Avery Homes (Nelson) Limited

Milton Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Milton Court Care Home is a purpose-built residential care home providing personal and nursing care for up to 148 people aged 65 and over. At the time of the inspection there were 111 people in residence.

The service comprises of six units, Sandringham, Windsor, Balmoral, Kensington, Highgrove and Buckingham. Kensington & Buckingham providing nursing care. Each unit has its own communal areas which includes a lounge, dining room and kitchenette. All bedrooms have en-suite shower rooms.

People's experience of using this service and what we found
Many people we spoke with referred to there not being enough staff and spoke of staff being very busy. Not everyone could tell us how this impacted on their care, but some people were able to express their views. Comments included staff's ability to provide timely personal care, and delays in the serving of their meals. A person told us, "The problem here is the shortage of staff. I got up at 5.55am this morning, I had to wait until 08.30am before they came and did my care. They didn't even bring me a cup of tea." They went onto say, "Sometimes my care is rushed, especially if they are short staffed."

Staff spoke about their roles and responsibilities, which included providing personal care, serving and supporting people with their meals, and completion of records. Staff told us their ability to provide timely and good quality care reflective of their role was impacted by there not being enough staff.

The needs of people had been considered in determining staffing numbers. However, comments received from people and staff indicated that staffing numbers were not sufficient to meet peoples' needs.

We observed staff interactions with people. We found improvements were needed as not all staff communicated with people whilst supporting them. We saw a member of staff remove soup away from a person, which they hadn't eaten. Staff did not ask the person if they wanted it.

Staff did not always enable people to undertake daily living activities as they did not always ensure people with the necessary items. For example, we saw a person being given their breakfast, they asked if we would get their dentures. We asked a member of staff who found them. The person told us they couldn't eat without them.

Staff were critical of the registered manager and management team. Staff spoke of not feeling valued, appreciated, or listened to. Staff spoke of poor communication and expressed improvements to communication and the opportunity to share their views as being a priority.

Views about meals were mixed, some stated they were of good quality and they enjoyed them, whilst others said the quality was not very good and sometimes their meal was cold.

A majority of people spoke positively about the staff. A person told us, "Some staff are excellent, kind and

they listen to me, generally speaking they are excellent and respectful." We saw positive staff interactions with people. A person who was distressed was being comforted by a member of staff, talking with them and making eye contact.

People's needed were assessed and documented. However, we found improvements were needed to ensure people's care needs were consistently documented throughout their records.

People's medication was administered safely. The service was clean and tidy. The registered manager worked in line with government guidance for COVID-19 infection prevention and control measures, including visiting arrangements of family members.

Staff said some changes had had a positive impact. Staff spoke well of the support they received from their immediate staff team and spoke positively about their training.

The registered manager had taken up their role in January 2021. The registered manager and regional manager had identified improvements were needed and had developed an action plan detailing their priorities to bring about change.

Systems and processes to monitor the quality of the service and review risk were in place. The registered manager and senior managerial staff who visited the service, undertook a range of audits to assure themselves as to the quality of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 29 December 2017).

Why we inspected
The inspection was prompted due to whistle-blowing concerns received about staffing levels. A decision was made for us to inspect and examine these risks. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Milton Court Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified a breach in relation to their being insufficient staff to meet people's needs consistently, and in a timely way at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Milton Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors, a specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Milton Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service short notice of the inspection on the first day of the inspection. We telephoned and spoke with the registered manager and informed them of our inspection 15 minutes prior to entering the service. This was to help the service and us manage the risks associated with COVID-19.

The registered manager was informed the inspection would be carried out over two days and that we would be returning the following day.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require provides to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group (CCG) who commission with the service. We used all of this information to plan our inspection.

During the inspection
We spoke and met with 35 people who used the service and two family members about their experience of the care provided. We spoke with 21 members of staff including the registered manager, deputy manager, regional manager, unit managers and nurses. We also had discussions with unit managers, senior care workers, care workers, a well-being and activity co-ordinator, a well-being and activity assistant and the house trainer.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including monitoring of quality and risk, policies and procedures and minutes of meetings.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The registered manager shared their development action plan and information related to hours staff worked.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● All staff directly responsible for providing personal care told us there were not enough staff to meet people's needs in a safe and timely way. A staff member told us, "At every supervision session I bring up the problem of staffing and the concerns I have of not having sufficient staff to meet people's needs. Nothing ever happens, we are told it's what we have, and have to work with it." A second staff member said, "We have to keep people waiting, buzzers go off a lot because people want to get up, but we can't help them when they need it. It's very stressful."

● Staff spoke of the impact of there not being enough staff. Some told us they had to 'borrow' staff from other units, which impacted on the other unit. A staff member said, "We always have to borrow from other floors, leaving them short." And, "We often take too long to answer a bell as we are giving care to someone else."

● People spoke of the impact of their not being enough staff. A person told us, "Sometimes my care is rushed, especially if they are short staffed." A second person said, "My breakfast was very late this morning." A person told us they hadn't had their breakfast, and at that time it was 09:44am.

● The registered manager had calculated staffing numbers based on people's needs. However, the assessment of staffing levels did not reflect people's and staff comments. A staff member spoke of their role in providing a range of support, which included personal care, meals and completion of records. They told us, "A lot of the time people who want to get up before breakfast have to wait, because we can't do breakfast and personal care at the same time. The night staff get those people who need hoisting up before we arrive, but it's not always their [person's] choice."

● Audits of call bell response times evidenced they were in the main answered promptly. However, audits do not record whether staff provided the care and support the person required when responding to the call bell. A member of staff told us, "I do hear call bells ringing for a long time sometimes. I think staff go in and turn them off, they say 'I will be with you in a few minutes' but are longer than a few minutes. It's a very unsettled time at the moment and staff and residents are being affected."

We found no evidence that people had been harmed. However, people and staff spoke of the impact on the quality and timeliness of care delivery, which placed people at risk. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had confirmed plans to introduce a new 'twilight shift', which would provide an additional member of staff on a nursing unit.

● Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). Records

were in place to evidence nursing staff were registered with the Nursing and Midwifery Council (NMC).

Assessing risk, safety monitoring and management

● Risk assessments were in place to reduce potential risks to people. However, these had not always been reviewed promptly, and information within other records was contradictory. For example, a person's daily notes reflected they were to be supported by two staff when walking as they were unsteady on their feet. However, the person's falls risk assessment, personal emergency evacuation plan and mobility care plan did not reflect these changes, these documents recorded the person walked independently with a zimmer frame (walking aid).

● Referrals were made to an appropriate health care professional where risks to people's health and welfare had increased. For example, when people were at risk of choking, they were referred to a speech and language therapist, and where people lost weight a dietician was contacted.

● Equipment used by staff to promote people's health and welfare, for example pressure relieving mattresses, hoists and other moving and handling equipment were maintained and used in line with manufactures' recommendations.

● People using the service spoke of feeling safe at the service and the reasons for this included, access to specialist equipment and having staff and others close by. A person told us, "Oh yes I feel safe here. It's all on one level so I don't have to use stairs, I can go in the lift. They got me this walking frame which makes me feel safer."

Using medicines safely

● Some areas of medicines management needed to be strengthened. For example, a person was prescribed different medications for the management of their pain. However, there was no guidance for staff as to which medication type, or the circumstances in which the medicine was to be given. The registered manager following our site visit informed us PRN protocols had been updated.

● We saw staff were patient and provided support and information to people when they administered their medication.

● Medicines were received, stored, administered and disposed of safely. Staff involved in handling medicines had received training in the administration of medication, and the electronic medication administration record system.

● People who were able to speak with us about their medication raised no concerns, a person told us. "I have no complaints about my tablets. The staff are very good at making sure I get them."

Systems and processes to safeguard people from the risk of abuse

● Staff were trained in safeguarding procedures and they knew what action to take to protect people from harm and abuse, and knew who to raise concerns with, including external organisations.

● The registered manager followed local safeguarding protocols and worked with the local authority to safeguard people and keep them safe.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.

● We were assured that the provider was accessing COVID -19 testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Many people spoke to us of the cleanliness of the service. A person told us, "It's wonderfully clean, spotless, they [staff] are always cleaning."

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● An analysis of accidents, incidents, safeguarding concerns and key aspects documenting people's care was undertaken monthly by the manager. Analysis of audits showed key information was accurately cross referenced across several documents, and any actions required were undertaken.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●Systems and processes to engage with staff to enable a positive culture and promote good outcomes for people was not effective.

● Staff spoke to us of low morale amongst the staff team, some spoke of not feeling valued or appreciated. A staff member told us, "Staff morale is low at the moment. I think it's because of a mixture of things, staff shortages, new management, lots of changes." A second staff member told us, "I feel undervalued." Another member of staff said, "I feel unwanted, and isolated. For the first time ever, I feel I don't want to continue working at the home. It's only for the residents I stay here." And another said, "It's very low [morale], everyone is feeling exhausted and feeling pressured. We are losing some good staff."

● Staff views were mixed as to whether the registered manager was approachable and visible in the service. A staff member told us, "I don't think [registered manager] is very approachable. They certainly haven't made any effort to get to know the staff team. They are not one of those managers who is always around, so far they haven't made a good impression." A second staff member told us, "I think the changes are good, however communication is poor. Messages get passed on through the senior [staff] or by a memo. The manager is not very visible, and they don't communicate well."

● The quality of staff interactions with people were mixed. Staff in some instances supported people with minimal or no conversation or involvement, whilst other staff were seen providing reassurance and comfort when people were upset and distressed.

● Most staff spoke positively of the introduction of a revised format and time of staff handover. They told us, "We now have a walk around handover, discuss any appointments for the day etc." Another member of staff told us, "Handovers have improved, we now do physical checks on all service users at the start of the shift."

● Staff spoke positively of their individual unit teams, stating staff worked together and supported each other. A staff member told us, "We have good team working, we are all very good to each other, we help each other out and we are cheery."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● A registered manager was in post and had taken up their role in January 2021.

● Staff spoke of not being listened to and some spoke of poor communication from the registered manager and management team. A staff member told us, "I am not averse to change, but I feel sometimes things have not changed for the better." Another member of staff told us, "Communication is poor. We had a senior staff

meeting recently which was the first meeting we have had. It was much needed, and we were able to give our views. They [management team] don't really seem to want to listen."
● Minutes of meetings for heads of department predated the appointment of the existing registered manager. The registered manager acknowledged they had not yet had a meeting with the care staff team, and that they would arrange to meet with staff soon.
● The registered manager implemented the provider's systems and processes to monitor the quality of the service, which included routine auditing and analysis. For example, safeguarding concerns and accidents and incidents were reviewed monthly and any themes or trends identified.
● The registered manager understood their role and responsibilities and was supported by a senior management team who visited the service as part of the providers monitoring of the service.
● Notifiable incidents were reported by the registered manager to the Care Quality Commission (CQC) and other agencies.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood and complied with the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, and providing truthful information and a written apology.
● The registered manager had responded in writing to complaints, addressing all aspects of the concern individually. Letters outlining the outcome of their investigation included an apology and any action to be taken as a result of their findings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager stated as far as they were aware the views of people using the service, their family members and those of staff had not been sought through the sending out of questionnaires or a survey.
● Meetings with family members had been held since the recent appointment of the new registered manager via video conferencing during the COVID-19 pandemic. Minutes of the meetings showed family members were updated as to the impact of COVID-19 on the service, and government guidance in relation to visiting arrangements had been shared and discussed.
● A face to face meeting of people using the service had taken place, specifically to seek their views about the quality of meals and the menu. In response to comments received, changes had been made to the menu and the dining experience.

Continuous learning and improving care
● Clinical risk registers were in place, which focused on key aspects of people's care. For example, catheter care, end of life, wound management and weight monitoring. These were undertaken monthly by each unit and reviewed by the registered manager to ensure action was being taken where appropriate to improve outcomes for people.
● Staff spoke positively about the training they received, and some spoke of training in key areas to enable them to provide care to people to support their health care needs. Some staff spoke positively about the direct support they received through their supervision with their line manager.
●The registered manager undertook a range of audits and root cause analysis in key areas, which included monitoring of people's care, medication, infection prevention and control, and reviewing of accidents and incidents.
● Regional managers visited the service as part of the provider's quality monitoring. Visits focused on quality monitoring and auditing a range of areas. For example, management, health and safety, records documenting people's care, the environment, speaking with people and staff. Reports as to their findings of

their visits included areas for improvement and these were kept under review.
● The registered manager, in conjunction with a regional manager had recognised improvements were needed. Following the inspection, they shared with us an action plan, which included timescales for achievement. Key areas for development focused on staffing and their deployment, skill mix of staff, improvements in communication with and within teams, recruitment of staff to vacant positions and continued improvements within the catering department.

Working in partnership with others
● The registered manager spoke of their contribution in the development of a pilot scheme with Milton Keynes local authority. The aim of the scheme was to improve the outcomes for people living with dementia through the development of training for staff in dementia care. Services would work towards attaining a bronze, silver or gold award.
● The local authority and Clinical Commissioning Group informed us the registered manager had proactively engaged well with them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service did not receive timely or consistent care as there were insufficient staff to meet their needs.