Surbiton Care Homes Limited

Milverton Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 25 May 2017 and was unannounced. At the previous inspection on 25 April 2016 we rated the service 'Requires Improvement' in two of the key questions we asked of services, 'Is the service safe?' and 'Is the service responsive?'. Therefore the service was rated overall as 'Requires improvement'. We however did not find any breaches of regulations at that inspection.

Milverton Nursing Home provides nursing care for up to 30 older people, some of whom were living with dementia. There were 28 people using the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our findings showed that the provider managed risks to people using the service and those relating to the premises well. However, risks relating to bed rails were not always well managed as some risks had not been appropriately risk assessed and mitigated. The registered manager told us they would take immediate action regarding these risks.

The registered manager had improved processes for recording incidents since our last inspection to ensure action in response to incidents was appropriate. In addition the registered manager had improved the complaints process to ensure all complaints were recorded and reviewed as part of improving the service.

The activities available to people had been extended since our last inspection to consider the needs of people who spent much time in their rooms to reduce the risks of social isolation. The activities officer organised activities based on people's interests. These included weekly outings, entertainers and group activities.
A programme of renovations to extend and improve the home was in place and included provision of a new conservatory and staff facilities.

The provider managed people's medicines safely as staff followed robust procedures in all aspects of medicines management.

Staff understood how to safeguard people at the service and had received training in this area. Staff knew the signs people may be being abused and the registered manager responded to concerns appropriately to keep people safe.

There were enough staff deployed to meet people's needs. The provider carried out appropriate checks to ensure only staff who were suitable worked with people. These checks included previous work experience and qualifications, including PINs for nurses, identification, right to work in UK and health conditions. A

programme of induction, supervision, appraisal and training was in place to help staff understand how to respond to people's needs. Staff felt supported by the registered manager.
Staff supported people with their healthcare needs including accessing healthcare professionals. Staff knew the people they supported. People's care plans contained sufficient detail about their support needs, backgrounds and preferences for staff to follow in providing care to them.

People were involved in decisions about their care and staff understood the importance of the Mental Capacity Act 2005 to their role, such as how to respond when people lacked capacity to consent to their care. The registered manager applied for authorisations to deprive people of their liberty appropriately under Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

People were provided with a choice of food and were positive about the food they received. The chef ensured food was prepared in accordance with people's specific dietary and health related needs.

People, relatives and staff told us the service was well-led and the registered manager regularly gathered and acted on their feedback about the service. The registered manager and staff, were aware of their role and responsibilities. The provider carried out a range of quality checks to monitor, assess and improve the quality of service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service safe. The provider checked staff were suitable to work with people prior to offering them employment and there were enough staff deployed to work with people.

Staff followed robust procedures to manage people's medicines safely.

Staff understood the signs people may be being abused and how to respond to these to keep people safe. The registered manager generally managed risks to people who use the service well. However, risks to people relating to bed rail usage were not always managed appropriately. The registered manager told us they would take immediate action to rectify this.

Is the service effective?

Good

The service was effective. Staff were supported through a programme of induction, supervision, appraisal and on-going training.

Staff followed the Mental Capacity Act 2005 in assessing whether people had capacity to make particular decisions and the provider was meeting legal requirements in relation to the Deprivation of Liberty Safeguards (DoLS).

People received and enjoyed a choice of food and were supported with their health needs appropriately.

Is the service caring?

Good

The service was caring. Staff were caring towards people and treated them with dignity and respect.

Staff knew the people they were supporting including their preferences, health needs and backgrounds.

People were encouraged to make decisions about their care. The service was working with the end of life team at the local hospice

in helping people to plan their end of life care.

Is the service responsive?

Good

The service was responsive. People's care was planned in response to their needs and people were involved in planning and reviewing their care. People had enough activities they were interested in to keep them occupied.

The registered manager investigated, responded to and recorded complaints appropriately.

Is the service well-led?

Good

The service was well-led. People, relatives, staff and professionals told us the registered manager led the service well and we found the registered manager and staff were aware of their responsibilities.

A range of audits were in place to assess, monitor and improve the quality of the service. People and staff were involved in running the service to help tailor it to their needs and preferences.

The provider was aware of their legal responsibilities including submitting statutory notifications to the CQC as required by law, such as of serious injuries.

Milverton Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 May 2017 and was unannounced. The inspection was undertaken by an inspector. Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people, four relatives, two care workers, two nurses, the chef, the activities officer, the receptionist, the administrator and the registered manager. We also spoke with a continuing care review officer from the clinical commissioning group (CCG) and a visiting physiotherapist. We reviewed four people's care records, three staff records and records relating to the management of the service. We looked at medicines management processes. Throughout the day we undertook general observations and used the short observation framework for inspection (SOFI) at lunchtime in the main lounge. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At our last inspection we found there was a risk the provider was not learning from incidents to prevent similar incidents from reoccurring. This was because the registered manager did not always record action taken in response to incidents. In addition the registered manager did not review incidents to identify any trends and patterns so plans could be put in place to help prevent similar incidents from happening again. At this inspection we found the registered manager had improved incident records and had put procedures in place to analyse incidents that occurred.

A relative told us, "We've been through all that [their relatives medicines management by the service], it's all fine." Another relative said, "[My family member's medicines] are never late." At our last inspection we found people received their medicines as prescribed. At this inspection people continued to receive their medicines as prescribed. Medicines were administered, received, disposed of and stored safely.

At the last inspection we found that protocols were not in place to inform staff when to give 'as required' (PRN) medicines to people and at what dose. These included some pain relief medicines. At this inspection we found the registered manager had reintroduced a pain scoring tool to assess people's pain levels. The registered manager had also produced some general guidance for staff to follow in administering as required medicines. However, this guidance was not specific for each person to include whether they were able to ask for the medicine and symptoms staff should look out for, such as non-verbal cues, to indicate they required the medicine. The registered manager told us they would review the guidance for each person's medicines as soon as possible to provide staff with clear and consistent information to follow.

At our last inspection we found staff understood their responsibilities to safeguard people from avoidable harm. At this inspection we found the registered manager continued to ensure staff understood their responsibilities in relation to this, with regular training and discussions of safeguarding topics at staff meetings and supervision. Staff told us they had no concerns about the behaviour of other staff in the team and if they did they would immediately report it internally or to the local authority safeguarding team. Our discussions with the registered manager and staff showed they understood the signs people may be being abused and how to respond to this as part of keeping people safe.

Processes were in place for the provider to manage specific risks to people, such as falling, developing pressure ulcers and becoming malnourished. The registered manager regularly carried out risk assessments and implemented risk management plans based on these to reduce risks to people. These risk management plans included providing people with pressure relieving equipment to reduce the risk of pressure ulcers, repositioning people regularly and providing the necessary hoists and slings to support people to transfer. Some people had bedrails in place to reduce the risk of them falling out of bed. Although there were risk assessments in place regarding bed rails they had not fully considered the risk of entrapment due to gaps between the bed rails and mattress, or of people rolling out of bed due to the bed rails being too low. When we raised our concerns with the registered manager they told us they would follow guidance from the Health and Safety Executive (HSE) in carrying our risk assessments in relation to bed rails and would take prompt action as necessary to mitigate any identified risks.

People and relatives told us there were sufficient staff deployed to meet people's needs. Our observations were in line with this and we saw staff responded to people who required their assistance, including responding to call bells, promptly. Staff told us there were enough staff deployed on each shift during the day time so they were able to care for people safely, without rushing. However, some staff told us that on the night shift one nurse was insufficient if people required high levels of nursing support. When we raised this with the registered manager they told us they were aware of this and were introducing a tool to assess staffing needs across the home. They told us they would introduce extra staff to meet people's changing needs if this was indicated as part of their ongoing assessments of staffing requirements.

Staff recruitment remained robust as at our last inspection. The provider continued to check applicants' qualifications and training, PIN for registered nurses, criminal records, identification, right to work in the UK, health conditions and employment history, including references, from previous employers.

The registered manager continued to manage risks to the premises well. Contracts were in place for external professionals to service and maintain systems including those relating to fire, gas appliances, water safety, portable electrical appliances and call bells. Staff continued to check the safety of the premises and equipment, including the general environment, hot water temperatures to reduce the risk of scalding and fire safety. A programme of renovation and upgrades was in place. The provider recently upgraded the call bell system across the home and had installed air conditioning in the medicine storage room to ensure medicines could be stored at a safe temperature. A conservatory was scheduled to be built later in the year to increase seating options for people as well as an additional staff room and bedrooms to increase the capacity of the home.

Good

Is the service effective?

Our findings

The provider supported staff to care for people through a suitable programme of training. Staff received regular training relevant to the needs of the people living in the home including dementia, safeguarding adults, moving and handling and fire safety. Staff also completed more in-depth training including diplomas in health and social care and end of life care training provided by the local hospice. The registered manager supported new staff to complete the Care Certificate. The Care Certificate is a national induction programme designed to give all new care workers the same knowledge, skills and behaviours when they begin their roles. It covers the basic range of topics all care workers should know as part of their role.

Records showed staff received regular supervision and an annual appraisal. Staff told us they felt well supported by their line managers and were able to use supervision as an opportunity to receive guidance on the best ways to care for individuals. Staff personal development and training was also reviewed during supervision.

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. Staff we spoke with understood their responsibilities in relation to the MCA code of practice. Staff ensured people who had capacity, or fluctuating capacity, to make certain decisions received the right support in making their own decisions. Where people lacked capacity to make certain decisions staff followed procedures to make decisions in people's 'best interests', involving their relatives and healthcare professionals as appropriate.

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). The registered manager applied to the local authority for authorisation to deprive people of their liberty, when necessary, as part of keeping them safe. Staff were aware of which people had DoLS authorisations in place and the conditions attached to these.

A person said, "The food is very good." A relative made a similar comment and added, "My family member has their food [prepared in a way to avoid choking], all staff know and they sit with her [during mealtimes to avoid the risk of choking]." People received choice of food and drink. We observed people eating at lunchtime and saw staff were allocated to ensure people who required assistance to eat, including those who ate in their rooms, received support. Staff provided people with adaptive cutlery and crockery to help them continue to eat independently. The chef had a good knowledge of people's needs in relation to their meals. They understood the specific ways individuals required their food, in line with advice from speech and language professionals, to reduce the risk of choking. They ensured people at risk of malnutrition received regular high calorie food. Staff monitored people's food and fluid intake where there were concerns, and where people received food via PEG (PEG is a feeding tube placed directly into a person's stomach) to make sure they had enough to eat. Staff also monitored people's weight to check their risk of

malnutrition and took action where required. A relative told us, "If [my family member's] weight has gone down they arrange for more [nutritional supplement]."

Staff supported people with their health needs and these needs were documented in people's care plans so staff were aware of them. Records confirmed people regularly saw the healthcare professionals they needed such as GPs, dentists, opticians, psychiatrists, tissue viability nurses and speech and language therapists. A physiotherapist visited the home weekly and people could opt for additional one to one sessions to help them with their mobility if they preferred.

Good

Is the service caring?

Our findings

People and their relatives were all positive about the service and the staff who cared for them. A person told us, "Staff are friendly." A relative told us, "It's brilliant! The staff are lovely!" A different relative said, "We are very pleased. We couldn't be happier".

A relative told us, "They look after [my family member] well." During our inspection we observed staff treat people with dignity and respect. Staff knocked on people's doors and greeted people as they entered their rooms. Staff took care to close doors and curtains before providing personal care to maintain people's dignity. People looked well-groomed because staff took care to ensure they wore clean, matching outfits and their personal care was maintained. In addition people could make an appointment with a hairdresser who visited weekly.

During our SOFI at lunchtime we observed staff supporting people to eat. Staff did not rush, allowing people to eat at their own pace. Staff spoke respectfully to people, explaining what food they were putting on the spoon, checking if people were enjoying the food by asking them or looking for non-verbal signs where people did not communicate verbally.

People and relatives told us staff knew them well. A person told us, "A person said, "The staff know me." A relative said, "All staff know [my family member]". Our discussion with staff showed they knew people's preferences, backgrounds and the people who were important to them. This information was recorded in people's care plans for staff to refer to in supporting people. People's preferences for the gender of care workers providing personal care to them were also recorded in their care plans and staff respected their wishes.

Staff understood people's cultural needs. A relative told us, "They make samosas and chapatti's for [my family member]" and described how the chef accommodated their family members food preferences and sometimes asked their advice on how to cook particular food items.

People were involved in decisions about their care as staff asked people about their views. People's care plans contained information about their ability and areas where they could make choices and how people who could not communicate verbally should be supported to make choices. Staff checked what people preferred to eat for each meal. Staff used pictorial menus and sat with people individually to help them understand and make their choices. The activities officer spent time talking with people and their relatives finding out what activities people enjoyed and delivering an activity programme according to people's preferences.

A professional told us it was always 'lively' with people visiting and professionals around which was 'reassuring'. We observed the service encouraged visitors to maintain people's relationships with those who were important to them and there was a regular flow of visitors to the service.

A professional commented the end of life care was very good. The registered manager continued to work

closely with the local hospice to enhance their practice in relation to end of life care. Hospice staff continued to work with staff, people and their families to develop advanced end of life care plans setting out how people preferred to receive their end of life care. The hospice and community palliative care team worked closely with staff when people received end of life care at the service. Staff told us they had spent time working at the hospice to experience how end of life care should be delivered which was 'a very good experience' and had also completed in-depth training and diplomas in end of life care. The provider continued to work towards achieving the Gold Standards Framework (GSF) accreditation. GSF is a framework for improving the quality and coordination of end of life care.

Good

Is the service responsive?

Our findings

A relative told us, "If there is something I think isn't right I go and see the manager, she puts it right." Another relative told us they had complained and it had been dealt with, "Very well." A third relative told us, "We have nothing to complain about whatsoever. If there is anything [we need] we only have to ask and it's sorted." At our last inspection we found verbal complaints were not always recorded which meant there was no process to review, identify trends and learn from concerns raised verbally. Other aspects of complaints management were appropriate. At this inspection we found the registered manager now recorded verbal complaints along with complaints raised in writing. The complaints process remained appropriate and people had confidence in how the registered manager responded to complaints.

A relative said, "There are plenty of activities. On Tuesday we were cooking. There's a cookery club and a gardening club." Another relative told us, "We have quizzes and bingo and we go on outings two to three times a month. We went to Richmond Park recently." At our last inspection we found there was a range of activities delivered at the service with opportunities for people to access the community. However, there were few opportunities for people to have one to one activities. This meant there was a risk that people who preferred to spend time in their room could feel socially isolated. At this inspection we found an activity officer in post who continued to deliver an activity programme people were interested in, based on input from people and their relatives. This activity programme included regular flower arranging, sensory activities such as food tasting, musical entertainment every Saturday and regular outings such as watching movies at a local church. The activity officer also incorporated one to one activities for people in their activity programme and included people who preferred to stay in their rooms. They also kept appropriate records for auditing purposes. This reduced the risks of people becoming socially isolated.

A relative told us, "[My family member's] care plan is in her room." They let me know if there are any changes." A different relative said, "We review the care plan every month. Most of the time nothing has changed." A professional commented the care plans were 'as good as anywhere' and staff were useful as they knew people well and were able to share the information they required. The registered manager assessed people's needs before they came to live at the home to check they would be able to meet their needs. They gathered information about people through talking with them and their relatives and reading available reports from external professionals such as social workers. People's care plans contained information about people's backgrounds, preferences, daily routines, preferred methods of communication and healthcare needs to help staff understand the people they supported better. People's care plans contained clear information for staff to support people in the best ways for them. The registered manager ensured people's care plans were reviewed monthly, involving people and their relatives as far as possible, to ensure information in them remained accurate and current.

People and their relatives told us staff were responsive to their needs. A relative told us how when staff noticed their family member's legs were swelling they immediately brought over a foot stool and supported her to raise her legs, then arranged an appointment with the GP. When we asked people how promptly staff responded to call bells a person said, "When I press the call bell staff come."

Good

Is the service well-led?

Our findings

People, relatives, professionals and staff were positive about the registered manager and their ability to lead and manage the service. A staff member told us the registered manager had been "very supportive" when their personal circumstances meant they required additional assistance at work. The registered manager had been registered with the service for over four years and was an experienced nursing home manager. Our inspection findings showed they had a good understanding of their role and responsibilities, as did their staff team. The registered manager kept up to date with best practice by attending regular meetings organised by the local authority, the local hospice focusing on end of life care, and by being a member of the Registered Nursing Home Association which specialises in advising and supporting nursing homes.

The provider continued to assess, monitor and improve the quality of service provision and support given to people and staff through various checks and audits. These included regular reviews of people's care plans and risk assessments, people's medical and health needs, checks of aspects of health and safety across the service, staff recruitment and training. The director held regular meetings with the registered manager every two weeks where they reviewed aspects of the service including adapting to meet people's changing needs, repairs and maintenance, safeguarding, staff supervision and training. The registered manager had also successfully improved the service in response to our inspection findings at our last inspection.

A relative told us, "We have residents and relatives meetings every three months with the manager and owner. Then we follow this up with our own meeting [called 'friends of Milverton' and we provide feedback [to the manager]. It's a two way street." In addition to 'relatives and residents meetings' and the 'friends of Milverton' group (a group set up by relatives to support each other and share ideas about the service) the provider sought feedback from people and their relatives through satisfaction surveys.

The registered manager held regular staff meetings which staff told us were useful as they were able discuss issues which were important to their role, share ideas and receive updates on service developments. The registered manager also regularly met with the nursing staff to discuss people's clinical needs and ensure they were being met and to ensure nurses had ample opportunity to feedback on the service.

Staff told us they worked well as a team and shifts were well organised and led by the nurse in charge. Our findings supported this. Staff were assigned clear responsibilities each shift which were agreed at handover. The nurse in charge also ensured a written shift plan was available for staff to refer to. In addition staff told us the registered manager, nurses and director were approachable and listened to any issues they wished to feedback on. In these ways there was clear leadership at the service.

The registered manager submitted statutory notifications to CQC as required by law, including allegations of abuse and police incidents. This meant CQC was able to monitor the volume and nature of these incidents at the service and how these incidents were being dealt with.