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Millbrook House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 February 2016 and 2 March 2016. We found a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2014. We asked the provider to take action to address this concern.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to this breach. We undertook a focused inspection on 7 September 2016 to check that they had they now met legal requirements. This report only covers our findings in relation to Regulation 12 Safe Care and Treatment. This covered one area whether they are 'Safe'. The other four areas 'Effective', 'Caring', 'Responsive' and ' Well led' were not assessed at this inspection.

You can read the report from our last comprehensive inspection on 29 February and 2 March 2016, by selecting the 'all reports' link for Millbrook House on our website at www.cqc.org.uk.

At the previous inspection we had concerns regarding a lack of care planning documentation around the use of fluid thickeners. Fluid thickeners are used to support people who have difficulty swallowing, eating and drinking. At this inspection our findings showed improvements had been made in relation to this. We found people's plan of care recorded the use of fluid thickeners to support them with their dietary requirements which meant this breach had been met.

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 safe.

We found that action had been taken to ensure people's plan of care recorded information relating to the safe use of fluid thickeners to support people with their dietary requirements.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' we would require a longer term track record of consistent good practice. We will review our rating for 'safe' at the next comprehensive inspection.

Millbrook House

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 focused inspection took place on 7 September 2016 and was unannounced. The inspection team consisted of an adult social care inspector. We visited the service to check that improvements had been made to meet the legal requirements identified after our comprehensive inspection on 29 February and 2 March 2016. We inspected the service against one of the five questions we ask about services; is the service safe. This is because the service was not meeting legal requirements in relation to Regulation 12 Safe Care and Treatment.

We looked at two people's care records, nutritional records and supporting documentation to evidence that fluid thickeners were administered as prescribed. We also looked at the nutritional training for staff and how people's nutritional care was audited. We spoke with the registered nurse, three members of the care team and an area manager. We contacted a commissioner of services prior to the inspection to seek feedback about the service.

Requires Improvement

Is the service safe?

Our findings

We previously visited this home on 29 February and 2 March 2016 and found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect of poor care planning around the use of fluid thickeners.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us about the improvements they had made to meet this breach. On this inspection we checked the improvements made were sufficient and found the breach had been met.

At this inspection we checked to see how the uses of fluid thickeners were managed for people who had difficulties swallowing. We looked at two people's care nutritional care records, staff training around the safe practice of administering fluid thickeners and how nutrition was audited (checked). We assessed the level of input from health professionals to ensure a consistent approach to ensuring people's welfare and safety who had a diagnosis of dysphagia (difficult in swallowing, eating and drinking). We spoke with the registered manager of the home, three members of the care team and an area manager. We found that all the records we looked at recorded sufficient information for staff to follow when supporting people with dysphagia.

The two care files we looked at recorded a nutritional assessment and a nutritional plan of care which recorded information of the consistency of fluids the person was able to manage. The care files were subject to review and the information recorded was up to date. Instructions for staff included the safe positioning of people when staff administered thickened fluids.

Records seen showed there was good input form external health professionals such as, a dietician, speech and language therapy (SALT) team and each person's own general practioner (GP). Regular reviews with health professionals took place to ensure people's nutrition was carefully monitored. Care records followed nutritional treatment plans which had been put in place by external health professionals.

Staff interviewed had a good knowledge regarding why fluid thickeners were used and how to monitor people's safety when helping them to eat and drink. Staff told us how they positioned people when supporting them with their meals and 'to sit upright for 30 minutes after' which helped to reduce the risk of choking and to improve people's digestion. Staff said us they had sufficient time to support people safely and for people to enjoy their meals. Staff discussed with us each person's nutritional care, the stage of thickened fluids each person had and how many scoops of fluid thickener were added to their drinks to ensure the right consistency. A staff member said, "If I had any worries about a resident not eating I would report it and I know what consistency the fluids have to be for each person."

A record was in place for recording the number of scoops of fluid thickener added to drinks and this was checked each day by the nurse in charge to make sure the right amount of scoops were added. A fluid balance chart also recorded the drinks offered to people and how much people had taken orally. The diet records seen were up to date. People's intake was monitored to make sure they had sufficient to eat and drink.

The registered manager told us about the nutritional training they had provided for staff following the last inspection. We saw the training covered the administration of fluid thickeners. A file was available with information for staff to refer to for advice on thickened fluids. This information was kept in people's rooms and also in the kitchen. Staff told us the nutritional training had been informative and they felt confident in supporting people who had difficulty swallowing and needed thickened fluids. Further training was being planned around the importance of fortified (meal replacement) drinks to help monitor people's calorie intake.

The registered manager told us they observed staff practice to ensure fluid thickeners were added and administered safely to people. We discussed with the registered manager recording staff competency checks to evidence staff's practice when administering fluid thickeners. The registered manager agreed to complete this to evidence staff's learning. We saw care plan audits which included a review of people's nutritional care. A fluid thickener audit was put into place during our inspection to help monitor more closely the provision of fluid thickeners.