived at the service and four relatives. We looked at three care plans, and seven people's medicine administration records (MARs). We spoke with seven members of staff, including the area manager, regional support manager, deputy manager, four care staff and the cook. We reviewed four staff files, including recruitment and training records.

We also completed observations around the service, in communal areas and in people's rooms with their permission.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe living at the service. One person said, "I feel safe, the staff make me feel safe."

Relatives we spoke with said, "My relative is most certainly safe which is the biggest relief of all. All staff follow procedures." And another relative said, "[relatives name] is safe."

People told us they received all their prescribed medication on time and when they needed it. We observed lunch time medication being administered to people safely.

The senior care worker administering the medicines followed safe practices and treated people respectfully.

Appropriate arrangements were in place for recording the administration of oral medicines. Staff had signed medicines administration records correctly after people had been given their medicines. Records of administration had been completed fully, indicating that people had received their medicines as prescribed. Medicine stocks were recorded correctly. Any medicines carried forward from the previous month were documented correctly. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records showed how much medicine the person had been given at each dose.

Medication kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators which stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Eye drops which have a short shelf life once open were marked with the date of opening. This meant that the staff could demonstrate that they could safely store and administer oral medicines.

We looked at the guidance information kept about medicines to be administered 'when required'. Protocols for how and when to use and arrangements for recording this information was in place for all people prescribed pain relief for example Paracetamol. However not all when required protocols were in place. For example, one person was prescribed Lorazepam for anxiety; there was no guidance on any techniques to use first before administering medicines, how often it could be used and the maximum dosage in 24 hours.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We saw that the registered provider completed a monthly audit and a daily system of medicine checks was also in place. We found these checks helped to identify any issues quickly in order to learn and prevent the errors happening again. However, the checks did not highlight the issues we found with topical medicines. One person was prescribed Piroxicam Gel to be applied two to three times a day. Records showed that the last application was on the 20 December 2015. Full dosage details of topical medicines were not recorded onto the topical medication administration record (TMAR). We discussed this with management who agreed to put a more robust recording system in

place for topical medicines.

We have recommended the registered person must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

Risks to people were assessed and plans put in place to minimise the chances of them occurring. Risk assessments were carried out in areas including wheelchair use, falls and diabetes. The registered provider used recognised risk assessment tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments, which helped identify the level of risk and appropriate preventative measures. Most risk assessments were specific and detailed how the risk could be minimised and how often it should be reviewed. However, we did see that some risk assessments were quite brief in detail. For example one person who was a diabetic, the risk was diabetic coma, however there were no details of signs of a diabetic coma, and what to do to prevent one if signs started to occur. We discussed this with management and they agreed to update the risk assessments.

Risks to people arising from the premises were assessed and monitored. Fire and general premises risk assessments had been carried out. Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. Records confirmed that monthly checks of emergency lighting, fire doors, water temperatures and window restrictors were carried out. Fire drills took place for both day and night staff. Fire drills recorded a start and end time and were reviewed each time to see how things went and if any improvements could be made.

Management completed a monthly safety checklist audit control of substances hazardous to health (COSHH), accidents and incidents and general safety.

We looked at individual personal emergency evacuation plans (PEEPS). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The service did not have an evacuation pack in place but the regional support manager had already highlighted the need for this and was in the process of implementing one.

Staff demonstrated a good working knowledge of safeguarding procedures. They were able to describe types of abuse, the signs to look for and the correct action to take.

The service had a whistleblowing policy that was available to staff. Whistleblowing is when a person tells someone they have concerns about the service they work for. The policy included clear instruction on raising a concern internally and externally. One staff member we spoke with said, "If I see anything that is happening, that should not be happening, I would report it."

The service recorded accidents and incidents in a dedicated accident/incident log and these were analysed monthly. Any actions that were triggered by the accidents or incidents were clearly recorded at the front of the file. This meant that there was an effective monitoring system in place that would identify any trends or action needed and thereby keep people safe from the risk of accidents.

We looked at the recruitment records of four staff. We saw evidence that pre-employment checks had been undertaken prior to staff starting work. Application forms were fully completed and we found there to be no unexplained gaps in employment. There were a minimum of two references on the files we looked at and Disclosure and Barring (DBS) checks had been carried out for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps

employers make safer recruiting decisions and also minimises the risk of unsuitable people working with children and vulnerable adults.

Through our observations and discussions with people and staff members, we found there were sufficient staff to meet the needs of the people who used the service. At the time of the inspection there were 30 people who used the service. We saw duty rotas which confirmed that there were enough staff on duty, there were four care staff from 8am to10pm daily and three staff from 10pm till 8am. There was also a team leader, activity coordinator and the deputy manager throughout the day. The registered provider had recently increased the care staff on duty from three to four. This was due to people who used the service, relatives and staff stating more staff were needed. One staff member said, "It was raised at a staff meeting that an extra member of staff was needed between the hours of 8am till 1pm, we got that extra member of staff. We then found we needed more help at night, again we got another member of staff." Another staff member said, "There are enough staff now in place."

Good

Is the service effective?

Our findings

All staff underwent a formal induction period. Staff shadowed experienced staff until such time as they were competent and felt confident to work alone. One staff we spoke with said, "I had numerous shadow shifts that only stopped when I felt competent." All staff received mandatory training that included areas such as health and safety, food handling, infection control, moving and handling and safeguarding. Mandatory training is training that the registered provider thinks is necessary to support people safely. Staff had also received additional training in areas such as keeping people safe whilst using bed rails and falls awareness.

Staff received regular supervision, every four to six weeks, and an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We saw records of these meetings on staff files. Areas discussed included training and development, personal responsibilities and the issues concerning people who used the service.

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. We saw that the registered manager was working within these guidelines and where people were waiting for reassessments the registered manager had evidence that they had requested the reassessment at least six weeks before it was required. At the time of our inspection one person was subject to DoLS authorisations,

All staff had received training on MCA and DoLS and staff demonstrated some understanding of the basic principles of the Act. Staff we spoke with said, "Everybody needs to be deemed to have capacity unless deemed otherwise, to help make decisions in their best interests." And another staff member said, "A DoLS is in place for their best interests due to them not being able to do things themselves."

Consent forms were signed by people, such as consent to care and treatment.

Staff were able to explain how they obtained consent from people before providing care. One staff member said, "I always ask them." Another staff member said, "I always gain consent before I do anything as well as explaining what I am going to do."

People were supported to maintain good health; they had health action plans in place that were reviewed on a monthly basis. We saw evidence that people were seen by health professionals such as dentists, opticians and chiropodists when needed.

People were supported to maintain a balanced diet. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the frequency determined by the MUST score, to detect any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team. Staff had received food hygiene training. The cook said they are kept up to date with people's dietary needs.

We observed a lunch and tea time both upstairs and downstairs. We saw menus were available on the wall. Tables were laid nicely with full condiments, such as salt, pepper, mustard, ketchup, brown sauce, mint sauce and salad cream. We observed that staff knew people well and what they liked with their meal which was a choice of chicken and mushroom in a creamed sauce or boiled beef and carrots. One staff member asked one person if they wanted their brown sauce and if they wanted help with it. Another staff member saw that someone was struggling so they approached them and quietly asked if they could manage or did they want a bit of help. This was done in a dignified and discreet manner.

People were complimentary about the food and comments included, "I am really enjoying this." And "Oh this is lovely." People were offered a drink of choice and on a few tables when people sat down they clinked glasses and said 'cheers', all laughing. One person had chosen soup for the tea time meal and said, "I enjoy my soup on a night."

A relative we spoke with said, "The food is lovely [person's name] enjoys their meals." And "The chef always asks what they want."

We saw people entered the dining room when they wanted and people were not rushed to eat their food. Some people chose to have their food in their own room; this was taken fully covered on a tray.

We asked the chef how they knew what people's dietary needs, likes and dislikes were. The chef showed us a file they keep on each person which documented whether they needed a fortified diet which was full of butter, creams and sugars or a soft diet. They also documented likes and dislikes such as what sandwich fillings they liked, what bread they preferred. The chef said, "I tend to know what each person likes and would go for, but I go round to each person on a morning to ask what they want for lunch, this gives me a chance to interact with them, for example one person said they did not like the soup the day before, I will ask what was wrong with it and change it to how they would like it."

The chef had done tasting sessions such as fish tasting where they did poached salmon, asparagus and lemon sauce or cod in a parsley crust. If people liked something it would be added to the menu. The chef had also done sandwich tasting sessions with different fillings and different ways to present a sandwich. The chef said, "We have a Scottish night coming up and we are having haggis and a seared salmon with honey glazed vegetables, if they like that it will go on the menu." We were told that people could have what they wanted.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the staff. One person said, "The staff are fine they make me feel comfortable." And another said, "The staff are lovely very kind."

People were encouraged to maintain relationships with family and friends. Visitors told us they were encouraged to visit at any time. One relative we spoke with said, "The staff are fine, they make me feel welcome." Another relative said, "I cannot speak highly enough about the staff, this is a wonderful place, staff are phenomenal and that is all of them from the cleaners to the managers." Another relative said, "The smiling faces my relative sees on the staff really brightens their day." And another relative said, "I am really really pleased my relative is living here."

People's privacy and dignity were respected and promoted. Staff were seen to be kind, friendly and caring. We asked staff how they supported people to maintain their dignity and privacy Staff we spoke with said, "I make sure doors and curtains are shut when providing personal care, or if talking to someone I would speak away from other people." And another staff member said, "I always explain what I am doing to help their dignity and so they understand."

Staff were happy in their job and had a positive attitude about the care provided by the service. One staff member said, "I really enjoy working here, it has shown me a huge difference in care I cannot fault it." Another staff member said, "It is a lovely home, it is gorgeous." And another staff member said, "The care here is good, it is the best place I have ever worked, I don't have one bad thing to say about it."

We asked staff how they promote peoples independence, staff we spoke with said "I get people to do the majority themselves, I ask if they need help but I don't pressure." Another staff member said, "I always say, you do what you can do and I will help with what you can't do, I always highlight what they can do themselves."

Through observations we saw that staff demonstrated a lovely, discreet and kind approach to people and knew people well. Throughout the inspection we saw staff treating people with dignity and respect. When speaking with people, they approached them and stood close to them to have conversations rather than shouting across communal areas. We heard lots of friendly banter taking place and lots of singing and laughing.

We saw that all people who used the service had access to an advocate if needed and information on local advocacy services was available. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. At the time of inspection no one living at the service had felt the need to use an advocate. Management were aware of the process and action to take should an advocate be needed.

We saw care plans covered end of life wishes and preferences or the service had documented that they had asked people and/or their relatives and were waiting for feedback.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We looked at care plans for three people who used the service. People's needs were assessed and care and support was planned and delivered in line with their individual care plan and in partnership with them. Individual choices and decisions were documented in the care plans and they were reviewed monthly or more frequently if needed.

The care plans we looked at were person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were legible, up to date and personalised. They contained detailed information about people's care needs, for example, in the management of risks associated with people's dietary needs and the risk of falling. The care plans contained detailed information about people's personal histories, likes and dislikes and the delivery of care and procedures, such as the assessment of people's mental capacity. People's choices and preferences were also documented. The daily records showed that these were taken into account when people received care, for example, in their choices of food and drink.

We asked staff what their understanding of person centred care was and if the care plans were easy to follow. Staff we spoke with said, "Person centred care is care centred around them as a person, our care plans are easy to follow." Another staff member said, "I think our care plans are easy to understand and follow, I am key worker for three people and each person has different needs and the care plans document this."

Staff we spoke with had an in-depth knowledge of the people they cared for and could easily explain how each person had different preferences and wishes.

People we spoke with were aware of their care plan. One relative said, "We have just had a review with my relative and went through the care plan."

Handover records showed that people's daily care was communicated when staff changed duty at the beginning and end of each shift. We saw these covered any issues to report for each person, any changes in medication or diet etc.

We saw evidence of activities taking place. People joined in a game of bingo in the morning then they had a cup of tea and had a reminiscence session. During this session there was lots of laughter and people were seen to be thoroughly enjoying it. Comments from people were, "Oh that was fun." "I really enjoyed that, it is funny what you remember." And "I love remembering about the good old days." Another person thanked the activity coordinator and said, "That was very nice, you do, do your best for us."

We asked people who used the service and their relatives if they thought there were enough activities in place. People we spoke with said, "Oh there is always something going on, there is enough for me." Another person said, "It is fine, I join in when I want but sometimes don't." Relatives we spoke to said, "There is

enough, I came the other day and there was a poetry session going on." Another relative said, "There is often sing a longs, [relative's name] loves a sing a long." And "They also do special treats for people's birthdays, it was my relatives 90th birthday and all the staff attended even if they were off duty." Another relative said, "The staff are very sociable."

We asked staff if they thought there was enough going on for the people who used the service. One staff member said, "It seems to always be the same people who join in, some people are happy on their own." And "We often have parties in the lounge and the activity coordinator leaves things out for people to help themselves, such as painting, crafts and books." Another staff member said, "We have quite a lot going on we had the library come in talking about Scotland the other day, everyone loved it, it was really interesting."

Staff also said they take time to sit with people in their rooms. One staff member said, "I often sit and talk to [person's name] about football, I don't know much about it but I am learning." Another staff member said, "If we are not too busy, I sit and have a chat with people, I love listening to their life stories."

The service had an up to date complaints policy in place. We looked at the complaints file and saw that four complaints had been received in the last 12 months. These had all been correctly documented and details from the investigations were also recorded. For example, people had complained that their laundry was not returned. The service looked into this and increased the laundry hours which we were told had eliminated the problem. However this was not documented.

We asked people's relatives if they had ever had to complain. One relative said, "I have never had to complain, I would know how to though." Another relative said, "Any concerns however small are sorted straight away."

Good

Is the service well-led?

Our findings

There was a registered manager who had been registered with the Care Quality Commission since November 2015. The registered manager was on maternity leave at the time of the inspection and the regional support manager and the deputy manager were overseeing the management of the service.

We asked people who used the service and their relatives what they thought of the management of the service. One person said, "They are all fine, I have no issues at all." A relative we spoke with said, "This is a lovely place and very professionally run." Another relative said, "I cannot fault the management or any of the staff, they keep in touch and contact me if anything happens."

We asked staff if they felt supported by the managers. Staff we spoke with said "They are brilliant, I cannot fault them, they are all very approachable and very professional." Another staff member said, "You can go to anyone in management, a team leader anyone, about anything they are very supportive."

We asked staff about the culture of the home. Staff we spoke with said, "It has a very open and honest culture, we are a small team and issues get aired as soon as they can be, the office is always open to speak to a manager." Another staff member said, "We have a very positive culture, anything people need they get and the care is very good, this is the best place I have worked and there is not one bad thing I can say and there is not one bad carer."

Meetings for people who used the service and their relatives took place regularly. These were done informally as tea and a drop in. The service checked people were happy or whether there were any changes people would like to see implemented. One person wanted to go out for a cigarette in the small hours of the morning, staff were now accommodating this. Other topics discussed were decorating, menus and any changes.

Staff meetings took place every two months for all staff and for heads of departments, team leaders, night staff and housekeepers. Topics discussed were infection control, staffing, recruitment and policies. Staff we spoke with said, "The meetings are good, we all contribute and any issues get resolved, for example we all thought we needed an extra staff member on a morning and this happened, then we all thought we needed an extra staff member on a night and it happened again."

We asked the deputy manager about the arrangements for obtaining feedback from people who used the service and their relatives. We were provided with the results of a survey which takes place annually. The one we were provided with was from 2015. The annual survey compared the results to the previous year to check for improvement or a downward trend. The results were positive and where an issue was raised actions were taken to overcome this. For example one issue was the laundry, the service put more hours into the laundry and people were satisfied.

We were also provided with a staff survey which had taken place in January 2016. This provided the service with what was going well and what they needed to focus on. An action plan was in place stating what

needed to be improved, how this would be achieved, who would make this happen and when would this be achieved.

We saw that systems were in place to monitor the quality of the care provided. Frequent quality audits were completed. These included checks of health and safety, infection control, kitchen, environment, medicines and care plans. These checks were regularly completed and monitored to ensure and maintain the effectiveness and quality of the care. However the medicine audits did not highlight the issues we found during inspection.

The management understood their role and responsibilities in relation to compliance with regulations and notifications were correctly made to CQC.