Millbrook House (Dorset) Limited

# Millbrook House (Dorset) Limited

**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 |

## Overall summary

This inspection took place on 3 and 4 December 2014 and was unannounced. Millbrook House provides accommodation and personal care for up to 33 older people. There were 28 people living there when we visited. This provider is required to recruit a registered manager for this type of service. There was a registered manager in post. 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 and associated Regulations about how the service is run.

At the last inspection on 16 December 2013, we asked the provider to take action to make improvements to ensure accurate and appropriate records were maintained. At

# Summary of findings

this inspection some improvements had been made but there were still some records that were not accurate or had not been completed. This put people at risk of inappropriate or unsafe care.

People were not safe living in the home because not all safeguarding concerns had been reported to the local authority. During the inspection we identified concerns about how some people were supported to remain safe and about some staff practice. We reported these concerns to the local authority safeguarding authority following our inspection.

There were enough staff to meet people's needs. Recruitment checks were completed before staff worked unsupervised at the home. All staff told us there were enough staff to meet people's needs. People told us that staff assisted them when they needed help. People received their medicines when they required them and medicines were stored safely.

Some people, who did not have mental capacity to make specific decisions, had their legal rights protected. Best interest decisions involved people's representatives and health care professionals in accordance with the principles of the Mental Capacity Act 2005.

The service was caring. People and their representatives spoke highly about the staff. People told us that staff were caring and were always there to help. People were supported by staff to meet their social and welfare needs. People were supported to take part in activities in the home, go out on trips and at times supported on a one to one basis with their social needs.

Staff were not always trained to meet people's needs. Some staff had not received training required to carry out their role.

There were insufficient monitoring of incidents to identify any actions necessary to meet people's changing needs. There were limited audits of care records to identify actions that were required to ensure people's needs were responded to. Staff gave us mixed feedback about how the service was managed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . These were in relation to safeguarding people, meeting people's needs, records and not monitoring the quality of the service effectively. 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

The service was not safe. Some safeguarding concerns had not been reported to the local authority safeguarding team. Some staff had not received safeguarding training.

Risks to the health and safety of everyone living in the home were not fully understood by the registered manager.

People told us they felt safe living in the home and that staff kept them safe.

People received their medicines as prescribed and medicines were stored safely.

There were enough staff to meet people's needs and recruitment checks were carried out before people started working in the home.

**Is the service effective?**

Requires Improvement

The service was not always effective. Staff had not received all training they required to carry out their roles. Staff gave us mixed feedback about how they were supported to carry out their role.

People received support to eat and drink when required. People spoke positively about the meals provided.

Not all staff understood the requirements of the Mental Capacity Act 2005. Some people's capacity to consent to their care and treatment was assessed and people's representatives were involved in 'best interest decisions'. However for some people who lacked capacity and sometimes declined personal care, there was not a best interest decision in place.

**Is the service caring?**

Good

Staff were caring and considerate towards people. We observed staff talking to people in a caring and respectful manner.

People and their relatives told us the staff were kind, caring and always respectful to them. They told us that they were involved in making decisions about their care. Staff told us they enjoyed working at the home.

**Is the service responsive?**

Requires Improvement

The service was not responsive to everyone's needs. Not all care plans provided enough information about how people's care needs should be met. Some staff raised concern about this and the risk that people may not have received care consistently.

# Summary of findings

People's representatives were involved in the planning of their care and told us they felt included in the process. People's views and concerns were not always listened to and acted upon. People's representatives were encouraged to give their feedback.

**Is the service well-led?**

Staff gave mixed feedback about the management of the service. Some staff told us they did not feel the registered manager was approachable.

Incident and accident reviews were not always timely and did not always identify the actions required. There were limited systems in place to review and monitor the service.

**Requires Improvement**

# Millbrook House (Dorset) Limited

**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 inspection took place on 3 and 4 December 2014 and was unannounced. The inspection was carried out by one inspector. We received information indicating people were not being cared for appropriately. We raised these concerns with the local authority prior to and during the course of our inspection.

During our inspection we spoke with the registered manager, the chef, and six care workers. We spoke with six people who were using the service and three people's representatives.

We looked at the care records of four people who used the service, four staff recruitment files, and 15 people's medicine administration records. We also looked at other records relating to the management of the service. This included certificates for the fire safety equipment. We carried out general observations in communal areas and during mealtimes.

Following our visit we spoke with four health professionals who provided us with information about how the service met people's needs and their experience of working with the staff in the home.

Requires Improvement

# Is the service safe?

## Our findings

The service was not safe because some risks to people were not managed. One person had sustained harm as a member of staff had not followed the person's care plan or moving and handling guidelines to ensure their safety. The registered manager told us they had formally spoken with the member of staff about their conduct. They also reminded them of the moving and handling guidelines that should have been followed.

The registered manager was not managing some identified risks. For example, there were two people who did not understand the risks of them leaving the service alone due to their dementia. Records showed that one person was found outside of the home on three occasions in the last three months, including being lost for a period of time. This meant their safety was at risk due to their dementia. The risk management plans lacked sufficient detail about how staff could manage these risks. This meant that people were at risk of receiving unsafe care. The external doors in the home were not fitted with an alarm to alert staff if they were opened. One member of staff said that the person was "not safe living here." We raised our concerns with the registered manager on the first day of our inspection. The registered manager took action that day and told us they had recognised the risk and arranged for a contractor to visit the following day. The registered manager told us they were arranging for external doors to be fitted with alarms.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not followed the protocol for reporting all allegations of abuse or neglect to the local authority. We saw there were two incidents that the registered manager had not reported to the local authority. There was no plan to ensure one person was protected from future harm. Staff told us they reported safeguarding concerns to the registered manager but they were not aware of what action was taken. Some staff had not received any training on how to safeguard adults. One member of staff told us, "It is not clear who reports safeguarding concerns, I thought the office sorted it all out." We raised our concerns with the local authority safeguarding team following our inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks relating to people's mobility, risks associated with choking and pressure sores were being managed. Staff told us about the identified risks and the plan of care for these people to manage these risks. One member of staff told us how they supported someone to move safely, "We use the hoist in two's (Two care workers). The care plan is clear." For another person, staff were clear about how much one person's fluids should be thickened following advice from a speech and language therapist and their required diet. Health professionals told us they were confident that staff followed guidance they had recommended, to ensure people's safety.

People told us they felt safe living in the home and were kept safe by staff. One person told us they had experienced falls at home and felt safe living in the home as staff supported them to reduce the risk of falling. People's relatives told us that they felt their relative was safe living in the home. One person's relative told us about the safety measures in place for someone who was at risk of falls. This action was taken following advice from a health professional. Another person told us that staff treated people well and they did not have concerns about how staff looked after people.

There were enough staff to provide the support people needed. All the staff and people who used the service told us there were enough staff. One person said, "There are lots of staff doing different jobs." Records relating to recruitment showed that the relevant checks were completed before permanent staff worked unsupervised at the home. These included employment references and criminal record checks.

People's medicines were stored safely and there was a system for the ordering, receipt and disposal of medicines. People received their medicines safely and when they needed them. Staff recorded when medicines were given to people and medicines were given at the correct time intervals. Medicines were administered by staff who had received training in order to carry out this role.

Requires Improvement

# Is the service safe?

The building was maintained and regular checks on lifting equipment and the fire detection system were carried out to make sure they remained safe.

Requires Improvement

# Is the service effective?

## Our findings

The service was not always effective because not all staff had received the training required to carry out their role. Staff gave us mixed feedback about the training and support they received to meet people's needs. Two members of staff told us the fire safety training was not practical and they were not confident about what action to take in an emergency. The majority of staff had not received update training on infection control. Other staff told us that they had not received training on the Mental Capacity Act 2005 or how to support people whose complex needs challenge. Some people in the home had complex needs, such as dementia and on occasions, required support when they became distressed. Staff had not received training on supporting people with dementia.

Some staff raised concerns about the effectiveness of 'training booklets' used in the home. The registered manager told us they had a plan to ensure that all staff received training in certain areas appropriate to their roles. They also said they were planning to carry out face to face training with staff as well using training booklets. The training planned included moving and handling, health and safety and safeguarding.

New staff received induction training and worked alongside experienced staff before starting to work unsupervised. One member of staff told us, "They are all very supportive." New staff had received training which included training for moving and handling, fire safety and infection control. However, not all new staff had received training on safeguarding adults.

Not all staff had received a supervision (meeting with a manager) but staff had received an annual appraisal. Concerns about staff practice were responded to. For example, in one staff file a staff member's practice was discussed and the required change was identified and documented..

People who required assistance to eat and drink received this support. People received support to eat and drink where required, and safe swallow guidelines were followed for one person with an identified risk of choking. People told us they had enough to eat and drink throughout the day and were positive about the food choice. One person's relative told us, if their relative slept late the staff made sure they never missed a meal and they were offered a late breakfast and lunch when necessary. One person told us, "You have always got a choice. The menu is always here." We observed that people's requests for food of their choice were responded to and provided.

The registered manager had an understanding of the Mental Capacity Act 2005. However, not all staff understood the meaning of the Mental Capacity Act 2005 when people lacked capacity to make decisions. Some people, who did not have mental capacity to make specific decisions, had their legal rights protected. This was because people's representatives and health care professionals had contributed to Best Interest decisions on their behalf. For example, a best interest's decision was made to decide on a person remaining to live in the home. A 'best interest' decision is made about a specific issue and involves people who know the person and takes into consideration their previous views and beliefs. However, there was no best interest decision recorded for one person who sometimes refused personal care. There was a risk that staff were providing care without a best interest decision in place.

People required some restrictions to be in place to keep them safe. The local authority had granted authorisations to deprive some people of their liberty in line with the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards can only be used when there is no less restrictive way of supporting a person safely. Staff were aware of the authorisations. For another person staff were using restrictive practices to 'prevent the person falling'. Staff had not identified that 'restrictions' were not in line with Deprivation of Liberty Safeguards (DoLS). We raised our concerns with the local authority following our inspection.

Relatives told us staff contacted their GP or other health professionals if needed. Staff told us they attended handover meetings to get an update on people's health and to ensure they understood how to meet people's needs. One member of staff told us, "We have a handover at 9.00am every morning." One relative told us that staff had worked with an occupational therapist to get advice on how to support the person's mobility. Another relative said, "They (the staff) have a good rapport with the GP." All of the health care professionals that we spoke with following the

Requires Improvement

# Is the service effective?

inspection told us that staff at the home contacted them promptly to make referrals for health care input. One healthcare professional told us, “Any equipment that is needed is sorted straight away.”

Records showed that people were seen by healthcare professionals in response to changing needs and management of existing conditions. Records also showed that people had access to dental and foot care professionals to meet their on going health needs.

Good

# Is the service caring?

## Our findings

People were cared for by staff that treated them with kindness and compassion. People and their relatives told us the staff were kind, caring and could not do enough for people. One person said, “We are really well looked after here”. Another person said, “They go out of their way to help people.” One person’s relative told us they were, “absolutely delighted” with how their relative was cared for. One member of staff said, “It is a lovely home.” The registered manager told us how they supported someone at the end of their life with care and compassion. A health professional told us about how someone had been cared for sensitively at the end of their life by the staff. They said, “They had been cared for beautifully (by the staff in the home)”.

We observed staff talking to people in a polite and respectful manner. Staff understood people’s needs and preferences and spent time talking with people in a friendly way. One person’s relative told us staff showed how much they cared and were interested in their relative as a person. One member of staff told us, “It is a lovely place to work.” Another member of staff told us how they supported someone to move to prevent them being uncomfortable or in pain because of their physical health conditions. They spoke about the person with care and compassion. One person told us, “All staff talk to people nicely.”

People and their relatives told us that they were involved in making decisions about their own care. They told us staff involved them daily in their care and asked them how they wished to spend their day. Relatives told us staff contacted them if they had any concerns about the person’s health or well-being. One person’s relative told us that staff had been supporting the person and their family to make decisions about how they wished to be cared for at the end of their life. The registered manager told us they had arranged a social event and had invited families to talk about end of life care and planning. The registered manager and the team were working on achieving the Gold Standard Framework in end of life care and advanced care planning. Another person’s relative event. They told us they had been able to talk to their relative about their wishes. Another person told us staff support people to maintain their independence. They said, “Staff let me to get on with things myself.”

People’s privacy was respected. Some people chose to spend all or part of the day in their own room and this was respected by staff. People had been supported to personalise their bedrooms with their belongings, such as photographs and pictures, to help people to feel at home. Bedroom doors were always kept closed when people were being supported with personal care. One relative told us staff were, “good with dignity” and told us how they supported their relative with their continence care in a sensitive way. Two people told us the staff respected their independence. One person told us, “Staff are very respectful.”

Requires Improvement

# Is the service responsive?

## Our findings

Not all care records provided an accurate record of people's needs and guidance for staff to follow. At the last inspection we found accurate records were not in place for each person who used the service. At this inspection we found that some improvements had been made including records of people's care needs and advice from health professionals had been recorded. Care plans and records had been updated in most cases in response to changing needs and provided personalised information. For example, one person's care plan had been reviewed as their health had deteriorated and the plan detailed how staff should support the person. Staff told us how they supported this person and this matched their care plan. Another person had equipment in place to support them and this was recorded in their care plan. However, there was a lack of detail in three people's care plans to ensure they received care that met their needs. For example, one care plan lacked detail about how staff should support the person when they became distressed and declined personal care. Records showed the person was distressed and their complex needs were challenging at times. The care plan did not provide guidance to staff on how they should support this person during these times. There was a lack of detail about how often some people should be checked by staff at night to ensure their needs were met.

Staff responded to people's requests for assistance. We looked at the care plan and incident records for someone who had recently been unwell. Their records showed that the person's GP and emergency service had been contacted when the person had become unwell. There were however, no records of the change to the plan of care for this person during this period. The registered manager told us when someone is unwell; staff monitor their condition more frequently using a monitoring chart. There were no records that this had happened for this person.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

We spoke with the registered manager about our concerns but they were unable to provide details of how the person had been looked after. They told us they felt confident the person had received the care they needed. Staff told us the person was improving and recovering.

People and their relatives were involved in the assessment and planning of their care. People's representatives had been involved in the planning of their care where appropriate. Staff responsible for co-ordinating care reviews told us that people and their representatives were involved as their needs changed and annually as part of their care reviews. People and their representatives spoke positively about how staff in the home involved them in the planning of their care. Another relative said, "They get me involved too which is nice."

People received support to take part in activities and were supported individually. People and relatives spoke positively about the trips that were arranged out of the home. During our inspection some people went out for afternoon tea and there was an activity plan for December. We spoke with a relative who was joining their family member on a trip. They spoke positively about how it was organised and told us they were looking forward to it. We observed social and religious activities taking place during our inspection and the people that took part looked like they had enjoyed them.

People and their representatives told us they were able to raise concerns and complaints with the staff team. One relative told us if they had any queries they emailed the registered manager and received prompt replies but they had never had to make a complaint. The registered manager told us no complaints had been made to them but they kept in regular contact with families and we saw evidence of this. People and their representatives were encouraged to give their feedback in meetings, social occasions and by completing annual surveys. Actions had taken place to improve the service. For example, the provider had introduced a sandwich and buffet supper as people fed back that they did not want two hot meals a day. Some feedback on surveys from residents had not always been followed through. There were two anonymous concerns on a survey completed at the end of December 2013 about how they were treated by some staff. The registered manager told us no action had been taken as the concerns were anonymous. No action had been taken to find out who had concerns about some staff working at the

Requires Improvement

# Is the service responsive?

home. The registered manager told us the next survey planned for January 2015 would ask people for their name as an option so that any concerns could be followed through.

Requires Improvement

# Is the service well-led?

## Our findings

There were limited quality assurance and governance systems in place to identify concerns or to drive improvement. For example, incidents were not monitored to identify any improvement to care provided and actions that needed to be addressed. Accidents were documented but there was no record of how these were audited to check whether lessons had been learnt and whether staff had followed the plan of care. Other incidents had not been reviewed to ensure people were protected from inappropriate or unsafe care. For example, how people were supported at night. There were audits in place for the administration of medicines. These audits had identified the improvements required and the actions taken.

There was no system in place to ensure that robust records were in place. Some care records lacked detail and there were gaps. There were gaps in the recording of concerns about people's behaviour. Care records from day and night care were not checked to ensure that concerns about any deterioration in people's health was reviewed. We spoke with the registered manager about two records of people's care that indicated one person was sometimes distressed at night and another person had been found outside by a night care worker. The registered manager told us they were not aware of these concerns. There was no system in place to monitor the quality or content of care records. For another person who had sustained a fall, there were no records of the review of the care they had received or what care staff had provided when it occurred. The registered manager told us they had spoken with staff about the care they had provided but this had not been recorded.

There was no evidence of systems in place to identify improvements required at the service. We identified concerns regarding arrangements to keep people safe due to their dementia. Some staff raised concerns that people could and had left the building through external doors as they had not been fitted with an alarm to alert staff and this put them at risk. We raised this with the registered manager who told us they agreed it was a concern and they started making arrangements after it was raised during the course of the inspection. The registered manager told us they had been thinking about carrying out these changes but it had not been actioned prior to our inspection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave us mixed feedback about how the home was managed and the registered manager's approach. One member of staff said, "She (the registered manager) is very open." Another member of staff told us, "The manager is approachable; you can go to her with anything." However, four out of the seven staff that we spoke with raised concerns with us that the registered manager was not approachable to all staff. Health professionals we spoke with talked positively about the registered manager and told us they felt they were approachable and the staff team followed through on recommendations made. They also told us that the registered manager and staff team asked for advice at times to ensure people's needs were being met.

Relatives and some staff told us the registered manager had a hands on approach to the care provided in the home. The registered manager told us they also provided care on a regular basis as this kept them up to date with people's needs and this had led to them identifying changes to one person's mobility needs. We saw the person's mobility care plan had been updated with input from a physiotherapist. One relative told us, "I am very happy. The (registered manager) is very good and hands on." People that live in the home spoke positively about the registered manager. One person told us, "She is very approachable and attentive." The registered manager told us they carried out unannounced night visits as well as working some night shifts to ensure people received a good standard of care throughout the day and night. However they were unable to provide any records detailing information of their findings on these unannounced visits or when the last unannounced visit took place.

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<br><br>The provider had not taken proper steps to ensure that the welfare and safety of each person in the delivery of care and in meeting their individual needs. (12) (1) (2) (a) (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People who use services and others were not safeguarded against the risk of abuse because the registered manager had not responded appropriately to all allegations of abuse. Regulation 13 (1) (3). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>People who use services were not protected from inappropriate or unsafe care because the registered manager had not monitored the quality of the service or managed the risks relating to the health, welfare and safety of service users.<br><br>Regulation 17 (1) (2) (a)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Action we have told the provider to take

People were not protected from inappropriate or unsafe care because not all records included appropriate information. Other records relating to the management of the service were not maintained.

Regulation 17 (2) (c) (d) (ii).