Prime Life Limited

Mill House & Cottages

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 November 2014 and 16 January 2015. After that inspection we received concerns in relation to how people were being supported with drinks, specific risks to people's safety and staffing levels. As a result we undertook a focused inspection on 9 November 2015 to look into those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mill House and Cottages on our website at www.cqc.org.uk.

Mill House and Cottages provides residential care for up to 44 older people, some of whom may be living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We had recently received some concerns about this service and decided to carry out a focused inspection to see whether we could substantiate the concerns that had been raised with us. On the day of our inspection we were welcomed into the home. The senior on duty was busy with the medicines round so upon arrival we walked around the service, spoke with people living there, spoke with staff and observed general day to day tasks being carried out. The manager arrived later in the morning as they had covered the night shift.

We did not confirm the concerns that had been raised with us. People were being supported in a safe manner and received assistance to drink as necessary.

Summary of findings

We found that the service was taking the necessary steps to ensure people who were at risk of falls had the risks to their safety reduced as far as was possible. People who were unable to use call bells were kept safe, but this required documenting as a risk assessment.

People who required support with drinks received this in a timely manner and were encouraged to drink. People who took their meals in bed were appropriately positioned to reduce the risk of swallowing difficulties.

There were enough staff to support people with their needs. This was kept under frequent review.

The ratings for all key questions and the overall rating of the service remain unchanged from our previous inspection of 21 November 2014 and 16 January 2015 when the service was rated 'good' throughout.

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?

Good

The service was safe.

People at risk of falls had plans in place to reduce the likelihood and impact of falls as far as was possible.

People cared for in bed were positioned to reduce the risk of choking when they were eating.

There were enough staff to meet people's needs in a timely manner.

Is the service effective?

Good

The service was effective.

People requiring staff support to drink and eat received the assistance they needed.

Mill House & Cottages

Detailed findings

Background to this inspection

We carried out an unannounced focused inspection of Mill House and Cottages on 9 November 2015 to look into concerns we received in relation to people being supported with drinks, specific risks to people's safety and staffing levels.

This inspection was undertaken by two inspectors.

Prior to this inspection we reviewed the information of concern we had received, as well as previous inspection reports, statutory notifications and enquiries. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with five people living in the home, four staff members, the registered manager and a regional manager. We observed how people were supported by staff and what actions staff took to ensure their safety and wellbeing.

We reviewed the care plans for six people which included supplementary care records such as daily notes and fluid charts. We looked at staffing documentation to establish how staffing levels were determined and whether they had been adhered to.

Good

Is the service safe?

Our findings

During this inspection we found that three people's rooms on the first floor had alarms fitted to their bedroom doors to alert staff that they were exiting their rooms because they required staff assistance to remain safe when mobilising. One of these three people had been assessed as at a high risk of falling and had experienced a few falls recently. This person had been offered, and had accepted, a room on the ground floor to which they were shortly about to move. This had been agreed upon in order to remove the risk of them falling down a staircase as this had been identified as a risk to their welfare. This person told us they felt safe in the home and they were pleased to be moving to a downstairs room.

Several people's rooms did not have cords attached to the call bell panels. This meant that people would be unable to summon staff if they needed them. The manager told us that these people did not have the ability to call for assistance so the cords were not being used. These people's care records confirmed that they had various health conditions which meant they would be unable to operate a call bell. During our inspection these people were all in communal areas and so were in the company of staff who were supporting them. The manager told us how the safety of these people was assured when they were in their rooms and how systems were in place for staff to check on them periodically. However the risks associated with people being unable to use call bells and the actions taken to mitigate this risk hadn't been documented within their care plans. Following this inspection the manager informed us that this had been rectified and that risk assessments were now in place which documented the actions staff were taking to keep people safe.

We received a concern that one person did not have the necessary equipment in place to meet their needs, which could pose a risk to their safety. A hospital bed that had been supplied to the home upon the person's discharge from hospital had not been suitable, neither had a sling the home had received which was requried to hoist the person. A new bed had subsequently been provided that was more appropriate. It had become apparent soon after the person's admission to the home that the equipment the home had received was not suitable. The service had taken prompt action in liaising with the community nurse who visited the person to review the person's needs in detail and order suitable equipment.

Prior to this inspection we had received a concern that people were at risk of choking because they were not supported to sit upright when eating. During this inspection we identified people being cared for in bed and looked at how they were positioned when meals were about to be served. All were in a seated position which would help them to swallow safely.

The service utilised a dependency tool to calculate the staffing level required. We saw how people's needs had been determined, how many hours care and support they required and how this translated to the numbers of staff required on duty. Six care staff were on duty during the day and four staff were required overnight, with one of these being a 'sleep in' staff member. The manager told us that she and other seniors were occasionally covering some night shifts at present due to staff absence but recruitment was underway.

We reviewed the staffing rotas over the previous four weeks and found that there was only one occasion where cover had been unable to be found for a 'sleep in' night shift. Other staff had been able to at least partially cover staff absences on three other day shifts in the same four week period when the service had been one staff member down.

We saw that staff were busy, but were able to provide a good standard of support to people and had time to chat with them. We spoke with people in a communal area who told us that there were usually enough staff around to assist people when necessary.

The only concern people raised with us was that following the installation of a new boiler the water in their rooms was now only lukewarm. We spoke with the manager who had not been on duty since the new boiler had been installed. They told us they would ensure that the heating engineers returned to rectify this problem.

Good

Is the service effective?

Our findings

We had received a concern that one person was not being supported to drink enough. This person needed staff assistance to drink. We reviewed fluid records for people who required staff support with drinks over the previous nine days. These clearly showed how much people had drunk and occasions when they had been offered a drink and had declined. We noted that whether people were in communal areas of the home or in their own rooms they had access to drinks. One person told us, 'There's always plenty to drink around here.'

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.

Mental capacity assessments were in place where there was uncertainty regarding people's capacity to make some decisions for themselves. However, these assessments did not extend to the use of door alarms fitted to the doors of people who were unable to consent to this arrangement. Therefore we had been unable to confirm that the decision had been made in the person's best interests. Following this inspection the manager informed us that this had been rectified.