

Croftwood Care UK Limited

New Milton House Residential Care Home

Inspection report

New Milton House Residential Care Home
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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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced inspection of New Milton House Residential Care Home on 23 March 2018.

New Milton House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. New Milton House Residential Care Home is registered to provide care to 39 people. At the time of this inspection the home was providing care to 35 people. The building was split in to two units, one was specifically for people with dementia and the other was a residential unit.

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 manager was going through the process of registration with the Care Quality Commission.

People we spoke with told us they felt safe at the home and people's relatives also told us they felt people were safe. During our visit, however we identified concerns with the service.

During our inspection, we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 9 person centred care; 11 need for consent and 12 safe care and treatment; of the Health and Social Care Act 2014 Regulations.

You can see what action we told the provider to take at the back of the full version of the report.

People received support with their health care. However care plans had not been updated accurately and contained guidance that if followed would pose a risk to people's health and safety. Care plans did not always reflect people's up to date needs and were in some cases contradictory.

Medication management including storage, documentation, administration, and protocols for medications prescribed to be taken 'as and when' was not safe or sufficient.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not always been followed and any conditions on authorisations to deprive a person of their liberty were not being met.

Audits were regularly carried out by the provider and the manager, however it was not always clear on the action plans whose responsibility it was to carry out any actions identified.

Staff were recruited safely, however evidence that staff received a proper induction was not in place. We saw

that staff had received suitable training that the provider identified as mandatory to do their job role effectively. All staff had been supervised in their role and staffing levels were consistent and were adapted to meet people's needs.

The staff at the home knew the people they were supporting and the care they needed. We observed staff to be kind and respectful towards people. The home provided a range of activities to occupy and interest people.

People and relatives we spoke with said they would know how to make a complaint, none of the people or their relatives we spoke with had any complaints. Care plans showed that people's GPs and other healthcare professionals were contacted for advice about people's health needs whenever necessary.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe

Medicines were not always safely managed.

Some care and risk documentation had not been fully completed and was contradictory.

Staff were trained in safeguarding and whistle blowing procedures.

Is the service effective?

Requires Improvement ●

The service was not always effective

The service was not always working within the principles of the Mental Capacity Act and any conditions on authorisations to deprive a person of their liberty were not being met.

Staff had received supervision and appraisal.

Parts of the environment met good practice guidance for supporting people living with dementia.

Is the service caring?

Requires Improvement ●

The service was not always caring

Confidentiality of peoples care and monitoring documents was not observed.

We observed staff to be caring, respectful and approachable.

People and visitors appeared at ease with staff.

Is the service responsive?

Requires Improvement ●

The service was not always responsive

Some people who lived in the home did not have a plan of care that was appropriate and met their needs.

A range of social activities was provided and the activities co-ordinators took time to build positive relationships with people and their families.

People felt they could raise concerns with staff if they had any.

Is the service well-led?

The service was not always well-led

Audits were in place however it was not clear who had responsibility or what time frames were in place for identified actions.

Policies were in place to guide staff however some of these were not dated so it was not clear how up to date they were.

The manager was going through the process with the Commission to become the registered manager.

Requires Improvement ●

New Milton House Residential Care 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 28 March 2018 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we asked for information from the local authority and we checked the website of Healthwatch for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During the inspection we spoke with four people living at New Milton House Residential Care Home and with five relatives and visitors. We talked with two staff on duty including ancillary staff. We also talked with the manager, deputy manager and area manager. We were also able to talk to a visiting professional who was a district nurse. We observed several other people who were supported by the service, who did not want, or were unable to talk with us.

We observed support for the majority of people who lived at the home. We reviewed a range of documentation including four care plans, medication records, and records for five staff members, staff training records, policies and procedures, auditing records, health and safety records and other records relating to how the home is managed.

Is the service safe?

Our findings

Each person we spoke with told us that they felt very safe in the home. This was supported by the visitors and family members that we spoke with. We looked at the records relating to any safeguarding incidents and we saw that the managers maintained a clear audit trail of any safeguarding incidents, what action had been taken to support any people who lived in the home and had made the required notifications to CQC. We asked staff members if they knew safeguarding processes and asked if they felt confident to know how to be able to report any type of potential abuse. All the staff we spoke with were able to show an understanding of the different types of abuse and how to report abuse.

However during the course of the inspection we identified concerns with aspects of the service.

Medicines were stored in two places. Those stored in the locked room by the office were temperature controlled and checked most days however, not all readings were in range and not checked on some days. Those medicines stored in a trolley under the stairs in the dementia unit were not locked to the wall and were not temperature controlled.

Controlled drugs were stored safely in a cupboard and the register was signed by two people at each administration. Regular stock balance checks were recorded and the stock checks we did were accurate. However, not all controlled medicines were stored as such. For instance, Temazepam tablets were stored in the trolley and we were told that the home had been told that they did not need to be in the controlled drug cupboard.

We saw that not all allergies were recorded on medication administration records (MAR's). For example, one person was allergic to flucloxacillin and the flu vaccine. This was recorded on the divider but not on the MAR charts. We also saw that one person had been prescribed co-codamol and their MAR stated two tablets to be given three times daily however these were given four times daily and box stated four times so the MAR had been incorrectly written. This meant people were not always being the correct amount of medications.

We found missing signatures missing on MAR's including both tablet, inhaler and topical medications (creams). We were unable to accurately audit some medicines as the medication stock balances were inaccurate. Examples included medications not being booked in when received from the pharmacy. We also identified instances where medication had not been given and one person who was prescribed 'as and when' medications' (PRN) had no appropriate protocols in place as the person was unable to tell staff the amount of medication needed. Another example was a box of medication stated 'one tablet when needed'. MAR stated 'one when needed' but then handwritten on 'must have in a morning.' The MAR reflected that it was not often administered.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always manage medicines safely.

We noted that risks to people's safety and well-being had been identified, such as the risks associated with

moving and handling, falls, pressure area care and nutrition and that plans had been put in place to minimise risk. However, during our inspection we noted that some documentation was contradictory, this included one person who had been referred to the speech and language therapists regarding needing food to be thickened. We found that these instructions were not always being followed and that not all staff knew the correct amount of thickener to use. We identified that there was no system in place to ensure all staff knew correct requirements regarding thickener. This meant the home had not clarified for staff what was a risk for people surrounding fluids.

We also saw that one person's nutrition plan stated that they needed encouragement and the review stated that they ate little. We saw no mention of any weight loss in the care plan or review. The risk assessment that monitors weight (MUST) reflected weight loss and the person's weight record showed a significant weight loss. However we saw no evidence that any action had been taken regarding this. Another person's mobility care plan stated that two staff were needed to assist with mobility with a wheelchair for longer distances. The monthly review stated the person required walking frame and one carer to mobilise. This is different to care plan and different to what staff told us.

We also became aware of a person who had often displayed behaviour that was difficult to manage and presented a risk to themselves and at times staff. We identified that the manager and staff were not following the G.P advice fully regarding medication that was prescribed for managing the risks identified.

These were additional breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always provide care and treatment in a safe way.

We looked at the personnel files of five staff. All of the files included evidence of a formal application process and checks in relation to criminal convictions and previous employment. We saw that all staff in the home had a Disclosure and Barring service (DBS) check completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. However we saw that not all staff references had been verified, this was brought to the managers attention.

We looked at staffing levels and saw that these had been consistent over the previous month. We spoke to some staff who thought there was enough people on duty and said that they had time to spend with people. At the time of inspection 35 people were living in the home and 54 staff were employed and each day there was usually five to six care staff including seniors, as well as administrative staff, kitchen staff, laundry staff, two activity staff and a maintenance person.

We saw the premises were safe. We looked at a variety of safety certificates that demonstrated that utilities and services, such as gas, electric and small portable electrical appliances had been tested and maintained and we saw that the fire alarm system had been checked regularly. Personal Emergency Evacuation Plans (PEEPS) had been completed for all of the people who lived in the home and were readily available in case they were required. We also saw call bells in rooms and one door sensor in use to help prevent falls. An evacuation sledge was in place on stairs in case of fire. We also saw that window restrictors were in place and wardrobes were attached to the wall for safety. Locked cupboards were available in people's rooms.

We observed that home was clean with no offensive odours. We noted that gloves and aprons were freely available and that antibacterial hand gel was available throughout the home.

We also looked at the records for accidents and incidents, we saw that actions had been taken following

each event, for example referrals to the G.P. We also saw that falls were monitored closely and acted on in a timely manner.

Is the service effective?

Our findings

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. We identified that was not always the case. Examples included one person having a 'Do not attempt resuscitation' document (DNAR) in place, it was stated that the person lacks capacity to be involved in decision and there had been family involvement however there was no evidence of capacity assessment regarding this. Other examples included family being consulted in a best interest decision where the mental capacity assessment was ticked 'yes' to family having lasting power of attorney, however when we asked for the relevant paperwork it was unable to be found so we were unsure if this was in place. We also saw that some consent forms were blank.

We also saw another person who had mental capacity assessment and best interest in place. A DoLS had been authorised however there was a condition on the authorisation that stated the home was to provide 1:1 time and opportunity to have support to access the community on a regular basis. There was no evidence of this support, discussed with the deputy manager who stated they thought the persons advocate was arranging it but it had not been 'chased up' with the advocate. The DoLS had been in place since November 2017. There was also consent forms signed by a staff member but states the person was unable to physically sign but had given consent. This was contradictory as there was a DoLS in place due to lacking capacity regarding where to live and care needs.

Another person's health needs care plan reflected health conditions and was reviewed February 2018. It stated 'can be given medicines covertly in his best interest'. However there was no evidence or plan for this in place. We saw a letter from a GP that stated the person could be given medications covertly. It did not state that they lacked capacity, had no mental capacity assessment or best interest record, it also did not state what medicines could be given or how. We saw no advice or input from a pharmacy or an advocate. Staff we spoke with said the person did not have the medicines given covertly, however the deputy manager believed everything was in place to give them this way if needed.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always provide care and treatment with the consent of the relevant people.

We saw that staff had attended a variety of training that included, deprivation of liberty, first aid, fire safety, infection control, moving and handling and safeguarding. We saw evidence that there was a supervision and

appraisal system for the staff. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs. However we identified that records regarding induction when first employed had not always been completed. This was brought to the managers attention.

The home was separated into two halves, one half supporting people living with dementia, the other side was residential. The side of the home supporting people with dementia, 'The Coppice', had been adapted to meet people's needs. Such as a reminiscence room, memory boxes outside bedroom doors, bathroom doors all yellow and bedroom doors red. An orientation board was on the wall in the dining room with date, day and weather.

We asked people if they liked the food and they told us that the food provided was nice and plentiful and that they enjoyed it, this was supported by the relatives we spoke with. Comments from people included "It's tasty" and "There's an excellent cook, the food is lovely" and a relative said "The food is lovely". We also saw that residents meetings included discussions about the food and suggestions were taken from people living in the home.

We spoke to a visiting health professional about the home and we were told that they had no worries about the service and that "On the whole there was good communication and information".

Is the service caring?

Our findings

Care plans were not stored securely. Upstairs in the dementia unit they stored in an unlocked cupboard in the lounge and downstairs were in an unlocked cupboard in the corridor. Daily records such as weights, skin records, daily reports, diet and fluid charts and behaviour charts, were seen to be stored in files on the worktop in the kitchen area of the downstairs dementia unit. This was brought to the manager's attention.

One of the people living at New Milton House told us, "They're very friendly" another said "This is a home from home". We also asked relatives and visitors if they thought the staff were caring and we were told "It's upped my faith in elderly care" and "They're really good". We were also told how a relative knew all of the staff and was always made welcome when they arrived. Another relative described staff as polite, friendly, courteous, approachable and knowledgeable. They were always made welcome and had joined their relative for some meals. They were kept up to date with any changes and staff managed to help his relative with care needs that had been refused when at home.

We also asked if the staff knew the likes and dislikes of the people living in the home. We were told by one person "Oh yes and they listen to me". We asked if people were encouraged to independent and we were told 'yes'. One person was able to tell us how they were able to go out when they wanted to and that there was no time limit on when they had to be back. We were told how the home endeavoured to have a homely atmosphere where people felt they could call it their home.

We observed staff throughout the day supporting people who lived at the home. Interactions between staff and the people they cared for were positive. All the staff we observed were respectful of people's dignity and supported them at their own pace.

We saw that the home devised and distributed a New Milton House Monthly News Letter. This informed people of upcoming events, activities and any news regarding the home. Relatives told us that there was always communication between them and the service and they felt they were kept informed of any issues. We also saw in people's care plans that they had accessed advocacy services when needed.

We saw that a residents meeting was also held regularly. This gave people the opportunity to access information about the home in a different format and that they were able to have input to the home.

Is the service responsive?

Our findings

We reviewed four care files, and each file had a 'care needs overview' document in place. This outlined the care needs of each person and was documented in the file. However we found some disconnect between care plans as well as the 'care needs overview' and the care plans. Examples included one person had an 'elimination plan', this had been reviewed and reflected the use of continence pads which was not reflected in the care plan. Another example was a person had a skin integrity review that stated they were to sit a specific pressure relieving cushion at all times but this was not in the care plan. Another example was a person's mental health and wellbeing plan held no mention of potential verbal aggression as stated in their care needs overview.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that an up to date plan of care was maintained for people living in the home.

The manager told us that there had been no complaints received. The home had a complaints policy that was on display for people to access, this was up to date and had been reviewed however it did not hold contact information. This was brought to the manager attention. This was displayed at the entrance to the building making it easily accessible for everyone. We asked people if they felt they could raise concerns and everyone said they could. One person told us "I have no problems, at all". Another person told us how they knew how to raise any issues and felt they would be listened to.

The home employed two activities co-ordinators and we were able to see that activities available displayed on notice board and monthly newsletter also displayed. Activities included Easter decorations, hairdresser, memory box, games, pizza making, sewing circle, sing-along, knit and natter and church services. There was greenhouse was also available for the use of the people living in the home. We were shown how the activities co-ordinator kept a 'memory folder' that reflected the interests of people living in the home. One person told us "There's plenty of activities". We were also shown a 'sensory garden' that was available to people living in the home.

We saw throughout the day that staff and people who lived at the home interacted with each other in the communal areas of the home. Visitors were welcomed at all times and were free to stay for as long as they wanted and were treated in a friendly and warm manner by the staff.

People's relatives fed back on the day of the inspection that their family member's needs were met and enhanced by the care at the home and that the care was very personal and attentive to particular needs of the person. One relative said "Every time I ask for something it's done" and "I feel better now that [person] is here".

At the time of inspection no one was receiving end of life care however the provider had an end of life policy in place and the ability to plan people's wishes.

Is the service well-led?

Our findings

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. At the time of inspection the manager was going through the registration process with CQC. The manager was supported by a deputy manager, the area manager and compliance officer. The manager understood their responsibilities in relation to the service and to registration with CQC.

The manager and the staff had a clear understanding of the culture of the home and were able to show us how they worked in partnership with other professionals and family members to make sure people received the support they needed. People had prompt access to medical and other healthcare support as and when needed. There were documented visits from district nurses, dieticians and GPs. We spent time talking to the manager and they told us how committed they were to providing a quality service.

The provider and manager monitored the quality of care at the home through regular audits, this included medication however we saw action plans had been created but no evidence as to whether actions had been addressed. Some of the actions were recorded and a number of audits, no evidence what action was to be taken or who was responsible for ensuring action was addressed.

We saw that a resident's satisfaction survey had been carried out in 2017. The outcome was mostly positive but 38% said not enough activities. 96% said staff are kind and respectful. 22/25 residents would recommend the home. An action plan had been created from the results and identified what had been done to address negative comments, such as speaking with the chef re menu's to ensure people's preferences were met. A monthly activity planner created and displayed and staff told to document all people's involvement in activities. This showed the manager listened to the people living there.

Additional quality questionnaires had been completed by staff and relatives. The manager had held a team meeting to discuss the comments received in surveys. Action plan states all issues discussed and addressed. Staff we spoke with told us that they felt supported by the incoming manager and deputy manager. One staff member said "I feel more comfortable with [manager]" and another staff member said "She listens to staff".

We looked at a selection of policies that included advocacy, agency workers, accidents, covert medicines, medicines management, equality and diversity and inclusion, dementia care, end of life care, health and safety, MCA, privacy and dignity, duty of candour, safeguarding and legionnaires. However none of the policies were dated so we were unsure when they had last been reviewed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that an up to date plan of care was maintained for people living in the home.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always provide care and treatment with the consent of the relevant people.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always manage medicines safely and the provider did not always provide care and treatment in a safe way.