Four Seasons (Bamford) Limited

Milverton Gate Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Milverton Gate Care Home on 16 October 2014 as an unannounced inspection.

At the last inspection on 9 August 2013 we found there were no breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008.

Milverton Gate is a nursing home providing care and accommodation to a maximum of 39 older people. On the day of our inspection there were 29 people living at the home.

A requirement of the service's registration is that they have a registered manager. 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. At the time of our inspection there was not a registered manager working at the service. The new manager was recruited to the service in April 2014. The new manager had made an application for registration with us at the time of our inspection.

Summary of findings

People told us, and we observed, there were not enough skilled and experienced staff at the home to meet people's needs.

People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe, as the provider was not delivering care and treatment that met people's individual needs, and ensured the welfare and safety of people.

Emergency plans were in place to minimise the disruption to people's care and support, and to make sure people were kept safe, in the event of a fire or other emergency that affected the premises.

People were provided with food that met their identified health needs. Some people needed to have their fluid intake monitored by staff due to their health condition. We saw the monitoring of fluid intake was not consistent. Records needed to be improved to monitor people's fluid intake accurately, to make sure they received the right amount of fluid to maintain their health.

There were appropriate policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. We saw from the records we looked at that where there were concerns about people's capacity to make decisions, appropriate assessments had been made.

People were supported to maintain their health and wellbeing through access to healthcare professionals.

Staff did not always acknowledge people and act in a caring manner towards people at Milverton Gate. We saw people did not always have their privacy and dignity respected by staff.

We saw people had access to advocacy services when they needed to. An advocate is a designated person who works as an independent advisor in another's best interest.

People did not have the support they needed to take part in interests and hobbies that met their individual needs and wishes.

The provider obtained feedback from people and their relatives about the service to identify where improvements were needed to the quality of service provision. People were able to make complaints or raise concerns with the provider which were investigated and responded to in a timely way.

The provider conducted audits and quality assurance checks at the service to identify areas that required improvement. We saw that audits had identified a number of areas of improvement, which the provider was acting upon. However, audits had not identified the need to increase staffing levels at the home.

Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the provider learned from those investigations to minimise the chance of them happening again.

You can see what action we told the provider to take at the back of the 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?

Inadequate

The service was not safe. There was not always enough skilled and experienced staff to meet people's needs.

The provider was not delivering care and treatment that met people's individual needs, and ensured the welfare and safety of people.

People who used the service were protected from the risk of abuse because the provider had appropriate policies and procedures in place to safeguard people.

Is the service effective?

Requires Improvement

The service was not consistently effective. People's fluid monitoring required improvement so that people's health was maintained.

We saw that there were appropriate policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not consistently caring. People did not always have their privacy and dignity respected by staff.

Staff did not always speak to people around them, or engage people in conversations. This meant staff did not act in a caring manner at all times.

We saw people had access to advocacy services, and that they could speak to an advocate when they needed to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in interests and hobbies that met their needs.

People and their relatives were asked to give feedback about the service, and could comment on where improvements were required.

Is the service well-led?

Requires Improvement

The service was not consistently well led. This was because there were breaches in the Regulations that the provider had not identified in quality assurance procedures.

The provider had sent notifications to us appropriately about important events and incidents that occurred at the home.

Milverton Gate Care Home

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.

We inspected the service on 16 October 2014 as an unannounced inspection.

This inspection was undertaken by two inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor that supported us had experience and knowledge in nursing. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service. The expert-by-experience that supported us had experience of caring for someone with a diagnosis of dementia.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their diagnoses. However, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we looked at and reviewed the Provider's Information Return (PIR). The document allows the provider to give us key information about the service, what it does well and what improvements they plan to make.

Before our inspection we also reviewed the information we held about the service. We looked at information received from relatives, from the local authority and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

We spoke with 14 people living at the home, six relatives of people who lived at the home, the activities co-ordinator, four care staff and a nurse. We also spoke with the area manager of the home and the manager of the home. In addition we spoke with one advocate. An advocate is a designated person who works as an independent advisor in another's best interest.

We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We looked at a range of records about people's care including four care files, daily records and charts for four people. This was to assess whether people's care delivery matched their records.

Inadequate

Is the service safe?

Our findings

When we arrived at the home at approximately 9.30am we saw that most people were still in their bedrooms. Some people we spoke with told us they had chosen to stay in bed, and others said they were waiting to get up. This was because there was insufficient staff to assist them to get up when they wanted to. People told us there was not always enough staff available to meet their needs. One person who lived at the home told us, "Sometimes you have to shout for up to 15 minutes before anyone comes to you." They added, "I think the service is even worse at night."

We asked staff about the staffing levels at the home. Staff we spoke with told us that there were not always enough staff to meet the needs of all the people who lived at the home when they needed assistance. One member of staff told us, "It is particularly downstairs. It is not the amount of people but the tasks." Another staff member told us, "If something unexpected comes up then we very easily get behind." We saw one person calling out for assistance; they waited for more than 15 minutes before a staff member acknowledged them calling out.

We saw during the day the communal areas were not always attended by staff. This meant people did not have staff on hand to support them when they need assistance.

We asked staff members whether they had time to read care plans, or sit and chat with people. They told us they did not have time to do these things. This meant there were not enough staff to meet essential care tasks such as reading documentation about people's care needs.

We saw four people waiting to eat their meal in the dining room who waited for more than 20 minutes before being given their meal. One member of staff told us, "We are running late with lunch today." Another staff member told us, "Typically people are being assisted to eat their lunch until after 2.30pm." We observed that lunch took around two hours for all the people at the home to have their meal. This was because there were not enough staff to assist people to eat their lunch earlier.

We saw one person waiting to be assisted to eat their meal in their bedroom on the ground floor at 1.15pm. The person had a meal in front of them but could not position themselves comfortably to eat their meal without assistance. The person called out for help several times. At 1.35pm we asked a member of staff to assist the person to eat their meal and re-position the person comfortably as no-one had responded to their calls. We noted the meal had gone cold while the person was waiting to be assisted and they were then offered food that was cold. This meant the person was not offered assistance in a timely way.

We saw there was a dependency tool in place used by the management team to review the needs of each person at the service on a regular basis. The tool was designed to assist the manager in making adjustments to staffing levels when people's needs changed. We saw the tool was being kept up to date, but this had not highlighted that the levels of staff may need to be increase to meet people's care needs.

This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.

There was a system in place to identify risks and protect people from harm. Staff members we spoke with told us people had a risk assessment in their care file for each risk to their health or wellbeing. The assessments detailed what the risk was; how harm could occur; possible triggers; and guidance for staff to take. We saw from people's care files that these risk assessments were not always up to date. For example, one person had a risk assessment in place regarding the use of bed rails. The risk assessment was not fully completed as it stated bed rails should not be used. However, we saw that the person had bed rails in place during our inspection. The risk assessment had not been altered when their needs had changed. This meant the person was receiving care that did not match their care records.

Risks were not always managed appropriately to keep people safe. We saw one person needed to be moved and re-positioned every 2 to 3 hours so the risk to them developing skin damage was minimised. We observed the communal area where the person was seated during our inspection and saw the person was not moved between 10.45am and 4.00pm. We brought this issue to the attention of the manager during our inspection who then organised a member of staff to assist the person to move. This lack of movement posed a risk to the person as they were not receiving the care and support they required.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare.

Most people we spoke with told us they felt safe living at the home. However, one person told us they weren't always

Is the service safe?

happy with the way staff treated them. We encouraged the person to raise this issue with the appropriate staff member or the manager if they continued to have concerns.

Staff we spoke with understood their responsibilities for keeping people safe and had an awareness of what constituted abuse or poor practice. Care staff told us they had completed training in safeguarding and knew what they should do if they had any concerns about people's safety or if they suspected abuse. Staff understood the importance of reporting safeguarding concerns to their manager. One member of staff explained how the manager would respond to any concerns. They told us the manager would, "Investigate it straightaway. See if any other people witnessed the incident and then they would report it to higher management and the CQC."

People who used the service were protected from the risk of abuse. Staff told us suitable recruitment procedures were in place which included references, full employment history checks, and Disclosure and Barring Service (DBS) checks before staff started working at the home. The DBS is a national agency that keeps records of criminal convictions.

We saw that there were leaflets on display in the reception area at the service which detailed information about how people could report safeguarding concerns to the local safeguarding team. However, we saw that the telephone numbers and contact details were not entered on the leaflet to make the information accessible to people who lived at the home or their relatives.

The manager notified us when they made referrals to the local authority safeguarding team. They kept us informed with the outcome of the referral and actions they had taken. The manager took appropriate action to safeguard people from the risk of abuse.

Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the home had completed an investigation to learn from incidents. These showed the manager recognised some areas of risk, and made improvements to manage risks where they had been identified.

Emergency plans were in place, for example around what to do in the event of a fire. The manager was able to show us an emergency plan. This plan detailed the actions to take in an emergency if the home could not be used. This meant there were clear instructions for staff to follow, so that the disruption to people's care and support was minimised.

We observed a medicines administration round and spoke to the member of staff who was responsible for the administration of medicines during our inspection. They told us that only nursing staff who had been trained in the safe handling of medicines could administer them. We found there was a safe procedure for storing and handling medicines.

We saw there was a protocol for administering medicines prescribed on an 'as required' (PRN) basis. For example, pain relief drugs. This meant people were given effective pain relief when it was required, and people were not given medicines when they did not need them.

We saw each person had a medicines administration record (MAR) which showed when medicine had been administered. We saw that medicines were audited, and procedures were reviewed regularly by the provider to make sure they were up to date and adhered to current guidelines.

Requires Improvement

Is the service effective?

Our findings

We observed a meal during the lunchtime period which began at 12.45pm. We saw people were offered a choice of meal, and the dining room areas were laid with table clothes, cutlery and condiments to help people enjoy their mealtime experience.

We saw that people were offered a choice of food that met their identified diet and health needs. One person's choice was to eat sandwiches, but we saw that they were at risk of choking on their food, and were offered alternative 'soft' food that reduced the risk of them choking. The person told us they still preferred to eat sandwiches, and had these whenever they could.

We saw that some people who were at risk of poor food or fluid intake were having their food and fluid intake monitored by the use of charts. We looked at four of these charts. We saw that recording on the charts was not consistent. Staff had not filled in some entries, for example, charts did not evidence that people were receiving fluid at night. This meant care records that would assist staff in monitoring people's health were not kept up to date.

We reviewed the fluid charts for one person and saw that on one day the drinks the person had received were recorded, but no amounts of the fluid intake had been noted. Charts did not show a total amount of fluid, and therefore people's intake was not monitored against a set target. This meant we could not be sure people were receiving the right amount of fluid to maintain their health, as records were not accurately maintained.

We saw one person who was having their food and fluid monitored by staff. Between 9.30am and 4.00pm on the day of our inspection no fluid intake had been recorded for the person on their care records or charts. We knew this was not correct as we had observed the person consuming fluid during our inspection.

People were not given fluid in a way that suited their preferences and needs. For example, we saw one person's care plan which stated that they preferred to be given drinks with a straw. We saw them being given drinks during the day in a lidded beaker. In addition, we saw some people had been left drinks by the side of their bed, or near where they were sitting. However, people could not always reach the drinks. This meant people at risk of poor fluid intake were not always supported to drink appropriately to meet their needs.

This was a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records.

Staff told us they received induction and training when they started work at the home. One staff member told us, "I went through an initial induction. I had to shadow experienced staff until my manual handling training was delivered."

Staff told us they were encouraged to keep their training up to date, and were provided with training materials and online training modules by the provider. One member of staff told us they had been able to start a nationally recognised qualification in health and social care whilst working at the home, which they hoped to continue with. This meant the manager supported some staff to obtain nationally recognised qualifications to promote their professional development.

We asked the manager how staff were supported at the home. The manager told us each shift was supervised by the nursing staff, which meant that regular agency staff were currently supervising the daily work of care staff. Staff received regular supervisions meetings and yearly appraisals. Regular supervision meetings provided an opportunity for staff to discuss personal development and training requirements to keep their skills up to date. Regular supervision meetings also enabled the manager to monitor the performance of staff, and discuss performance issues.

We asked staff about the handover they received when they started their shift, and whether it was effective in keeping them up to date with changes to people's care needs. One staff member told us, "The nurse will tell us if there have been any concerns." Another staff member said, "If there is anything major the nurses will come up and let us know." This meant staff were kept up to date about changes to people's care.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA sets out the requirements that

Requires Improvement

Is the service effective?

ensure decisions are made in people's best interest when they are unable to do this for themselves. DoLS make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

People's capacity was being assessed in accordance with the MCA. We saw where decisions were needed the person, their family, or healthcare professionals had been involved in the process. We saw that people's consent to care and treatment was recorded on their care files where they were able to consent. This meant that people, and others that where important to them, were involved in making decisions around their care to make sure it was in their best interest.

The manager understood their responsibilities under DoLS. The manager told us they had recently obtained guidance from the local authority to make sure they were not unlawfully depriving people of their liberty. No-one at the home had a DoLS in place; however a recent application had been made for one person at the home who required a DoLS. This meant the manager was acting in accordance with recent DoLS guidance.

We saw some people had agreed that in the event of them having a cardiac arrest the emergency services should not attempt cardiac resuscitation (DNAR). The manager informed us that thirteen people were awaiting updates to their DNAR paperwork as the paperwork was not currently valid. This meant that while the updates were taking pace, people at the service were at risk of being resuscitated against their wishes. We asked the manager if the people affected, or their relatives had been informed. The manager told us they had not discussed this issue with people who used the service or their relatives. This meant people were not being involved in important information that related to their health.

We looked at the health records of the people who used the service. We saw that each person was provided with regular health checks, and they were supported to see their GP, optician, dietician, and dentist where a need had been identified. We saw people were able to access other professionals in relation to their care such as the speech and language therapist. This meant people were supported to maintain their health and wellbeing through access to healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if the staff were caring, and talked to them appropriately. One relative told us, "Care is good; [Name] is always clean and well." They added, "Staff are friendly."

We saw some staff were caring and attentive during our inspection. One staff member we observed was kind and gentle when approaching a person to offer them personal care, they explained the care they were offering, and spoke to the person in low tones so that others did not overhear their conversation. This respected their privacy.

People told us they liked the staff. We observed some staff chatted to people in their bedrooms or in the communal areas as they completed care tasks. People told us that staff did not have time to sit and talk with them, and were very task orientated. One relative told us, "I feel [Name] is always last in the queue." We observed care staff were task orientated through most of the day. We saw staff walked through communal areas and did not always speak to people around them, or engage people in conversations.

People we spoke with told us they or their relatives were involved in planning their care when their care plans were initially agreed. We looked at the care files for four people who lived at the home. We saw care plans were tailored to meet the needs of each person according to their support requirements, skills and wishes.

We asked people if they were involved in making decisions about their care and how they spent their time. People we spoke with told us they could spend their time how they wanted. One person told us they liked to get up at different times. Staff we spoke with knew people should be given the choice to stay in bed or in their room if they wanted to. They explained how they offered other choices to people. One staff member told us, "When we go in to wash people we will give them a choice of clothes. We ask them what they want to wear."

We saw people had access to advocacy services, and that they could speak to an advocate when they needed to. We met an advocate during our inspection who was visiting someone at the home. They explained they were involved in care reviews for the person, and asked staff to provide key information about the person's health care needs so that they could act in the person's best interests.

We observed people did not always have their privacy and dignity respected by staff. This was because we saw one person was lying in bed with their body exposed, and the door to their bedroom had been left wide open.

In another person's room we saw incontinence wear had been left out following personal care. The person had left their room. However, the soiled incontinence wear remained in view of people passing the room, which did not respect the person's dignity.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they were supported in taking part in hobbies and interests they enjoyed. One person told us they would like more outside activities organised at the home.

We asked members of staff if they knew about people's interests. Staff were able to explain in detail the interests and preferences of some people who lived at the home. One member of staff told us about people's spiritual needs, and explained that a priest visited the home regularly to offer Holy Communion. They added, "I think it is very hard for whoever does them [activities]. When there is entertainment, people all love it, their faces light up." They went on to say, "If we did have an extra pair of hands I am sure it would help."

We saw that there was a member of staff to support people in taking part in interests and hobbies inside the home. However, we observed that the staff member spent some of their time involved in care duties during our inspection. This meant the staff member could not devote their time to providing support to people so that they could access interests and hobbies that met their needs.

Not everyone had access to a call bell. For example, we saw one person who was partially sighted who was unable to locate their call bell. We saw the person called out for assistance from staff, but staff did not always acknowledge them. This meant staff did not act in a responsive manner at all times.

We saw that people or their relatives were asked to give feedback about the service. We saw a range of different meetings took place to gather views from people, their relatives and staff. The meetings were recorded and where improvements or changes had been suggested these improvements had been written into an action plan, which was followed up by the manager. We saw that action plans were also reviewed during quality assurance visits by the area manager to track the progress of completion.

People told us they knew how to raise concerns with staff members or the manager if they needed to. We saw there was information about how to make a complaint available on the noticeboard in the reception area of the home. It was also contained in the service user guide that each person received when they moved to the home.

We saw the manager kept a complaints log where any complaints regarding the service were kept. Complaints were responded to in accordance with the complaint policy. This log enabled the manager and the provider to assess any trends or patterns in complaints to improve the service.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives whether they felt the home was well led. People told us there had been a recent improvement in the home since the new manager began working there.

We found the provider needed to improve how the home was led, as there were a number of breaches in the Health and Social Care Act 2008 and associated Regulations. For example, people told us, and we observed there was not enough qualified, skilled and experienced staff at the home to meet people's needs.

The provider completed a number of checks to ensure they provided a good quality service. For example, regular audits and regular visits to the home to speak with people, relatives and staff, and check records were completed correctly. We saw that where issues had been identified in quality assurance checks and audits, action plans had been generated to make improvements. Action plans were monitored by the area manager to ensure they had been completed. This meant the provider played an active role in quality assurance, and ensured the service continuously improved.

Recent audits had highlighted the requirement for permanent staff so that a consistent knowledge based existed amongst staff at the home. Staff recruitment was in progress at the time of our visit to reduce the number of agency staff. However, we found the number of care staff needed to be increased at the home, which had not been picked up in the staff dependency tool analysis, or in recent audits.

We saw that the manager had recognised the need to improve staff supervision and a new deputy manager had already been recruited to assist with this. This meant the manager was acting on this identified need.

The provider was not keeping accurate and up to date care records in respect of each person who used the service. We saw that there was a review of care records taking place during our inspection because the manager had identified the need for care records to be up dated. This meant the manager had already identified the need for improved care record keeping before our inspection.

A requirement of the service's registration is that they have a registered manager. At our inspection there was not a registered manager working at the service. There had been a new manager recruited to the service in April 2014 shortly after the previous manager had left, and the new manager had applied for registration with us. This meant the provider was pro-actively trying to fill the registered manager position.

The manager told us the area manager visited the home regularly to offer them support. On the day of our visit the area manager was visiting the home. They explained they were on hand to support the manager whenever they were required. This meant the manager received regular support from the wider organisation to assist them in their role.

The provider was working with the manager to identify an improvement plan which would benefit people at the home. For example, the manager had identified that improved nutrition would benefit people at the home, and had recently implemented a new initiative called 'food first' to improve people's nutritional intake. The 'food first' initiative was being used to promote fortified food rather than nutritional supplements to prevent weight loss amongst people at the home. This meant the manager was pro-actively identifying improvements that could be made to the quality of the service.

The provider had sent notifications to us appropriately about important events and incidents that occurred at the home. However, the manager told us that notifications following events at the service were delayed at the time of our inspection due to pressure of work.

We saw customer satisfaction forms were sent annually to people who used the service and their relatives, as the results of the surveys were on display at the home. We saw the latest customer satisfaction survey from 2013, where the results had been analysed by the provider against similar surveys at their other homes to compare the information. Where results were different we saw the provider looked into the causes of the differences to see whether improvements could be made at the home.

People and their relatives told us they were able to be involved in developing the service they received at the home. This was because they were involved in meetings to gather their feedback, and could leave their comments on feedback forms located in the reception area.

Staff told us that the managers worked alongside staff at the home and they had the opportunity to talk with them if they wished. We saw the service held staff meetings to

Requires Improvement

Is the service well-led?

gather feedback from staff regularly. Meetings were recorded and detailed feedback about the home. We saw staff had an opportunity to raise any issues, or give feedback, in the 'any other business' section of the meeting. We saw from the minutes that, where an issue had been raised, the manager had informed staff what action they would take to resolve the issue.

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 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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them, as the provider was not keeping accurate and up to date care records in respect of each service user. Regulation 20 (1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services were not protected against the risks associated with staffing because the provider had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of people. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks associated with receiving care or treatment that is inappropriate or unsafe because planning and care delivery did not ensure the welfare and safety of the service user. Regulation 9 (1)(b)(ii).