Milestones Trust

Humphry Repton House

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**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Humphry Repton House on 6 April 2015. At which there were a number of areas identified that required improvement. We had found that staffing levels were not assessed in a way that ensured the numbers were always correct to meet people's needs. This meant there was not enough staff on duty at certain times.

We had also found that people were supported by staff who had a varied understanding of the Mental Capacity Act 2005. Some staff clearly understood what their legal responsibilities were while other staff were not sure. The provider had a quality monitoring system in place to ensure checks were undertaken on the service people received. However, audits and checks that the registered manager was required to do were not done as often as the provider's policy required. This meant there were risks that people could receive unsafe and unsuitable care.

After the comprehensive inspection, the provider wrote to us to say what they would do to improve the service. We undertook a focused inspection on 4 March 2016 to check that they had followed their plan and to confirm that they had taken action to improve the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Humphry Repton House' on our website at www.cqc.org.uk.

At our focused inspection on 4 March 2016, we found that the provider had not fully implemented their plan which they had told us would be completed by October 2015.

The way that staffing was deployed across the home did not always fully meet people's needs. This meant there was not enough competent staff on duty at all times who knew people well to meet their needs.

People were still supported by staff who had a varied understanding of the Mental Capacity Act 2005. Some staff knew what their legal responsibilities were while other staff did not have the same level of understanding.

The management audits and checks were not done as often as the provider's policy required. This meant there were risks that people could receive unsafe and unsuitable care.

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

Some aspects of the service were not safe

There was not always enough suitably qualified staff to provide the support people needed and there was a risk people could receive unsafe care.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective

Staff had a varied understanding of the requirements of the Mental Capacity Act 2005. This could affect people's legal rights if staff do not understand the implications of this legislation on people who used the services.

Staff were not always properly supervised to ensure they knew how to provide effective care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Audits and checks on the quality care and service people received were not always being done as often as the provider's own policy required. There could be risks that people receive unsafe and unsuitable care.

The staff felt supported by the new acting manager and senior manager.

Humphry Repton 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 follow up on what we found at the last inspection.

The inspection took place on 4 March 2016 and was unannounced. The inspection was carried out by two inspectors.

Because of their complex needs, people were not able to verbally tell us their views of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four care records, a sample of medicine administration records and one month's staff duty rosters, We also looked at a range of quality audits and a number of records that related to how the home was run.

We spoke to the new acting manager and a new senior manager. The acting manager was a registered manager in another home run by the same provider. We also spoke with two nurses and six care staff and we met with seven people who use the service.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of the home on 06 April 2015 we had found that had found that staffing levels were not assessed in a way that ensured the numbers were always correct to meet people's needs. This meant there was not enough staff on duty at certain times.

At this inspection, we found that there was not always the right number of suitably qualified staff on duty to meet people's full range of needs. A need to rely on agency staff on a regular basis meant some of those staff did not always know people well. The service had a range of staff on duty. We meet the manager, senior support workers, support workers, maintenance and administration staff. The home also had four out of 12 care support staff that were supplied by a care agency and two of the other staff told us they were bank staff. On the day of our inspection the service was being run by a care team where half of the staff were not full time nor permanent. We observed how this affected the support people received. For example, some staff asked people what they wanted or explained to people what they were going to do for them. However we also observed a group of staff who spoke amongst themselves rather than involving the service users who were sat beside them. On member of staff drank out of a two litre plastic bottle and was texting on her mobile phone rather than engaging with the clients sat around her. We observed one person who sat in the same place all morning, with little stimulation or being offered any meaningful occupation. Staff were not always respectful of issues of confidentiality and were observed speaking about people in front of other people. Three staff were in a room with four people and were discussing amongst themselves people's sleeping habits and body washing arrangements. The discussion we observed was neither respectful or compassionate. We also saw staff briefly stood over a person whilst helping them to eat their dinner and staff who just spooned food into people's mouths without any discussion. Staff also told us "we have to many agency we need staff who know the clients."

The manager showed us how the service's administration staff worked on maintaining the staffing levels which they thought were right for meeting the needs of people in the home. We saw that on some days in the future there was not the number of staff scheduled to work to meet the minimum staffing levels. However, we were assured that the staff which the service needed to cover the shift would be found before the shift started. Staff told us "sometimes there are not enough staff to do the things you want to do" and "definitely needs to be more staff but it's not as bad as it was." The area manager explained there was a restriction on admissions into the home until the service was able to recruit more permanent staff.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of the home on 06 April 2015, we had found that had found that the system in place to try and ensure that the requirements of the Mental Capacity Act 2005 were followed was not fully effective.

At this inspection, we found that people did not always receive effective care and support because staff did not have the skills and knowledge to meet their needs. Staff told us they felt supported by the manager with their training. However, a quarter of the staff on duty were from a care agency and some of their practices demonstrated their lack of training when working with people with dementia.

We observed one agency care staff stood behind people who were awake and staring into space, rather than sitting down with them and occupying them. Another observation was of a person who was sat down at a table all morning occupying himself by either removing his slippers or playing with the tablecloth in front of him. During the morning an agency worker walked in, removed the table cloth from him and tidily relayed it across the table. We notice later on that the person had thrown the table cloth across the room. One permanent staff when asked about the skills of the staff told us "it can be rubbish. To many agency staff some are just here for the money and not the care" and another said "we have so many agency staff. Some are pretty good but others are not."

Most of the people in the home did not have the capacity to make their own decisions which meant they were unable to give consent for their care and treatment. Several of the staff we spoke with did not have a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. When asked staff explained how they would be kind and negotiate with people to arrive to a decision but they did not appreciate that they might be working outside a legal framework. Staff told us "I would try and prevent them from doing it" or "if it's a risk, we can't let them do things by themselves, one of us has to be with them, I don't really know." The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of the home on 06 April 2015, we had found that audits and checks on the quality care and service people received were not always being done as often as the provider's own policy required. There were risks that people could receive unsafe and unsuitable care.

There was a system to ensure that the quality and safety of the service people received was monitored. However, audits had not been carried out regularly over the last six months. This meant that there was a failure of management at that time to pick up any shortfalls in the running of the service. Areas that should have been regularly checked included care planning processes, the views of people at the home about their care, management of medicines, health and safety in the environment, staffing levels, and staff training. We bought this matter to the attention of the news managers supporting the home. They said they had picked up that the previous registered managers audits had not been kept up to date. For example, the matters we had found at our visit. These were around staffing, staff supervision, and systems around the Mental Capacity Act in the home had not been highlighted as needing improvement.

The new acting manager and senior manager had run a staff meeting for the team. At the meeting, a range of subjects including safeguarding people, the way the home was run and peoples care needs were discussed. Staff told us that they felt they could make their views known to both new managers and have an open discussion. They also said that they felt they could now be involved in how the service was run. Staff told us they had good communication with each other, as there was a handover at each shift and a communication book in use to record important information. This meant that staff could quickly access information when needed.

The staff were aware of the values of their organisation. These included being respectful, being inclusive and working with people in a way that was person centred. One key value staff told us was important was to care for people in a person centred way as unique individuals.