Iceni Care Limited

Mill Lodge

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

Summary of findings

Overall summary

About the service:
Mill Lodge provides care and support for up to three people with learning disabilities. On the day of our inspection three people were living in the service.

People's experience of using this service:
People living at the service told us that staff were kind and caring. People felt listened to and well supported.

Further improvements were needed to ensure care plans and risk assessments were accurate and sufficiently detailed. Environmental risks had not always been addressed promptly to ensure people lived in a safe environment.

There were auditing systems in place, but these had not identified the issues we found during this inspection.

People were supported by staff to take their prescribed medicines. Improvements were required where people were away from the service on social leave to ensure best practice was being followed and that people received their medicines in the safest way. The provider was in the process of addressing this.

Staff understood the importance of supporting people make their own decisions and followed the principles of the Mental Capacity Act 2005 when delivering people's care. However, the service needed to implement a system to ensure that any DoLS were reviewed promptly and new applications made where necessary.

There were sufficient staff working in the service. Recruitment procedures were in place to ensure staff were suitable for their roles.

Food and fluid charts were in place for people at risk of malnutrition or dehydration so staff could monitor this.

People had regular access to activities they enjoyed. People were encouraged to take part in activities which helped them gain confidence and feel they were positively contributing.

Staff understood the need to keep people safe from abuse and what was required to do this. Staff had received training in this area, and were clear they would report concerns to a manager or appropriate outside agency without delay.

Each person had their own bedroom with a communal lounge, dining room and kitchen that they could access.

The service worked within the principles and values that underpin Registering the Right Support and other

best practice guidance. This ensured that people could live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

Rating at last inspection:
At the last inspection the service was rated Good. (Report published October 2016).

Why we inspected:
We inspected this service in line with our inspection schedule for services currently rated as Good.
Enforcement:
Action we told the provider to take is outlined at the back of the report.

Follow up:
We will continue to monitor this service according to our inspection schedule in line with the rating of 'Requires Improvement'.

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

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 effective?

Requires Improvement

The service was not always Effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was Caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Details are in our Well-led findings below.

Mill Lodge

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
One inspector carried out this inspection on 24 April 2019.

Service and service type:
Mill Lodge is a residential home that is registered to provide accommodation and personal care to a maximum of three people. At the time of our inspection, three people were living there. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. 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:
This inspection was announced. We gave the service 24 hours' notice of the inspection visit because it is small and we needed to be sure that the manager was available to meet us.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We also contacted the local authority and safeguarding team for feedback about the service.

During the inspection, we spoke with three people who lived at the service. We carried out observations of people receiving support. We spoke with the registered manager, residential services manager, a director, a social worker, and two members of support staff who worked at the service. Following the inspection, we spoke with one relative.

We looked at two care records in relation to people who used the service. This included medicines records. We also looked at two staff files as well as records relating to the management of the service, recruitment, policies and systems for monitoring quality.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

- Risk assessments were in place and included areas such as oral health, nutrition, mental health, and safety related risks. However, these had not always been updated fully.
- Where people might be deemed as at risk at certain times due to changes in their presentation, there was not sufficient guidance for staff on what action they should take in these circumstances.
- Some people experienced periods where they felt upset or distressed, but there was not always guidance in place for staff so they knew how to support people effectively in these circumstances.
- There was a fire risk assessment in place, which had a suggested review date of 2017. Within this we found recommendations were made which included improvements in escape routes and measures to limit the spread of fire within the building. We were advised that there had been an unfortunate oversight and these recommendations had not been completed.
- We found the main boiler was housed in an unsecured cupboard with exposed hot pipes, which posed a potential risk of a person burning themselves if they came into contact with them.

This above constitutes a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider informed us that a fire risk assessment and servicing was scheduled for 3 May 2019, where the necessary recommendations would be addressed as required.
- Some wardrobes had been secured to the wall to prevent the risk of furniture falling on people. There were still some wardrobes which needed to be secured to the wall, but one person was still deciding where in the room they wanted this located.
- Emergency plans were in place to ensure people were supported in the event of a fire. None of the people living at the service had mobility difficulties, but some would need reassurance to leave the building promptly. Fire drills were carried out at the service, so people were familiar with the sound of the alarm and what to do in the event that they needed to evacuate.
- There were systems in place to ensure that water systems were monitored to prevent the risk of legionella.

Staffing and recruitment

- People told us they thought there were sufficient staff on duty. One person said, "Always staff around when I need them." A relative told us, "Whenever I go in there are staff available."
- There was one staff member available at the service over the 24 hour period. People were often out during the day at the nearby day centre, or out in the community. Additional staff were available if needed at the

provider's other locations, and staff told us they worked across the locations when needed. One staff member said, "Staffing is ok, there is the odd occasion if someone is poorly, but staff do come over quickly if needed. And there is an 'on call' manager always on the end of the phone." Transport was provided by day centre staff for people who needed it to attend.

● Safe recruitment procedures were followed. Records showed that appropriate checks were in place to make sure staff were suitable to work in this type of service before they started work.

Using medicines safely

● People were supported by staff to take their prescribed medicines. Staff were trained in administering medicines and received observed competency checks.

● Where people were going to be out for the day, staff had been 'secondary dispensing' medicines. Secondary dispensing is when medicines are removed from the original dispensed containers and put into pots or compliance aids in advance of the time of administration. This is not considered good practice as this process removes the safety net of checking the medicine, strength and dose with the medicine administration record (MAR) and label on the medicine.

● The residential services manager told us that a recent training provider had highlighted this as a potential risk and they were already taking action to change their practice.

● There were no instructions on how people liked to take their medicines. For example, with a glass of water, or with food. The provider told us that people were able to communicate how they wished to take their medicines, and therefore did not feel this was necessary.

Systems and processes to safeguard people from the risk of abuse

● The provider had safeguarding systems in place and all staff interviewed had a good understanding of what to do to make sure people were protected from harm or abuse. They had received appropriate training.

● People told us they felt safe living in the service. One person said, "Nice staff. They are alright, kind, they listen to me." Another said, "All the staff are nice here."

● There had not been any recent safeguarding referrals made by the service. The provider told us there had not been any incidents which would warrant a referral.

Preventing and controlling infection

● Staff had access to personal protective equipment such as gloves and aprons to prevent the spread of infection.

● Staff received training in infection control and food hygiene.

● The communal areas of the service were clean. People were encouraged to keep their own rooms clean, but support was given where needed, and where people agreed to this.

● The carpet in one person's bedroom had a malodour and looked like it needed to be replaced. We brought this to the attention of the provider, who confirmed following the inspection that they had arranged a replacement carpet to be fitted, along with any others that looked in need of renewing.

Learning lessons when things go wrong

● During a recent team meeting we saw that lessons had been learnt and safer systems were planned to improve the process for people when taking their medicines away from the service.

● Management were keen to develop and learn from feedback. During the inspection visit we discussed areas for improvement in relation to care documentation and the environment with the residential services manager. They were committed to making the changes promptly to enhance people's care.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance

●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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met."

● No one living at the service had a current DoLS application. Some people's care needs indicated that these may be required to ensure that care was lawful. The residential services manager told us that one person had an urgent DoLS in place but this had expired in March 2019. When we advised them that a new application should have been made, they submitted an application immediately.

● The service did not have a log in place of DoLS applications made so they could monitor when applications were made and ensure they were reviewed when needed.

● For one other person, the service had liaised with their social worker, who confirmed with us that they were making the necessary DoLS application.

● People told us that staff always asked for consent before supporting them with tasks. One person said, "They [staff] always ask my permission to help me."

● Staff understood the importance of supporting people make their own decisions. One staff member told us, "[Person] only responds if they know you well. [Person] can make some decisions, not the more complex ones. We [staff] try and get people to make their own decisions. For example, we try and get [person] to make the right decisions about food by telling them the healthier options available and why that might be better for them."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The service used technology to improve communication between staff via a mobile phone application. Staff used this to discuss shift changes or if they wanted to advise of sickness. The registered manager told us that any information relating to people should be made via a phone call, or if the application is used, that only people's initials were used.

● We advised the registered manager to review the use of the application to share information, and ensure this met GDPR (General Data Protection Regulation) requirements. Any electronic systems in use to transfer

confidential information must have robust security systems in place. They agreed to review their policy relating to this.
● Care records contained information related to people's medical history, personal care, medicines, mobility, nutrition, communication, and keeping safe.
● Assessments were obtained from health and social care professionals prior to people coming to live at the service. These were used to help plan people's care.

Staff support: induction, training, skills and experience
● Staff received training relevant to their role, which included safeguarding, the MCA, medicines, moving and handling, first aid, and food hygiene. Other relevant training such as Autism and managing challenging behaviour had either been completed, or was scheduled to take place in May 2019.
● One staff member told us, "We have a training provider that comes in to do the training they are very good. If there is anything more specialist we need, such as if someone had a stoma, we could ask for this."
● There was an induction process for new staff, which included training, spot checks, and shadowing of experienced staff. One staff member told us, "I worked for two weeks, I was given shadow shifts, they did say if it wasn't not enough I could do extra, it was left up to me. Time was also given to read all of the care plans and be introduced to all service users."
● Staff received supervision and appraisal sessions. One staff member said, "Every three months we get supervision. We discuss our well-being, and I feel listened to."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have enough to eat and drink. Some people just needed prompting to prepare their food, whilst other people needed more support to complete the task safely.
● One person told us, "The food is lovely. Sometimes I do my own food. I'm on a diet, the staff support me with that."
● Menu choices were devised with people. A staff member told us they were currently in the process of updating people's food preferences to make sure there was a good variety available.
● People's care plans included information on their nutritional needs, and we saw that people were referred to relevant professionals where required to give advice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Health and social care professionals were arranged when needed to support people. This included GP's, dieticians, dentists and social workers.
● There was communication with community based professionals, and a system of effective handover of information between staff on a daily basis.
● A social care professional told us, "They [Staff] are great, very positive people. Very good service; it's not an old style residential setting, its more supported there so people can live their lives." A relative said, "[Family member] has been the most settled I have ever seen them. The staff are very good with [family member]."

Adapting service, design, decoration to meet people's needs
● Some areas of the environment looked in need of redecoration. Some carpets looked quite old and worn, but the provider informed us these would be replaced promptly.
● People's rooms were personalised and decorated to their preferences. Some people had put pictures on their bedroom doors.
● People had access to a communal lounge area where they could socialise, or have time alone in their own room. One person said, "I like being in my room, I like my own company."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us that staff were kind and caring. One person told us, "The staff are nice. I'm happy." People were comfortable and happy in the company of staff and staff treated people with compassion and kindness. We observed laughter between staff and people.
- People received care and support from staff who had got to know them well. Staff spoke knowledgeably about people's likes, dislikes, interests and what was important to them.
- People were supported to maintain relationships with family and those important to them.
- Staff members were enthusiastic about the care and support that they provided and talked with warmth and affection about the people using the service.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in creating their care plans, which was evident through the level of person centred detail within them. However, where reviews had taken place, or staff had written updates by hand, it was not clear if the person had been involved.
- Information about people's communication needs were assessed and recorded in their care plans. For example, one person's care plan said, "I can communicate verbally, however, I have limited vocabulary. I am able to make choices about what I would like to do at home and at the day centre."
- Staff supported people to make decisions about their care, for example, when they wanted to get up, what they wanted to wear and how they wanted to spend their time. Care plans also reflected this.
- 'House meetings' took place on a weekly or monthly basis, depending on when people were available. These meetings discussed relevant issues and asked people's opinions in relation to the food and activities on offer.

Respecting and promoting people's privacy, dignity and independence

- People's private, confidential information was stored securely in the office and people could have private time in their rooms when they chose to.
- People were encouraged to learn new skills and be as independent as they could. For example, they were supported with household tasks, such as their washing, cleaning their own rooms and caring for their belongings.
- People were supported to be involved in the décor of their home. For example, choosing the colour scheme and personalising their rooms. We saw that each person's bedroom reflected their individual tastes and interests.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- The residential services manager told us that care plans were reviewed every three months or when there was a change in people's needs.
- We found information contained within care plans was not always accurate.
- Some information was not accurate in relation to people's who may become distressed, or not sufficiently detailed to ensure staff had clear guidance to support people in the most effective way.
- Where some staff had written changes on care plans, and crossed out old information, they had not been updated electronically so the care plan looked organised and professional.
- People completed monthly review forms where they could circle happy and sad faces to indicate how they felt about different aspects of their care. We noted that on occasions the sad face had been circled, but there were no comments to show why, or if staff had followed up on this.
- One of the directors told us that a team leader had been on sick leave, and they used to update the care plans. They concluded that this was why the care plans had not been updated promptly.
- People has regular access to activities they enjoyed. Some people worked in café's and day centres, and they told us they enjoyed this. This helped people to gain confidence and feel they were positively contributing, regardless of their disability.
- The registered manager told us how they supported people into employment if that was their aim. People had access to the Iceni day centre, which supported internships, with an emphasis on supporting people to get jobs, whether it was voluntary or paid.
- They told us they had supported five people into work placements previously, including one person who achieved paid employment in retail.

End of life care and support

- The residential services manager informed us no people were receiving end of life support at the time of our inspection. However, there was no documentation available to use if this were needed, such as a template to record what people's wishes were in their final hours. They confirmed that where end of life issues arose they would involve appropriate services including the person's GP.
- Staff had not received training in end of life care.

Improving care quality in response to complaints or concerns

- The service had a complaints procedure for people and relatives to raise concerns.
- We saw that where concerns had been raised, a response had been sent in a timely manner.
- People told us they would complain if they were not happy about something. One person said, "I can speak to staff, if I wasn't happy about something."

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

Requires improvement: Service management and leadership was inconsistent. Some regulations may or may not have been met.

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

- Care plans and risk assessments contained inaccurate and sometimes insufficient information so staff had clear guidance to follow.
- The registered provider and manager had not recognised the impact of the team leader not currently working in the service, which meant that care plans and risk assessments had not been updated.
- There were auditing systems in place, but these had not identified the issues we found during this inspection.
- Environmental risks had not always been addressed promptly to ensure people lived in a safe environment.
- The registered provider was not carrying out their own quality assurance audits to ensure the service was operating safely in all areas.

This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A director told us during our discussions that they planned to ask other staff if they wished to apply for the team leader role on a temporary basis to assist with the improvements and provide staff with a development opportunity.
- Roles and responsibilities within the management team and for staff were clearly defined.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The registered provider and manager were committed to making improvements promptly. They were open and transparent about the shortfalls found and welcomed our feedback to improve people's care.
- Though there were improvements to be made within the service, the culture within the service was friendly and person-centred. The registered manager told us, "It's great here, we do the best we can for the guys [people], we do go the extra mile."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were issued with annual feedback questionnaires. Where concerns were raised or feedback that needed to be addressed, a summary of the findings was devised. Some relatives had been invited to meetings if they wanted to discuss feedback in more detail. A relative told us, "Staff ask my

opinion on [family member's] care. They listen to what I say and I feel involved. [Residential services manager] really does listen."
● Staff spoke highly of the organisation and felt supported. One staff member said, "I do think the service is well-led. We are very supported. I've worked in lots of care homes and wow, this is so different, good paperwork, nothing is left, can always turn to someone. We all help each other, really good teamwork." Another said, "The best job I've had. Yes, it can be stressful and tiring, but we go out happy."

Continuous learning and improving care
● Further learning and the use of best practice guidance would be beneficial to the service. Such as the transfer of personal data and associated guidance, and end of life care. The provider told us that if a training need arose for end of life care, they would address this promptly.
● There was an out of hours system in place which supported staff should events arise outside of office hours. Anything that occurred out of hours was communicated back to the managers promptly.
● A new training provider had recently been sourced. Both the residential services manager and staff commented how beneficial they had found them.
● Learning was implemented promptly to improve people's care. For example, advice from the new training provider in relation to people's medicines had been used to change systems and make them safer.

Working in partnership with others
● The service worked in partnership and collaboration with a number of key organisations to support care provision, joined-up care and ensure service development. One professional said, "They are very good, they contact us when needed."

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not always accurate and lacked clear guidance for staff. 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised 17 (1) (2) (a)