Prime Life Limited

# Mill House & Cottages

## 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? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

What life is like for people using this service:
The quality of care provided, leadership and oversight of the home had deteriorated since our last inspection. The provider had recently begun to identify this and during our inspection took actions to address it.

People were not always supported to take their medicines in a safe way. Not all staff followed the providers systems for ensuring the administration of medicines which resulted in a significant error during the inspection.

There was enough staff on duty to keep people safe. Several staff had recently left which meant temporary staff supplied via an employment agency had been used. New staff had been recruited but were still in the process of becoming familiar to people. This had led to a period whereby people felt unsettled. Existing staff were working hard to support these new staff as they felt the manager was overwhelmed and did not have the time to do so.

Checks to ensure the environment was safe and clean had not been completed. We found areas which posed a risk to people because they had not been kept in good repair or regularly cleaned. Items which posed a risk to people such as cleaning equipment had not been kept securely.

Staff were kind and considerate to people, however during busy periods became task focussed and did not always ensure they were responsive to people's needs. Staff ensured people's privacy was maintained, and sought their consent before providing them with care.

Some people's care records had not been updated since September 2018, where needs had changed, not all staff were aware of this. Staff had not always fully completed the daily records of people's wellbeing. This had not been identified because the manager had not reviewed them as was required.

The provider's systems to check the quality and safety of the service had not been undertaken by the manager since the departure of the previously registered manager in October 2018. We found that there had not been sufficient oversight of people's day to day care, some actions to mitigate changes in people's wellbeing had not been taken. The provider took immediate action to address this. A deterioration in communication between the manager and staff contributed to people not receiving the care they needed in some instances.

Staff understood the need to keep people safe and what was required to do this. Staff had received training in this area, and were clear they would report concerns to a manager or appropriate outside agency without delay.

More information is in Detailed Findings below:

Rating at last inspection: At the last inspection the service was rated Good (Report published 21 February 2018). At this inspection we changed the overall rating to Requires Improvement.

About the service: Mill House and Cottages is a residential care home that is registered to provide accommodation and personal or nursing care to a maximum of 44 people. At the time of our inspection, 34 people were living there.

Why we inspected: This inspection was carried out in response to incidents that had occurred in the service and concerns that had been raised about the safety, quality and management of the service.

Follow up:  We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve the rating of the service to at least Good. We will require them to provide an action plan detailing how this will be achieved. We will revisit the service in the future to check if improvements have been made.

## 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

Details are in our Safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

# Mill House & Cottages

**Detailed findings**

## Background to this inspection

The inspection: We carried out this responsive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We undertook this because we had received concerns regarding the managements of the home and the safe care and treatment of people living there. This inspection checked 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.

Inspection team: Two inspectors and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Mill House and Cottages is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service is required to have a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Although the service had a manager in place, they were not yet registered with the CQC.

Notice of inspection: This inspection was unannounced.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about and we sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection, we spoke with four people who used the service, three relatives and a visiting healthcare professional to ask about their experience of the care provided. We carried out observations of people receiving support and spoke with the acting manager and four care staff who worked at the service. We also spoke with the providers regional operations manager and two regional directors who were visiting

the service. We looked at records in relation to people who used the service. We also looked at staff files as well as records relating to the management of the service, recruitment, policies and systems for monitoring quality.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means people were protected from abuse and avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection;

● Staff knew where people required support to reduce the risk of avoidable harm. However, the daily records used to monitor those risks such as hydration and nutrition, swallowing difficulties and skin integrity were not detailed nor used by staff to understand progress or risk. The manager had not undertaken daily checks of these records which was the providers stated frequency. The regional manager responded quickly during the inspection and made arrangements to ensure the manager and staff were supported to improve the way they recorded and reviewed information.

● Visit records and correspondence confirmed that health and social care professionals were generally promptly involved when people experienced any health or wellbeing issues. However, for one person the re-referral criteria set by their dietician had been met but had not been acted on This meant that the person's health and well-being was put at risk due to their weight loss. The providers system of reviewing and tracking people's weights on a monthly basis for comparison where they were at risk, had not been undertaken by the manager since coming into post in November 2018.

● On the second day of our inspection we found that a staff member had not administered medicines as per the providers stated process to ensure that people received them safely and as the prescriber intended. This resulted in an incident whereby an incorrect dose was taken. We made the regional manager aware of this without delay who took the appropriate actions expected. Further observations however confirmed that other staff followed the providers procedure for the administration of medicines

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found areas of the home, including areas where food was served or staff washed their hands to be very dirty. Items that should be stored securely and presented a risk to people such as cleaning fluids, toiletries and sharp objects were not secured in line with the relevant legislation and requirements. We took action during the inspection to ensure this was addressed immediately, and the provider did so.

● We found some areas in the home to be cluttered with personal belongings and equipment. In one area we found a large battery for use in a mobile hoist on charge underneath a large amount of flammable materials and paper which presented a fire hazard.

● Some areas of the home had very damaged painted surfaces, which meant they could not be kept adequately clean. The issues we had found had not been identified by the manager and checks to ensure the premises were safe and free from danger had not been completed since they came into post.

● Communal lounge areas and some corridors had a noticeable mal-odour that remained throughout our inspection.

This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that they received their medicines as they expected.
● Medicines were safely stored and destroyed for example, where people refused to take them or they were no longer required.
● People told us they were happy with the support they received to take their medicines. One person told us, "The staff are very keen to make sure you have the right medicines."
● People told us they felt safe, relatives confirmed this. One person said, "Yes I do feel safe, the staff will try to get you anything you want, they are so helpful."
● Where people experienced periods of distress or anxiety staff knew how to respond effectively. This was because they knew people's preferences and what approach worked to enable the person to relax.
● Emergency plans had recently been reviewed following feedback from local environmental health officers. Improved plans were now in place to ensure people were supported in the event of an emergency such as a fire.
● Staff used personal protective equipment to help prevent the spread of healthcare related infections.

Learning lessons when things go wrong
● The manager did not always review risk assessments and care plans following incidents such as a significant weight loss. Where community professionals had recorded that actions needed to be taken, staff had not always evidenced that they had been addressed.

Staffing levels
● People we spoke with had mixed views on whether recently there was always enough staff on duty. Relatives we spoke with all felt that staffing levels were suitable. Comments included, "Yes I think there is enough, there's always someone in the lounge when I visit keeping an eye on everyone." Another relative told us, "We come at different times and days and there are always enough staff around."
●There had been a recent high turnover of care workers and senior care workers. New care staff had been recruited and temporary staff supplied via an employment agency used to cover vacancies. Efforts were made to maintain as much consistency for people as possible.
●The provider had ensured enough staff were on shift so that people received support in a timely way. A tool was used to monitor the number of staff required, based on people's needs.
●We saw all staff had been recruited safely by the provider, with safety checks completed by the recruitment agency for temporary staff.
Safeguarding systems and processes
●The provider had effective safeguarding systems in place and all staff interviewed had a good understanding of what to do to make sure people were protected from harm or abuse. They had received appropriate and effective training.
●The provider had reported, as required, any safeguarding concerns to the local authority and the Care Quality Commission without delay.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Supporting people to eat and drink enough with choice in a balanced diet

● Risk assessments and care plans in relation to nutritional needs had not always been updated and did not always provide clear guidance for staff to follow. We found conflicting information in records and the practice of staff differed as they did not have the correct information about people's specific dietary needs. For example, we observed a person who required a soft textured meal according to their care plan, was given a normal meal which was not soft, because staff and the mealtime checklist had not been updated to reflect this change. The person was unable to eat the meal and was not offered an alternative when it was left uneaten. However other records showed that appropriate care and support was being provided.

● Staff did not accurately record, in detail people's intake of food or fluids where it was deemed essential to do so to ensure a person's wellbeing. The monitoring of these records had not taken place since October 2018. Where actions to address peoples weight loss had been required, these had not been taken as a result.

This is a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that they enjoyed the food provided and could choose what they wanted. One person told us, "If you wanted something special, I'm sure the cook would do it for you."

Staff providing consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Prior to our inspection we received concerns that referrals for care and treatment by community based professionals where not always completed in a timely way. We identified incidences of this during our inspection.

● Senior staff needed to improve their communication with community based professionals and ensure they have a system of effective handover of information between staffing and shift changes.

● Assessments were obtained from health and social care professionals prior to people's admission to the home, and used to help plan people's care.

Staff skills, knowledge and experience

● The home had recently employed several new staff. These newly recruited staff told us they had been supported and mentored by existing staff. Experienced staff that we spoke to were enthusiastic about developing new team members but felt that this was required because the manager was overwhelmed and did not have the capacity.

● Staff received training in all areas required to enable them to undertake their duties. Staff told us that they enjoyed partaking in this and that the face to face delivery of it was an effective way of learning.

● People and their relatives told us that the found the staff to be well trained and knew what they were doing. However, we observed mixed practice from staff when communicating with people, or having the

skills and confidence in supporting people when they were confused.

Adapting service, design, decoration to meet people's needs
●Technology and equipment was used effectively to meet people's care and support needs. People had access to call bells to alert staff to when they required support. Sensor mats were in place for people who were at high risk of falls.
●The building design met the physical needs of people living in the service with wide spacious corridors and handrails to support people with mobility difficulties.
● The provider was in the process of arranging new signage that would be easier for people living with dementia to use. People's bedroom doors had pictures and posters, with information about them to enable them to recognise which was their bedroom.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● Where people were deprived of their liberty, the home worked with the local authority to seek authorisation for this to ensure this was lawful.
● Staff ensured that people were involved in decisions about their care; and could tell us what they needed to do to make sure decisions were taken in people's best interests.
● Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported; Supporting people to express their views and be involved in making decisions about their care

- Staff were kind and showed compassion towards people, however, at times became task orientated. They did not consistently ensure support was focussed on the person. For example, we observed at a mealtime, some people were given their meal without being told what it was. Condiments were not offered, when people did ask for condiments, these were not brought in a timely way.
- People were not always asked what they would like to do, or where they would like to sit before being moved in a wheelchair. Choices were not always given when selecting a radio station or TV channel, with some staff putting on what they preferred rather than asking people.
- People and their relatives were able to share information about their life history, important relationships, likes, dislikes and preferences when moving into the home. However, people told us that they were not involved in reviewing their care to check if any changes were required.
- Staff provided support and comfort to people who were upset and anxious to help relax them.
- People were positive about the caring attitudes of staff. Comments included, "I get on with the staff very well, nothings any trouble. We have a laugh and a joke." A relative told us, "The staff are very caring."

Respecting and promoting people's privacy, dignity and independence

- People's right to privacy and confidentiality was respected. Staff ensured they delivered personal care to people in private. One person said, "Oh yes, I get enough privacy."
- Staff knocked on doors and waited for a response before entering bedrooms, bathrooms and toilets and people told us this was usual.
- Records relating to people's care were kept confidential and staff understood the importance of discussing people's care in a private location.
- People told us they felt listened to. Staff knew how people liked to be addressed and called people by their preferred name or title.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means that services met people's needs.

Personalised care

● Care plans we looked at had been regularly updated and reviewed up to the present for one person, with prompt action taken to involve health professionals when appropriate. However, vital information regarding two people had not been updated since September 2018. This meant these people's health and welfare had not been recorded so that appropriate action could be taken to ensure their continued good health.

● The provider had a programme of suggested activities for staff to co-ordinate. People told us that they enjoyed many of these. However, we saw that outside of these activities, staff did not have the time to spend to sit and talk with people. Staff we spoke to told us that they would try to do this but rarely had the time to do so. We saw that people spent long periods of time without input or stimulation.

● People's care plans were laid out in a clear, consistent and well organised format. They contained helpful advice for staff to use when providing care and support to people. For example, detecting the signs when people with limited verbal communication were experiencing pain.

● People's needs were identified, including those related to protected equality characteristics, and their choices and preferences were regularly met and reviewed.

● Reasonable adjustments were now made where appropriate and the service identified, recorded, shared and met the information and communication needs of people with a disability or sensory loss, as required by the Accessible Information Standard.

Improving care quality in response to complaints or concerns

● None of the people we spoke with had ever made a complaint or raised a concern, however they all felt confident that if they did make a complaint it would be dealt with quickly.

● We saw that any complaints received had been investigated and addressed providing the complainant with a formal response, in line with the service's complaints procedures.

●The home provided a range of accessible ways to do this through regular surveys and other meetings held with people and their relatives. People and family members were given information about how to make a complaint.

End of life care and support

● Care plans contained some information about peoples wishes and needs to be taken into consideration at the end of their lives. Plans needed to be clearer in detailing when people had declined to discuss this or had not expressed a preference.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Leadership and management; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements; Working in partnership with others; Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong; Continuous learning and improving care

- The homes previous registered manager and several experienced staff had left at the same time. This had resulted in a period of instability and change. A new manager had been employed since October 2018 and received comprehensive support from the regional manager who was very familiar with the service.
- The manager had very limited experience of leadership and the regulatory requirements they were responsible for. Staff reported that the home was not running as well as it should be, and that the manager appeared overwhelmed. Staff told us that this impacted on the support that they themselves received. Communication regarding people's changing needs between the manager, senior staff and staff was not consistent or sufficient enough to ensure they were met.
- The provider had extensive quality assurance systems in place to be used by the manager and staff to ensure that safe high-quality care was provided. However, the manager had not used or completed these fully. The checks they were expected to complete had not been undertaken, although they confirmed they understood they were required to do so. This had resulted in people being put at risk because shortfalls in their care were not identified. Actions to ensure the welfare of people when changes to their wellbeing had occurred had not always taken place.
- Community professionals involved in the health and well being of people, including those from the local authority, reported that essential information was not always shared accurately or in a timely way.
- The provider had begun to identify that its systems to ensure the safety and quality of the home had not been fully completed. However, sufficient or timely action had not been taken to address this until concerns were raised during the inspection. At this point, extensive and comprehensive actions were taken. The providers regional directors acted with candour and were open and responsive in addressing the concerns we raised.

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

Engaging and involving people using the service, the public and staff

- The provider engaged with people and their relatives using satisfaction surveys and meetings. These showed that people had been satisfied with the quality of care provided.
- We saw that the providers regional manager and directors knew people and their relatives very well, and took the time to speak with people whilst they were at the home.
- The home had an annual event in the summer which was open to the public. People attended events in the community such as Christmas services and events at the local church.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There were risks to people's safety associated with the way their support needs were managed. Risks to people, and the planned actions to help mitigate them were not adequately planned, adhered to or monitored. Medicines were not always safely managed. 1, 2 (a) (b) (d) (e) (g) and (I). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>People at risk from not eating or drinking enough, were not adequately monitored to promote their health. Some records had not been amended to detail changes where there had been a review by a community professional. 1, 2 (a) (b) 4 (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Premises and equipment were not always kept clean or secure. 1 (a), (b), (c), (e) (f) 2 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems for monitoring and improving the quality and safety of the service and having |

regard to the accuracy of records were not operating effectively. 1, 2 (a), (b), (c)