Care Quality Commission

Colleycare Limited

Milford Lodge Care Home

Inspection report

Priory End
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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

The inspection took place on 09 July 2015 and was unannounced. The service is newly registered and had not been inspected before. Milford Lodge is a residential care home that provides accommodation and personal care for up to 60 older people, some of whom live with dementia. The accommodation was arranged over three floors and at the time of our inspection there were 38 people living at the home.

There is a manager in post who has registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. However, the registered manager was absent from the home on an extended period of extended leave. The management of the home was being covered by members of the provider's senior management team. An experienced acting manager was at the home Tuesday to Thursday inclusive and the regional manager covered Monday and Friday.

Summary of findings

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection a number of appropriate applications had been made to the local authority in relation to people who lived at the home.

We found that the effectiveness of staff deployment lacked consistency across the home and there were insufficient staff to cope with the demands placed upon them. The quality of care provided often lacked consistency across different units and floors at the home mainly because of lack of staff. People told us that they felt their needs were not met safely at all times due to lack of staffing.

Staff had received training in how to safeguard people against the risks of abuse. They were able to describe with confidence what constitutes abuse and the reporting procedure they would follow to raise their concerns.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs.

We found that medication had been administered following best practice guidelines, however not always at the times prescribed. People had access to health care professionals when necessary and their health needs were met. The environment and equipment used, including mobility aids and safety equipment were well maintained and kept people safe.

Staff obtained people's consent before providing the day to day care they required. We found that processes to establish if people had lacked capacity for certain decisions were not always followed in line with the MCA 2005. Staff had no clear guidance in how to ensure the care delivered was in the person's best interest.

People expressed mixed views about the skills, experience and abilities of the staff who supported them. We found that staff had received training relevant to their roles. Staff had regular supervisions to discuss and review their performance and professional development.

People expressed mixed views about the standard of food provided at the home. We saw that the meals served were hot and that people were regularly offered a choice of drinks. We also found that the menu request for people was done the day before and no visual choice was given for people with dementia to enable them to make informed choices.

Most people told us they were looked after in a kind and compassionate way by staff who knew them well.

Information contained in records about people's medical histories was held securely and confidentiality sufficiently maintained. People and their relatives told us they were involved in the planning, delivery and reviews of the care provided.

People told us the care they received was not always personalised or delivered in a preferred way. We found that most staff had taken time to get to know the people they supported and were knowledgeable about their likes, dislikes and personal circumstances.

People expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their individual needs. We saw that where complaints had been made they were recorded and investigated. However, there were no records to show that positive lessons had been learnt or that service delivery was improved from the complaints raised.

People knew about the management and leadership arrangements at the home. However, they told us that communication was not effective between management staff and people.

At this inspection we found the service to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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?

Requires improvement 

The service was not always safe.

There were not always sufficient numbers of suitable staff available to meet people's needs at all times and in all areas of the home.

Staff knew what constituted abuse and told us that they would escalate any concerns they had.

People were supported to take their medicines safely but not always at the required times.

Potential risks to people's health were identified however there was no plan on how identified risks were consistently managed.

Safe and effective recruitment practices were followed.

Is the service effective?

Requires improvement 

The service was not always effective.

People `s day to day needs had not always been met effectively or in a timely way.

Consent in relation to care was obtained by staff prior to deliver care People who lacked capacity to consent had no best interest decision made in their favour to ensure the care they received was in their best interest.

People were supported to eat a healthy balanced diet however they expressed mixed views about the quality of the food.

Staff received regular supervision and training to give them the knowledge and competency to meet people `s needs.

Is the service caring?

Good 

The service was caring.

People were treated with warmth, kindness and respect.

Staff had a good understanding of people's needs and wishes and people were involved in decisions about their care.

People's dignity and privacy was promoted.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People did not always receive personalised care as staff

People were provided with a wide range of activities. However, not everyone who wanted to was supported to take part in activities.

Summary of findings

People were confident to raise concerns. However positive lessons were not learned from these or actioned in an effective way

Is the service well-led?

Requires improvement

The service has not always been well led.

Systems used to quality assure services, manage risks and drive improvement were not as effective as they could have been.

People were aware of the management arrangements at the home but felt that it was poorly run and communication was ineffective

Staff told us they understood their roles and responsibilities and had confidence in taking matters to management. However, some staff lacked confidence that their report will result in any actions.

Milford Lodge 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.

The inspection was carried out on 09 July 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who lived at the home, four relatives, 11 staff members, a health care professional, the home manager, the deputy manager and assistant manager.

We looked at care plans relating to six people who lived at the home, and three staff files. We also carried out observations in communal lounges and dining rooms and 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 due to complex health needs.

Requires improvement

Is the service safe?

Our findings

Staff, visitors and people who used the service all told us that they felt there were not enough staff on duty to safely meet people's needs. We found that although staff had a good knowledge of people's likes and dislikes they did not always deliver care in a way that suited individual needs. One person told us, "When they [staff] are washing or showering me they get called away all the time, then it takes forever and I`m not ready for my day." Another person said, "I wake up at eight in the morning but then I am still not ready by eleven."

On the ground floor there were two staff to meet the needs of people who lived with dementia. Two people required two staff members to support them to transfer and provide personal care. Two people needed staff to provide them with continuous re-assurance and emotional support for much of the day.

This meant that whilst this care was being delivered there would be no staff available to support the remaining nine people on the unit.

On some occasions one staff was needed to provide support elsewhere on a different floor leaving just one staff to give reassurance and assist the people. As a result people became anxious and distressed. For example, in the morning we heard a person asking staff to sit down and help them; they were tearful and needed reassurance. Staff was present in the room and they stopped and gave reassurance as many times they could, however there was no time to sit down as other people needed attention as well. The person calmed down after they had a cup of tea and they started knitting. A staff member said, "It is difficult to leave the room [communal areas] when we both need to assist one person, we need to leave them alone and rush back."

In the morning of the inspection there were two emergencies where people were found on the floor. Staff had to stop medication administration to attend to the needs of these people. This caused more than one hour delay in administration of medication including medicines that needed to be given at a set time otherwise they may be less effective. One person said, "One of the staff knows my times but the others should too. My drugs need to be timed."

On the day of the inspection we noted that call bells were responded to in a timely manner. However, people told us that this wasn't always the case. One person told us that recently they were outside in the garden and needed to come in but the call bell was put by the window on the inside so they couldn't get to it. They had to shout for a visitor in the car park who then alerted staff. On another occasion the call bell was poked through the window but the resident rang three times but no-one came. They said, "I was stuck there for ages."

Another person told us, "There aren't enough staff at night. One night the corridors were empty and silent and I got really nervous so I rang my call bell. They came from downstairs and told me not to keep ringing the call bell because they were really short staffed."

We overheard a visitor complaining in the office that when their relative moved into the home it was promised that a permanent staff will be based on the top floor to look after the five people who lived there, however this was not the case and they were increasingly concerned that if their relative had a fall and could not reach their call bell to ring for help it was nobody there to help.

We asked the acting manager about this and they told us that a staff member is floating between the units and checks people on the top floor hourly. However this arrangement left people at risk of not getting help in case they had falls and not able to summon for help.

We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that there were sufficient numbers of suitable staff to meet people`s need safely.

Staff was knowledgeable about safeguarding people who lived at the service from abuse and they were able to describe with confidence what constituted abuse. They told us that they would report any concerns they had appropriately. One staff member said, "I am confident that the management team would act on any concerns that I report to them but I do know that I could take any concerns straight to the safeguarding team or to CQC." Information about how to report concerns, including contact details for the local authority, was prominently displayed in communal areas of the home.

Requires improvement

Is the service safe?

This showed us that the provider had taken reasonable steps to identify the possibility of abuse and prevent it before it occurred.

We found that safe and effective recruitment practices had been followed to ensure that staff did not start work until satisfactory employment checks had been completed. Two staff members told us and records confirmed that they had been recently recruited and that robust recruitment practices were followed. The acting manager told us that they had a recruitment drive and staff was recruited in the vacancies to avoid using agency staff.

We observed staff carry out a medicines administration rounds and noted they used a safe working practice and encouraged people with their medicine, going at their pace without rushing them. However, we noted that the staff were constantly interrupted whilst administering the medicines which meant that there was an increased risk of potential errors and that some people did not receive their medicines at the times prescribed.

We discussed this with the management team and they immediately put actions in place so that people who were prescribed time critical medicines for 0800hrs daily had these administered by the night staff thus removing the risks associated with late administration

We found that risks to people's health and well-being were identified in areas such as falls, moving and handling and nutrition. Staff were knowledgeable about these risks, however they had not been provided any clear guidance about how to reduce or manage them effectively. For example we found that a tool was used to identify the level of fall risk for a person and this was medium. There was no guidance developed for staff on how to control and lower the risk further.

Requires improvement

Is the service effective?

Our findings

A visitor said, “One of the things we like here is that staff introduces themselves when they come into the room and they tell [person] exactly what they are here to do.” One person said, “They always tell me what my food is and they cut it up for me.”

We saw and staff told us that they received training when they started working there and the topics included: manual handling, dementia training, health and safety. Staff did not receive training about specific medical conditions which some people had in their care. This meant people were looked after by staff who did not have the necessary understanding and knowledge to meet their needs effectively.

One person who lived with a specific medical condition told us they felt that staff did not understand their needs, they often felt rushed and this caused them anxiety. They said, “They don’t understand my [condition] here. They say they can take people with [medical condition] but they don’t understand it.” One staff member confirmed that they had no training in how to look after people with that medical condition.

Staff members told us that they received regular supervision from their manager and that they were able to discuss any aspect of their role with senior members of the team.

We observed that staff gained people’s consent prior to support being provided and gave people time to respond and express their wishes. Staff said they had received training about the Mental Capacity act and Deprivation of Liberty Safeguards and that they understood what it meant.

We found that where people had behaviours which could challenge others, the staff had identified that they lacked capacity to take certain decisions. However a plan of care was not developed to reflect that the care the person received was in their best interest and this was not in line with the Mental Capacity act 2005. For example we saw a behaviour plan which explained that the person will scream and shout whilst receiving personal care or a shower. When we checked the care plan, there was no best interest decision completed to ensure that the care this person received was in their best interest. Staff confirmed that there is no best interest decision in place for this person and they were not able to tell us the reason why the person was shouting.

At the time of the inspection we were told that applications had been made to the local authority in relation to people who lived at Milford Lodge and could not leave the premises on their own, they needed constant supervision.

We observed a person at risk of malnutrition and dehydration whose care plan detailed how they needed constant reassurance and encouragement to eat and drink. Staff prompted the person to drink however they did not sit with the person and ensure this person had sufficient to drink. When staff communicated about the persons intake we heard that they said the person had drank a cup of tea. We had to intervene to let them know that the cup of tea was taken away by another staff member and the person had no drinks. After we informed the staff about this person they had given reassurance and assistance to the person to drink and later to eat their meals. Staff was not able to tell us how much is the recommended fluid amount for the person to have in a day and they were not monitoring fluid intake, they monitored and recoded food intake. This meant that risk of dehydration had not been monitored or managed effectively.

People accommodated on the first and second floor were encouraged to have their lunch in the Orangery dining room on the ground floor. This was a pleasant environment and we noted people chatting sociably whilst they had their lunchtime meal. Tables were nicely laid with cloths, condiments and menus to remind people of the meals options available on the day. We saw from menus that there were three options available daily, including a vegetarian option. . People were offered a choice of soft drinks and there was the option of wine available to accompany lunch.

On the unit for people living with dementia the tables were laid nicely and people were encouraged to sit and enjoy their meal. However, people were not shown the food available to help them confirm choices they made a day before, staff dished out the meal and placed it in front of people encouraging them to eat. One person said, “I have special cutlery and if they [staff] give it to me I can manage but sometimes they don’t and then is really difficult.”

Requires improvement

Is the service effective?

People were offered a choice of drinks and top ups as well. We saw that the menu was varied and offered a good variety of choices. However people `s opinion about food was mixed. One person told us, “The food used to be alright, well sort of but now it is almost always awful.” Another person said, “The food is sometimes cold because it comes up from downstairs.” Another person told us, “There is plenty to eat, so much that it is rare I eat it all up.”

We noted that timely referrals had been made to external health professionals. For example, we noted that a person had lost weight and saw that a dietician, speech and language therapist had reviewed the person’s care needs. However, although the advice given had been incorporated into the person’s care it had not been followed by staff effectively. For example, we observed two people who had been given food supplements to drink with their morning medication. The build-up drinks were left on their table and removed untouched before lunch time meal. We overheard both people saying to staff, they didn’t like the drinks. Only when we mentioned this to the interim manager they made suggestions for staff to try and administer the build-up drinks frozen like an ice-cream or contact the GP to prescribe the supplement in a different form.

People’s health needs were met effectively. We saw that chiropodists, dentists and opticians visited the home regularly. Staff told us that a GP visited the home each Monday and Friday. A healthcare professional told us they attended the home regularly to provide nursing support. They said they were satisfied with the care that was provided for people and that the staff team were responsive to instructions from them.

Good

Is the service caring?

Our findings

Staff were friendly, courteous and smiling when approaching people. We observed sensitive and kind interactions between staff and people who used the service. Staff was able to adapt their communication and approach to people`s needs. All interaction we saw was friendly, kind and showed that people and staff had developed good relationships based on respect and trust.

Whilst staff was dealing with an emergency in the morning we heard the gardener providing re-assurance for people in a kind and gentle manner to prevent theme getting anxious.

One person said, "I like it here, it is lovely, they look after me very well, they care about me and the staff are lovely." Another person said, "The night staff are sometimes agency and they are terrible. They are sharp with me so now I go into a panic at night. It really worries me."

The acting manager was investigating issues happening at night and they had recruited permanent staff to avoid using agency staff.

Staff knew people`s needs well. For example, a person who was anxious and cried a lot staff told us," [Name] suffers with low mood, today [they] struggled." Another staff said, "When [name] is upset they upset everybody else as well and this has an impact on anxiety levels. Sometimes they needs one to one." One staff member said, "People here are cared for by genuine staff who really care."

People were involved in discussions about their care and we saw they had been involved in their plan of care. Staff gave people enough time to respond and then acted upon the choices people made.

On the day of the inspection a person was moving into the home. Staff offered kind reassurance to the person who was upset. Staff said, "We would want you to stay here with us so we can look after you."

We found that people's personal and private information was kept securely to promote confidentiality. A visiting health professional said, "They are really security conscious, everything is always locked away."

Relatives told us there were no restrictions in place when visiting the home. One relative told us that they were always welcomed into the home at any time and were invited to join in with all the social functions. We were also told by staff that relatives had been invited to stay at the home when they were visiting people and had travelled a long distance or when their relatives were going through a difficult time.

People could choose where they spent their time. There were several communal areas within the home and people also had their own bedrooms in which to entertain visitors. One staff member said, "I work for the people, if they want to have lunch in their room they can."

We found that staff were providing end of life care for people. One staff member said, "We like to keep people here, in their own home if it is possible." A relative of a late person said, "The staff were wonderful right to the end."

People`s dignity and privacy were promoted. We saw staff acted on people`s preference to have their bedroom doors closed or open if they wished. We saw staff gently prompting people and lead the way to their bedrooms if they needed support with personal care.

Requires improvement

Is the service responsive?

Our findings

One person told us that they felt embarrassed as they did not recognise people and they didn`t feel they could socialize. They spent time just in their bedroom waiting for staff to engage with them. They said, “If I would have a bit more support I would go about a bit more.” Another person said, “They haven’t got a clue how to shave me.” One visitor said, “I think they [people] are completely unstimulated.” Another person said, “I love sitting outside even if it is cold but I can`t always get out there, no staff is available to take me.”

Activity staff were available to provide stimulation and engagement for people seven days a week. We saw that there was a variety of opportunities provided. For example, the week prior to our inspection there had been a visit from representatives of a locally based professional association football club. A relative told us how nice it was to see their parent so engaged and animated by the visit

We saw that people were assisted to go shopping so that they could purchase personal items themselves. We found that people were invited to play board games, a PAT dog visited the home, a garden party had been arranged and a ‘Mocktail’ making session had taken place. However, we found that not everybody was able to participate in the activities. One person said, “Breakfast is late, then I can`t go to the activities. Lunch is late sometimes and then I can`t go to the afternoon activities.”

On the residential unit there was a selection of books available, many in a large print version, for people to access at will. We saw questions that had been prepared for a topical quiz about tennis. There was a schedule for religious services arranged so that people had the opportunity to of observe their faith in the home monthly.

The guidance provided to staff lacked consistency. For example the notes for one person said they need hearing aids for both ears and staff to ensure they have good communication with the person. There was no guidance for staff to follow on how to achieve good communication.

There were some good examples of person centred guidance for people accommodated on the residential unit, such as information for staff about how a person liked to spend their evenings; ‘In the evening I like to spend time in the lounge with other residents and read. I enjoy a glass of sherry or white wine in the evening.’

Staff had access to information to guide them on how to support a person who had recently been diagnosed with dementia. The guidance stated that the person sometimes felt they were losing their independence as a result of the diagnosis and that staff should continuously reassure the person.

People and visitors told us they were involved in the review of their care plan. One visitor said, “They [staff] show us the care plan, we can always read anything, we just have to ask.”

We saw that people’s complaints had been logged and responded to. However, concerns raised verbally had not been captured in this process. For example, we overheard a relative complaining in the office in the morning, however in the afternoon when we asked the manager they were not aware of the complaint and it was not recorded. There were no systems to identify trends or patterns of concerns raised.

Meetings were held for people who used the service to share their views on how the home was run. However, we found they were centred on the activity provision and did not encourage or empower people to make suggestions about how other areas of the service could be improved.

Requires improvement

Is the service well-led?

Our findings

Staff had mixed views about the management arrangements in the home. One staff member said, “Management are approachable but it seems they don’t action anything we report.” Another staff member said, “Managers are very approachable, they listen.”

We saw that staff meetings took place and that these covered various internal issues around the home such as laundry and maintenance. These meetings were also used to identify areas of good practice for the registered manager to thank the team for some good support provided to a person. We found that although staff were listened to by the management team, they were not confident that any actions will be taken about their concerns or ideas.

We found that the quality of care provided lacked consistency and varied significantly between different units and floors at the home. When problems or difficulties arose, for example in an emergency or at mealtimes, the insufficient staffing levels had a negative impact on people`s experience, increased waiting times and delayed their medicines being given. We were told by staff that they have reported this to management, however an additional staff member was allocated to work in the home just after we feedback to the acting manager our observations.

People and visitors were aware of management arrangements whilst the registered manager was absent. However, they told us, “The main problem is the communication between the managers and us, they don’t communicate.” Another person said, “The problem with this place is that it isn`t run properly.”

We saw that a meeting for relatives took place in May and the issues raised by the relatives were exactly the same issues we identified. For example, some of the areas discussed included discussions about the quality of food, issues with communication between shifts and staff to relatives and quality of the activities. However, it was not clear if any of these were actioned. The service was not able to demonstrate that they use people`s experience and feedback to continuously drive improvement of the service delivery.

We saw that the registered manager sent out a survey to gather the views of staff, relatives and other professionals about the quality of the service delivered. Following the surveys there were no meaningful actions plans developed for the areas of improvement identified or meetings with people who use the service to discuss these areas.

We saw a record of audits undertaken around areas of the service such as care plans, infection control and kitchen hygiene. However, these were not detailed, they were not regular and did not indicate what specifically had been looked at and what the findings were. There was nothing to indicate that issues had been identified by these audits or what action had been taken to address them. The acting manager viewed these documents with us and agreed that they were not effective audits.

We found that the registered manager monitored the dependency levels of people, however when we checked and carried out observations we found that there were more people with high dependency levels than reflected in that assessment. Staff also confirmed that the people we observed were high dependency. The failure to properly assess and monitor people’s needs meant that staffing levels and deployment had not always been sufficient or effective.

We found that the quality and safety of the services provided was not assessed effectively, the management had not listened to staff feedback regarding inadequate staffing levels and no improvements were made to the standard of the services provided following feedback from relatives, staff and people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered person did not take proper steps to ensure that there were sufficient numbers staff available to meet people's needs at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not developed effective systems to monitor and improve the quality of the service provided.