Laudcare Limited

Millbrow Care Home

Inspection report

Millbrow
Widnes
Cheshire
WA8 6QT

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29 January 2016

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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

At the comprehensive inspection of this service in July 2015 we found the provider was meeting all the regulations we looked at and was rated as a GOOD service.

This responsive inspection was carried out to look at concerns raised by Halton Council with regard to infection control and leadership of the service.

This report only covers our findings in relation to the Safe and Well-Led domain.

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

Millbrow is a purpose built two-storey care home situated in the Mill Brow area of Widnes. The home is accessible by public transport and convenient for the town centre. The home is part of the Four Seasons Healthcare group of care services. It is registered to provide nursing and personal care for up to 44 people. There were 41 people living there at the time of the inspection.

There was a registered manager at Millbrow. 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.

During this inspection we found breaches of the Regulations in respect of safeguarding service users from abuse and improper treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report

We found that since our last inspection the premises had been redecorated and some furnishings had been replaced. We were aware that concerns had been raised by Infection Prevention and Control regarding the standard of cleanliness of serving trolleys and during a walk round of the home it was noted that some rooms were malodorous of urine and toilet areas were soiled. Domestic staff only worked until 2.15pm each day which provided insufficient time to ensure all areas of the home were kept hygienic.

Risk assessments were in need of update to include details of any action taken to minimise avoidable harm.in respect of the management of the home and premises.
Notifications and records of accidents and incidents were not always managed appropriately.

People living in the home and their relatives said staff were attentive and caring. They said that if they had any concerns they were addressed promptly. People told us that they felt safe, the food was good.

Medicines were well managed and a new clinical room has been created by utilising a decommissioned

bathroom on the upstairs unit.

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 keeping people safe.

The maintenance and cleaning of the premises did not ensure effective infection control.

Notifications in respect of safeguarding, accidents and incidents were not correctly managed and therefore did not protect people from possible harm.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was not fully aware of her role and responsibilities in respect of meeting the requirements of the Health and Social Care Act and associated Regulations.

Records showed that the registered manager used a tick box system to show audits had been completed but during discussions she was unable to advise what she would do if any shortfalls were identified.

Millbrow Care Home

Detailed findings

Background to this inspection

This responsive inspection was carried out on 29 January 2016 to look at concerns raised by Halton Council with regard to infection control and the management of the service.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led.

This inspection was carried out by one adult social care inspector.

We spoke with nine people who used the service, five staff members, the registered manager, the peripatetic manager, one clinical lead nurse, area manager and a maintenance person. We also held discussions with a member of Halton Quality Assurance team who was visiting the premises at the time of our inspection. We looked at the duty rotas for the home, risk assessment documentation, emergency plans and an action plan which had been produced by the provider. We undertook a tour of the building and with permission looked in people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

Staff told us that they had received training in safeguarding as part of their induction and we saw from the current annual training plan that safeguarding training was provided to all staff as an on-going process. They were clear about the process they would follow if they suspected that abuse was taking place. They told us who they would report their concerns to and they said they thought that any allegations would be investigated by the registered manager and provider. They also told us that where required they would also escalate concerns to external bodies. This included the local authority safeguarding team, the police and the Care Quality Commission.

However, the records we hold about the service showed that the provider had not always notified us about any safeguarding incidents and had therefore not taken appropriate action to make sure people who used the service were protected. We found that when an incident had occurred at the service the registered manager and the registered provider had not always taken the correct action and informed the local authority safeguarding team and the Care Quality Commission. Discussion with the registered manager identified that she was not fully aware of her responsibilities in respect of notification of safeguarding and accidents and incidents. However we saw that since this issue had been raised she had taken advice from her area manager and had acquired some knowledge and understanding of the process involved.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not ensured that systems and processes were established and operated effectively to prevent abuse of service users.

We saw that risk assessments of the management of the home and premises had not been updated, for example in relation to the use of hoists, slings and lifts, since the registered manager had been appointed. We discussed this with the registered manager who advised that she was still not sure what her role involved and would ask for guidance from her line manager. Further information regarding the governance of the home is provided in the well led section of this report.

We looked at the duty rotas for the last two weeks, the week of our visit and projected rotas for the next two weeks. The home was being staffed with two clinical lead nurses working between the two units and five care staff on each unit during the hours of 8.00am until 8.00pm. The rota stated that night staff comprised of one clinical lead nurse and six care staff working from 8.00pm until 8.00am across the two units. The staffing rotas we looked at and our observations during the visit demonstrated that there were sufficient numbers of staff on duty to meet the needs of the people living at the home.

However we saw rotas which showed that two domestic staff were employed between the hours of 9.00am until 2.15pm seven days a week. Observations of these staff undertaking their duties demonstrated how difficult it was for them to fully maintain the cleanliness of the premises as they held responsibility for the cleanliness and basic hygiene for 41 bedrooms, several communal bathrooms and toilets and the lounges and dining areas of the home. We noted that some toilet areas were soiled and three bedrooms held unpleasant smells of urine during our tour of the premises. Care staff told us that they cleaned toilet areas

whenever they could but we saw how difficult it was to maintain the basic hygiene in these areas. We spoke with the registered manager and the area manager about this issue.

They told us that they were in the process of reviewing the staffing levels for domestic staff and were addressing the shortfall by increasing their hours. Staff training files showed that they had received training in infection control to include handwashing and hygiene and cleaning rotas included check lists which were signed by domestic staff when they had completed each task. We saw that the check lists had been signed to identify what areas had been cleaned, however staff told us they could not always complete their full cleaning duties due to the time allocated to them. The home had appointed an infection control lead whose responsibility included updating and monitoring infection control policies. However we did not see any evidence to show that the policies had been updated.

We saw that new members of staff had been employed and some were on induction or shadowing shifts, which meant they shadowed a senior member of staff until they felt comfortable to provide care for people on their own.

We saw records which identified that the service had been without a maintenance person for several months. However we saw that a person had now been employed to cover all the maintenance and building and services risk assessments. We noted that they were in the process of fixing leaking taps in bathrooms seven and three, replacing flooring in bathroom three and replacing a call cord in bathroom five.

A new clinical room had been created which was spacious and hygienic. We reviewed the arrangements for the storage administration and disposal of medicines and saw that they were in line with national guidance. Some people had been prescribed medicine that was to be taken 'as required'. We saw that on occasions some people had exercised their right not to take this medicine and saw that this decision had been accepted and recorded correctly by staff. We looked at recent audits of medicines management which had been conducted internally by a senior member of the nursing staff and saw that actions had been taken to address any issues raised.

Requires Improvement

Is the service well-led?

Our findings

People living in the home told us "The manager is great, what a nice person", "She is a lovely girl and is always around for us" and "She does a good job, we are all fine here".

The registered manager displayed a great passion for her role but lacked some understanding of the requirements of the role of a registered manager. Staff spoke highly of her as a person and told us she was approachable, very pleasant but sometimes they felt she was a little out of her depth managing all the aspects of the home. In discussion with the registered manager she identified that she had some uncertainty about her role. She also identified lack of understanding of the process involved with notifying CQC and the local authority regarding safeguarding issues and notifications regarding death, injury or accidents. We checked records and noted that notifications relating to the outcome of DoLS applications, safeguarding concerns or other incidents that had occurred within the home had not always been forwarded to CQC in accordance with the requirements of their registration. Registered locations such as Millbrow are required to notify the Care Quality Commission (CQC) of certain events.

This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. The registered provider had failed to notify the Commission of incidents that had occurred whilst operating the service in accordance with this legislation. We have written to the provider separately to this report about this matter.

We saw that the registered manager carried out a range of checks and audits at the home. We also saw that they reported back to the provider organisation on a monthly basis, detailing any complaints, compliments, incident reports or accidents, sickness levels and staff training completed. We also saw that care plans, food audits, safeguarding and people's experiences and end of life were audited monthly. Wound care was audited weekly which tracked and triggered actions. Daily medication audits were in place and monthly manager medication audits undertaken. People told us and we saw that the registered manager regularly walked around the home to check on things and see how people were. We saw that although audits were completed each month some areas of concern such as overall staffing levels and lift safety had been recorded but not addressed. Records showed that the registered manager used a tick box system to show audits had been completed but during discussions she was unable to advise what she would do if any shortfalls were identified. Examples of this included her lack of understanding in respect of reporting accidents or incidents, dealing with complaints and addressing staffing issues.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that effective systems were in place to assess, monitor and mitigate risks relating to the health and safety of service users.

We met with the area manager who advised that he was aware of the registered manager's gaps in knowledge and lack of understanding in her role and as a consequence he had arranged to mentor her for a short period of time to ensure she fully understood her role and the responsibilities involved.

The registered manager told us there were a range of staff meetings with nurses, care staff and domestic staff. Documentation we looked at confirmed this. They told us that they tried to work with staff and engage them to discuss any ideas or areas of concern. Staff told us that they felt the registered manager was transparent and enabled them to speak their mind without fear of reprisal.

We saw that surveys were used to gain people's perceptions of the staff and services provided. Questionnaires were provided for people who lived in the home and their relatives and other professionals who may be involved with their care. We saw some questionnaires that had been returned that all the comments made were most positive.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured that people were safeguarded from harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers did not have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.