Milkwood Care Ltd

Milkwood House 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 effective?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 March 2015. Breaches of legal requirements were found. We issued warning notices for breaches in relation to medicines, care and welfare, safeguarding people from abuse, and assessing and monitoring the quality of service provision. We issued compliance actions for the remaining breaches. These related to: requirements relating to workers, supporting workers and records. The provider was required to meet the requirements of the warning notices by 4 May 2015. Following the comprehensive inspection, the provider submitted a report of actions and informed us that they would meet the requirements of the compliance actions by 10 May 2015.

We undertook this focused inspection to check that the provider had met the requirements of the warning notices and followed their action plan to address all regulatory breaches, and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Milkwood House Care Home' on our website at www.cqc.org.uk.

Milkwood House Care Home is a 43 bed residential care home registered to provide care for older people who may experience dementia. At the time of the inspection there were 29 people using the service.

Summary of findings

Since the previous inspection the registered manager had left the service and a new manager had been appointed. They told us they would be submitting their application to become the registered manager for the service shortly. 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.

Medicines were safely administered and recorded as prescribed. However, although the provider had taken action to ensure medicines were stored at the correct temperature they had not fully resolved this issue to ensure people's medicines were effective. There was variation in the level of detail contained within care plans to support people whose behaviour may challenge, and for people with breathing or heart conditions, who may require emergency medicines. This meant staff may not have access to sufficient guidance to support people safely.

People were safe from the risk of abuse. Staff had undertaken safeguarding training and understood their roles and responsibilities to protect people. Staff documented all incidents to ensure there was a record of any injury people had sustained. The manager had referred people to the local authority safeguarding team where relevant to safeguard them. People whose behaviours may present a risk to themselves or others had been referred to relevant professionals such as the Community Mental Health Team to ensure they received the support they required.

If people experienced a fall, staff followed the provider's falls protocol to ensure they received the support they needed to promote their safety. Risks to people had been assessed and managed appropriately.

Staff had been required to provide a full record of their employment history to ensure their suitability to work with people.

Staff were required to undertake the care industry standard induction training. They had completed a range of training to support them in their role and there was a rolling programme of training for staff across the course of the year. Staff received regular supervision. People were cared for by staff who were supported effectively in their role.

People were weighed regularly. If they were identified as at risk from weight loss, staff took action and referred them to the GP for review. Risks to people associated with malnutrition were identified and managed effectively.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager had submitted DoLS applications to the local authority for people who lacked the capacity to consent to their care and treatment. People were protected from the risks of any controls on their liberty being unlawful.

The audit and reporting systems were being operated effectively in order to identify issues that could impact upon the quality of people's care or their safety. Consideration had been given to people's feedback about the service. People were protected as their records were complete and contained appropriate information. Records were easy to locate and stored safely.

The provider had taken sufficient action to meet the requirements of the warning notices and compliance actions. In relation to care and welfare, safety, assessing and monitoring the quality of service provision, requirements relating to workers, staff support and records. The provider needed to make further improvements to medicines in order to fully meet the requirements of this regulation.

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

Summary of findings

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

We found actions had been taken but people were not always safe.

Actions had been taken to protect people against the risks associated with medicines. However, further work was required to fully ensure people's safety.

Staff understood how to safeguard people. Relevant referrals had been made to professionals and the local authority to safeguard people from the risk of abuse.

Risks to people had been identified and managed to ensure people were safe.

The recruitment process ensured all of the required evidence in relation to staff was available to protect people from unsuitable staff.

This meant that the provider was now meeting legal requirements in relation to care and welfare, safeguarding people and requirements relating to workers. Further improvements were required to ensure the provider fully met the regulations in relation to medicines.

Is the service effective?

Requires improvement

We found action had been taken to improve effectiveness.

Staff had received an induction, training and supervision to ensure they were able to effectively provide people's care to the required standard.

People had been adequately protected against the risks of malnutrition or dehydration.

Where people were deprived of their liberty this was legally authorised.

This meant that the provider was now meeting this legal requirement.

This key question has been rated as requires improvement because there has not been enough time for the demonstration of consistent good practice in all areas.

Is the service well-led?

Requires improvement

We found action had been taken to improve the leadership of the service and the monitoring of the quality of people's care.

Systems had been used effectively to monitor the quality of the service people received.

People's records were complete and could be located promptly.

This meant that the provider was now meeting this legal requirement.

Summary of findings

This key question has been rated as requires improvement because there has not been enough time for the demonstration of consistent good practice in all areas.

Milkwood House 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.

We undertook an unannounced focused inspection of Milkwood House Care Home on 8 June 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 9 March 2015 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe? is the service effective? and is the service well-led? This is because the service was not meeting some legal requirements in relation to these questions.

The inspection was undertaken by an inspector and a pharmacist. During the inspection we spoke with four people and a district nurse. We also spoke with the manager and the registered manager from another of the provider's services who was supporting the manager. We spoke with the Group Operations Manager, the deputy manager and three care staff. We reviewed records relating to nine people's care and support such as their care plans, risk assessments and charts documenting the care provided. We observed staff interactions with people and a staff handover. We reviewed records relating to the management of the service, three staff recruitment files and five staff supervision records. We used this information to consider whether the provider had taken sufficient actions to address the breaches of the Regulations found in March 2015.

Requires improvement

Is the service safe?

Our findings

At our inspection on 9 March 2015 we found people had not been adequately protected against the risks associated with the unsafe use of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Staff had not adequately recorded incidents involving people or considered whether they should be reported under safeguarding procedures. Staff had not referred people to outside agencies, such as the local authority safeguarding team following incidents to ensure people received the care and support they required. Not all staff had received training in safeguarding people. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People had not always been adequately monitored following a fall to ensure their safety. The risks to people from choking had not been assessed. People did not always have relevant risk assessments in place. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Not all staff had provided a full employment history, to enable the provider to fully assess their suitability to work with vulnerable people. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our focused inspection on 8 June 2015 we found that the provider had met the requirements of the warning notices in relation to the requirements of Regulations 9, 11 and 13 described above. However, the provider needed to make further improvements to medicines to ensure they fully met the requirements of this regulation. The provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 21 described above.

Improvements had been made in relation to medicines administration, medicines storage, the availability of medicines for people and information to support the administration of medicines. However, the provider needed to make further improvements to ensure they fully met the requirements of the regulation. Which requires people's medicines to be managed properly and safely.

Whilst medicines requiring refrigeration were stored within the recommended temperature range, the room temperature records indicated the medicines storage room was exceeding the recommended temperature for some medicines. The service had an action plan to resolve the issue that had not been fully implemented. The service had a portable air conditioner however; this was not always effective. This meant people's medicines may not have been always been stored correctly.

People's Medicines Administration Records (MARs) were complete. Staff explained how they applied creams to people as part of their personal care, and records confirmed creams were applied. However, not all eye drops and liquid medicines had a date of opening and may not have been within their recommended date of usage, which placed people at risk of receiving ineffective medicine.

Information to support staff in the administration of medicines was available, including people's ability to indicate their needs verbally or by other means. However, the service had recently changed community pharmacy and three people had discrepancies in their allergy information, which the provider agreed to follow up. The service has suspended homely remedies and arranged for a GP to prescribe all medicines. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds. A person had received covert medicine. The service acknowledged this remained outstanding and they were awaiting specialist pharmacist advice from their new community pharmacy provider. People remained at risk of harm as medicines had not been managed safely.

Whilst the effectiveness of medicines was monitored, care plans were occasionally not fully documented. We reviewed one person's records who was prescribed a medicine that required monitoring. The clinic letters, dose changes and subsequent test dates were within their care plan. Seven people were prescribed medication for four medical conditions. The associated care plans for four people contained details of the medical condition and when and how the relevant medicines should be taken. However, for three people with one medical condition; one medicine had been omitted from their care plans. This left them at risk as staff did not have access to relevant guidance.

The failure to fully protect people from the risks associated with the unsafe management of medicines was a

Requires improvement

Is the service safe?

continuing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person commented "I feel safe in the care of staff." The manager told us all but three care staff had completed safeguarding training and arrangements had been made for these staff to do so shortly. Records confirmed this. Staff were able to demonstrate their knowledge of how to safeguard people and were familiar with the relevant policies and procedures. They understood the types of abuse people might be at risk from, and the reporting procedures to raise concerns.

If staff had observed people had a bruise they had completed an incident form. This contained a body map to document exactly where on the person the bruise was first seen and the actions staff had taken, for example alerting the GP. This ensured there was a clear record of when and where any bruises had been noted in order to inform any investigations. Where potential safeguarding incidents had occurred staff had documented them and alerted senior staff. The manager told us since the last inspection they had made three referrals to the local authority safeguarding team, which records confirmed. Where they had been unsure if other incidents required referral they had sought advice from the local safeguarding team to ensure people were safe. If people's behaviours presented a risk to themselves or others the manager had taken action to refer them to relevant professionals, such as the GP or the Community Mental Health Team, for assessment and further advice. This ensured people received the support they required. People were kept safe as staff had received relevant training and took the correct actions to protect people from the risk of abuse.

People felt safe in the care of staff following a fall. One person commented "Staff care for me well if I have a fall." Staff were required to follow the provider's falls protocol. This described the actions they should take, including completing an incident form and documenting the fall in the person's daily records. Staff understood the falls protocol and had informed relevant people such as the GP and family. Following a fall people had been reviewed by a GP when required and changes had been made to their medicines or care plan. Staff updated people's falls records to enable them to monitor the frequency of people's falls and any patterns in factors such as the time of day. When people experienced a fall staff took the correct actions to manage the risk of them experiencing future falls.

Risks to people had been assessed. Where a risk had been identified people had a care plan in place to manage the risk and protect them from harm. Some people had been assessed as at risk of developing pressure ulcers and had been referred to the district nursing service. We spoke with a district nurse who told us nobody was being treated for a pressure ulcer. They said staff provided people with the correct pressure care to protect them from developing ulcers. Not all people identified as at risk had a specific skin care plan. Risks associated with them developing a pressure sore were addressed within their personal hygiene care plan. We discussed this with the manager, as a specific skin care plan for these people would have provided clearer guidance for staff. The manager took immediate action and ensured these people had a specific skin care plan. People's records included a choking risk assessment to ensure any risks to people from choking were identified and managed safely. People were safe as risks to them had been assessed and risk management plans were in place.

Some people remained in their room during the inspection. We checked on these people across the course of the inspection and found staff had supported their identified care needs. For example, people had been supported to change their body position either in their room or whilst on bed rest, as required. Staff told us they knew who required regular checks through their staff handover. However, there was no record to demonstrate how often staff had checked upon them. We discussed this with the manager who took action and introduced a record sheet for staff to complete. We checked upon people later during the inspection and saw staff had completed each person's record sheet to demonstrate when their welfare had last been checked. People were safe as their welfare had been monitored and the manager took action to ensure these checks were documented.

Following the amendment of the provider's staff application form the provision of a full employment history including any breaks from employment was now a requirement. This was to enable the provider to fully assess people's suitability to work with people. The deputy manager said all existing staff had been required to

Requires improvement

Is the service safe?

complete their full employment history, and records confirmed this. People were safe as the provider had taken action to ensure the required pre-employment for all staff were complete.

Requires improvement

Is the service effective?

Our findings

At our inspection on 9 March 2015 we found staff had not been required to undertake the social care industry induction standards, or sufficient training and supervision. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The risks to people from malnutrition had not been managed effectively. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Adequate arrangements were not in place to ensure the use of any form of control used with people was not unlawful or excessive. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our focused inspection on 8 June 2015 we found that the provider had met the requirements of the warning notices in relation to the requirements of Regulations 9 and 11 described above. The provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 23 described above.

The deputy manager said since the last inspection "Staff feel supported" and a person commented "Staff know what they are doing." The deputy manager told us the provider now required and supported staff to complete the social care industry induction standards, and records confirmed this. The provider had identified a range of required training to enable staff to provide people's care effectively. This included areas such as safeguarding, moving and handling, fire safety, infection control, first aid, medicines, dementia care and the Mental Capacity Act (MCA) 2005. Staff confirmed they had undertaken training since the last inspection. The provider had arranged an ongoing training programme for staff across the course of the year. Staff told us they were now receiving regular supervision and records confirmed this. Staff supervision records demonstrated what had been discussed with staff. They showed staff were being supported with their ongoing development either through completing further qualifications or undertaking lead roles for specific areas within the service, such as end of life care or continence. People were cared for by staff who were sufficiently trained and supported to carry out their role effectively.

People told us "They [staff] weigh us regularly." Staff told us people were weighed monthly, and those assessed as at risk from malnutrition were weighed weekly. Records confirmed this. The manager said senior staff had been trained in how to complete the Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults who are at risk from either malnourishment or being overweight. People's MUST had been calculated and reviewed regularly. People's nutritional care plans provided staff with guidance about the action they should take if a person was malnourished, such as referring them to the GP and giving them fortified milkshakes. Records confirmed staff had taken these actions to ensure people were supported to meet their dietary needs. When fluid charts were being used to monitor people's fluid intake, staff had accurately recorded the amount of fluids they had drunk across the course of the day. Staff had written guidance about how to calculate the volume of fluids. When people's food intake was being monitored using a food chart, staff had accurately recorded how much of each meal people had eaten. The risks to people from malnutrition were managed effectively.

The Deprivation of Liberty Safeguards (DoLS) protect the rights of people, by ensuring where there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The deputy manager told us staff had attended DoLS training and knew who was subject to DoLS. They showed us the prompt cards staff carried with key information about the MCA 2005 and DoLS. The manager told us where they believed the person lacked the capacity to consent, they had completed an assessment of that person's ability to consent to receive care and treatment. As a result applications had been made to the local authority to authorise the deprivation of liberty for 21 people. Some of the applications had been authorised and others were still being processed. People's records in relation to DoLS were stored on their files to enable staff to have ready access to information about the restrictions placed upon people's liberty. Some staff had completed challenging behaviour training to enable them to more effectively manage people's behaviours that may challenge staff. Where people lacked the capacity to consent to their care and treatment their rights had been protected, as the provider had followed relevant legislation and guidance.

Requires improvement

Is the service well-led?

Our findings

At our inspection on 9 March 2015 we found the provider had not effectively operated their systems to monitor the quality of the service provided and identify risks to people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People's care records had not been accurately maintained, and were not easily located. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our focused inspection on 8 June 2015 we found that the provider had met the requirements of the warning notice in relation to the requirements of Regulations 10 described above. The provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 20 described above.

Various aspects of the service had been audited since the last inspection including medicines, the use of bedrails and wound care for example. The most recent medicines audit demonstrated that actions had been taken to resolve concerns identified by the previous audit. The audit had identified the ongoing issues with the temperature of the medicines room. The manager informed us that since moving to a different community pharmacy they were in the process of scheduling an external audit. People were safe as systems to monitor the safety of medicines were being used effectively. The auditing system identified areas of the service requiring improvement. For example, a person's records had been audited and it was identified they needed a care plan; action was taken to complete this. The findings of the nutrition audit demonstrated that people received effective nutritional support. The Group Operations Manager explained that as the manager was new in post they had not yet completed their quarterly quality audit for this service. However, following the previous inspection they had revised their own audit methodology to include a review of the records audited by managers, to ensure the accuracy of reporting. The provider had reviewed and adjusted their auditing process to ensure a more thorough and effective analysis of the audit results. People were protected as audits were being completed effectively to drive improvements in the quality of the service.

When an incident occurred the manager told us they reviewed the incident forms, signed them and discussed the incident with staff where required. Staff documented the incident in people's daily noted and on an incident form to ensure incidents were cross referenced. Required follow-up actions were identified and completed to protect people from the risk of repetition, records confirmed this. People were protected as the provider was using their systems to assess potential risks to people effectively.

Due consideration was given by the provider to feedback about people's care. One person told us "They give you a chance to express your views. They take action if you are not happy." Records showed the views of people, relatives and staff had been sought through meetings. At the relatives meeting on 13 May 2015 people's relatives were updated on progress on the falls protocol, and how the service was managing people's weight loss. Relatives were encouraged to speak with the manager about any issues they wished to raise. Records showed the manager had responded to a complaint they had received, acknowledging the points made and stating the actions they planned to take in response. The manager told us customer care forms were due to be sent out at the end of July 2015. This would enable people to provide formal feedback on the quality of the service. People's feedback was being listened to.

People's records were completed fully. One person had a behaviour chart and an associated behaviour care plan in place. The behaviour chart showed the date, the trigger, the behaviour and the support provided to the person. This enabled staff to clearly document the person's behaviours to inform discussions with the Community Mental Health Team in relation to meeting the person's needs and identifying the most appropriate support for them. The deputy manager told us a client of the day system had been introduced to ensure all people's care plans and records were reviewed on a set day each month.

People's records had been moved within the service to ensure they were secure but easily accessible for staff. People were protected as their confidential records contained complete and appropriate information, and were stored safely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The failure to fully protect people from the risks associated with the unsafe management of medicines was a continuing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.