Kensington Care Limited

Milton Lodge Residential Care Home

Inspection report

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Bournemouth
Dorset
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13 July 2016
14 July 2016
15 July 2016

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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?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 13, 14 and 15 July 2016. At the last inspection completed in December 2015 the provider was not compliant with all the regulations and a Warning Notice was served. This was because accurate, complete contemporaneous records were not maintained in respect of each person living at the home. Two requirement actions were also made; one concerning the failure to meet the requirements of the Mental Capacity Act 2005 and another concerning the support, supervision and appraisal of staff.

Milton Lodge is registered to accommodate and provide personal care for up to 18 people. The home aims to meet the needs of older people, including those living
with dementia. At the time of this inspection there were 12 people living at the home.

Since the last inspection in December 2015, the person who was the registered manager had ceased working at the home and a new manager had been appointed. They were in the process of registering with the Commission but were absent on the days of our inspection. The provider, the duty manager and senior care workers therefore assisted us throughout the inspection. We also spoke with two other members of staff, a visiting relative and a person's legal representative.

Overall, the relative and staff were very positive about the standards of care and the way people were cared for and supported.

People were safe living at the home as steps had been taken to make sure the environment and the way people were cared for and treated were safe. Some improvement was still needed concerning record keeping.

Staff had been trained in safeguarding adults and were knowledgeable about the types of abuse and how to take action if they had concerns. Training had been booked for newly appointed staff.

Accidents and incidents were monitored to look for any trends where action could be taken to reduce likelihood of their recurrence.

There were sufficient staff to meet the needs of people accommodated.

Recruitment procedures were being followed to make sure that suitable, qualified staff were employed at the home but there could be some improvement in record keeping.

Medicines were administered by trained staff and generally managed safely. Improvements could be made with better monitoring of medicine administration records to reduce gaps in recording.

The staff team were both knowledgeable and informed about people's care and support needs. There were

good communication systems in place to make sure staff worked to agreed objectives.

Staff felt supported by management but there could still be improvement in making sure formal supervision sessions with a line manager took place in line with the home's procedure.

Staff were aware of the requirements of the Mental Capacity Act 2005 and acted in people's best interests where people lacked capacity to make specific decisions, although this could be better evidenced in the records. People were consulted and gave consent to their care where they were able.

The home was compliant with the Deprivation of Liberty Safeguards with appropriate applications being made to the local authority.

People were provided with a good standard of food and their nutritional needs met.

People's care needs had been assessed. Comprehensive and detailed care plans had been developed to inform staff of how to care for people. The plans were person centred, covered all areas of people's needs and were generally up to date.

We saw staffing supporting people in a compassionate and caring way. The relative we spoke with was satisfied with the standards of care provided at the home. Staff were knowledgeable about people's needs.

A member of staff was employed to provide activities to keep people meaningfully occupied.

There was a complaint system in place and this was well-publicised.

Should people need to transfer to another service, systems were in place to make sure that important information would be passed on so that people could experience continuity of care.

The home had a new manager who had the confidence of a largely newly recruited staff team. There was a positive, open culture in the home.

There were systems in place to audit and monitor the quality of service provided to people.

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

People were protected from risks to their safety; some improvement could still be made concerning record keeping.

Staff were trained in safeguarding adults.

There were sufficient staff employed at the home to meet people's needs.

Staff were recruited safely.

Medicines were managed safely but improvement could be made concerning record keeping.

Is the service effective?

Requires Improvement

Staff felt supported by management but there could still be improvement in making sure formal supervision sessions with a line manager took place.

Staff were aware of the requirements of the Mental Capacity Act 2005 but improvements could still be made in evidencing how best interest decisions had been made.

People were supported to have access to healthcare as necessary.

People were supported to eat and drink appropriately.

Is the service caring?

Good

We observed that staff treated people with warmth and compassion.

Staff respected people's choices and supported them to maintain their privacy and dignity.

Is the service responsive?

Good

People's care needs had been assessed. Comprehensive and detailed care plans had been developed.

A range of activities were provided to keep people occupied.

People's concerns and complaints were responded to and taken seriously.

Is the service well-led?

Good

A new manager had been appointed and staff felt there was leadership and good morale.

Surveys had been sent out to gain views of relatives about the quality of service provided.

There were systems in place to monitor and assess the quality and safety of the service provided.

Milton Lodge Residential 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 was 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 did not ask for a Provider Information Return (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered manager had prepared a PIR and provided this at the beginning of the inspection. The information contained was used as part of this inspection.

We reviewed the notifications we had been sent from the service since we carried out our last inspection. A notification is information about important events which the service is required to send us by law.

This inspection took place on 13, 14 and 15 July 2016 and was unannounced. Two inspectors carried out the inspection over the three days. We met and spoke with the majority of people living at the home. As the majority of people were living with dementia 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.

We looked at four people's care and support records and reviewed the medication administration records for everyone living at the home. We also looked at records relating to the management of the service including staffing rotas, staff recruitment and training records, premises maintenance records, a selection of the provider's audits and policies and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

The visiting relative we spoke with said they had confidence in the home and had no concerns for their relative's safety. Overall, the provider had taken steps to make sure people were protected from avoidable harm and abuse thus ensuring people's human rights were protected.

The members of staff we spoke with were knowledgeable about identifying the signs of abuse and knew how to make safeguarding referrals to the local social services. The staff were also aware of the provider's policy for safeguarding people. Information notices were displayed in the home as a prompt for staff.

At the last inspection in December 2015 we found the staff team had completed training in adult safeguarding that included knowledge about the types of abuse. Records were in place to show that all staff had received this training and that they received update training each year. Since that time, new members of staff had been appointed and the manager had identified, following an incident that warranted a safeguarding referral, that some new staff needed further training. A training course in safeguarding adults had been arranged for five staff in August.

At the last inspection we issued a Warning Notice for a repeated breach of a Regulation. The provider had failed to comply with a requirement action from an inspection in January 2015 when risk assessments, such as moving and handling assessments and bedrail assessments, were not up to date. At this inspection we found that the systems in place to ensure risks were minimised in delivering people's care were satisfactory, although improvements in record keeping could still be made.

Risk assessments for topics commonly affecting older people had been carried out and recorded on the files for people whose records we checked. The assessments included malnutrition, falls, moving and handling, the use of bedrails and skin care amongst others. They had been reviewed monthly to make sure that information for staff was up to date. These assessments informed the care plans that had also been developed.

We spent time looking around the premises and noted that since the last inspection many of the bedrooms had been redecorated and the home was clean with no unpleasant odours. We did not identify any obvious hazards that could cause harm to people as actions to minimise risks had been taken. These included the covering of radiators to protect people from scalding surfaces, window restrictors fitted to windows above the ground floor to prevent accidents and ensuring freestanding wardrobes could not be pulled over. A report from the provider's water company identified some recommended actions, namely, two faulty thermostatic mixing valves and component additions to improve the performance and compliance of the cold water tank situated in the loft. The provider had addressed and actioned these matters before completion of the inspection. The provider also agreed to making sure the bath hoist in the bathroom on the first floor was repaired, so that people had a choice of either a bath or a shower, and taking action with regard to the drain in the downstairs wet room which was slow draining.

Improvements in monitoring the fire safety systems was discussed and agreed with the deputy manager and

also the provider. A notice in reception stated the fire safety system would be tested every Monday, a notice in the fire log book stated it would be tested on a Friday but records had been completed for testing more often on a Tuesday. The deputy manager told us that the fire fighting equipment check was carried out each week but there was no record of this. It was agreed there would be a set time each week for testing the fire safety system and this and other checks would be monitored by the delegated person for fire safety. The fire risk assessment had not been reviewed for a number of years. The provider arranged for a new fire risk assessment to be carried out by a contractor later in the month of the inspection. On one of the inspection days, a fire safety contractor visited the home to test the safety systems.

The manager monitored accidents and incidents that had occurred. Records were maintained individually of any accidents or incidents. These were periodically reviewed to look for any trends where action could be taken to reduce the incidence recurrence. Actions taken to reduce incidence of further accidents included the fitting of bedrails to prevent people from falling from bed and the use of pressure mats to inform staff if a person got up in the night.

Personal evacuation plans to make sure people were safe in the event of fire had been completed and other plans put in place for the event of other emergency situations. There was also a "Business Continuity and Emergency Plan" in place that set out procedures to be followed in such emergencies as electrical power failure, fire or loss of heating.

All the staff and the relative we spoke with were satisfied with the levels of staffing provided, which they said were sufficient to meet people's needs. Throughout our inspection the staffing as described on the duty roster was met with; four care staff on duty between 8am and 2pm, three between 2pm and 8pm and two awake staff on duty during the night time period. The day before our inspection concerns were raised because staff sickness had meant that there were only three staff on duty that morning until 10am. No member of staff was able to administer medicines until that time. Staff and the provider told us this had been an exception. We looked at the duty roster for the week ahead and there was a member of staff designated for responsibility for administering medicines for each shift. The provider also informed us of a new on-call roster that would ensure that staff had a senior to call on in the event of emergencies. We spoke with two senior carers who were satisfied with this arrangement.

Recruitment records for three members of staff who had started working at the home since the last inspection, showed that recruitment procedures had been followed. Required checks had been carried out but some required records were not immediately available because the manager was not present. However, we were able to evidence that these records had been collated and filed elsewhere. These included a photograph of the staff member concerned, proof of their identity, references, a health declaration and a full employment history with gaps explained and reasons given for ceasing work when working in care. A check had also been made with the Disclosure and Barring Service to make sure people were suitable to work with people in a care setting.

There were systems in place to make sure that medicines were managed safely. A member of staff ordered medicines required and checked the order when this was delivered to the home by the pharmacist. Staff responsible for administration of medicines had been trained and had their competency assessed. Medication administration records showed that people had received medicines as required, although there were a small number of gaps within the recording. There was information as well as body maps in people's rooms to show staff where to apply prescribed creams. Again there some gaps in the recording of creams application. Checking the controlled drugs register, we found that some medicines that had been returned to the pharmacist had not been reconciled in the register. The records of medicines returned to the pharmacist evidenced that the medicines were no longer in custody of the home and the controlled drugs

register amended accordingly.

Although auditing of fridge temperatures and medication administration records (MARS) had been carried out the preceding month, we recommend better monitoring of medication recording systems to reduce such errors and gaps in recording.

There was good practice of a photograph of the person concerned at the front of people's MARs together with information about allergies they had to any medicines. Where a variable dose of a medicine had been prescribed, the number of tablets given was recorded.

Some people had 'as required' medicines prescribed who did not have capacity to understand when these were required. For the majority of people there were protocols written for the staff to guide them when a person would require these medicines. By the end of the inspection one of the senior staff had checked and made sure there was a protocol in place for everyone who did not have capacity concerning these medicines.

The home had adequate storage facilities for all medicines including a small fridge that was checked daily to make sure it was working within the correct temperature range. The provider had ordered a new lockable small fridge for storing medicines requiring refrigeration as concerns had been raised because the old fridge could not be locked.

Overall there was a system in place to account for all medicines entering the home.

Requires Improvement

Is the service effective?

Our findings

The relative we spoke with told us that they had confidence in the staff team and that their relative's needs were met at all times.

At the last two inspections, January and December 2015, training systems were in place to make sure staff had the skills necessary for their role. At this inspection we spoke with three members of staff who had been recruited since the last inspection. They said they had not yet received much training, however; these staff had years of previous experience of working in care and training courses had been booked for them by the manager for July and August. These included; Role of Health Worker, Duty of Care, Person Centred Care and Dignity, Safeguarding Adults and Infection Control, Awareness of Mental Health, Dementia and L.D., Personal Development, Communicate Effectively, Equality & Diversity and Food & Nutrition, Emergency First Aid, and Health & Safety with Fire Course Review. Members of staff new to care were inducted under the Care Certificate. Staff told us that they had received basic induction when they started work in the home, telling us that this had been satisfactory.

At the last inspection we made a requirement action as staff were not supported through formal and informal supervision. At this inspection all staff we spoke with told us they felt supported by the manager and deputy manager. They told us that the manager was always available and there was an 'open door' policy so that any issues were addressed promptly. The home has a policy of formal supervision of once every eight weeks a direct face to face meeting with a line manager. Individual records of formal supervision were held on people's personal files and there was also evidence of some direct observation, for example of managing people's skin care. However; despite improvement in managing staff supervision it was not evident that the policy was being met with respect to all staff. This was still an area for improvement.

Staff were knowledgeable about the needs of individuals we discussed with them. They told us there was good communication through staff handovers at the beginning of each change of shift and a staff communication book. When we last inspected the home there was poor communication between the home and the district nursing service. Communication had improved with the introduction of a communication book. A member of staff told us, "Morale is very good, everyone gets on very well together and there are better systems."

At the last inspection we made a requirement concerning compliance with the Mental Capacity Act 2005 (MCA). This 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 be as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications to the local authority had been made appropriately for people deprived of their liberty. On one

day of the inspection we met with one person's financial appointee under a DoLS. They told us that they had been involved in a 'best interest' meeting and that the home was involved and complying with the conditions attached to the person's DoLS.

Staff had some knowledge and understanding of the (MCA). Further training, arranged for staff later in the month, should ensure the approach to caring for people is carried out in accordance with the requirements of the MCA. A mental capacity assessment had been completed for people who lacked capacity to make some decisions. The assessment provided guidance to staff about areas of people's lives where they could make decisions and those areas where they could not give consent. For example, one person's assessment informed that they could sometimes make decisions about what they wanted to eat and what they wanted to wear. The assessment guided staff to take time to listen to the person, to act on their wishes but to make the decision on their behalf if they did not have the capacity to give consent.

There could be improvement in the recording of these assessments with more information concerning the people involved in making 'best interest' decisions. For example, it was also not evident on people's records as to whether any relatives held any legal orders, such as a Lasting Power of Attorney for health and welfare. Where people had bedrails in place and they did not have capacity to give consent, we saw that relatives had often signed for consent. However, it was not clear whether they had this legal authority for this decision making by means of a Lasting Power of Attorney for health and welfare.

People were supported to have sufficient to eat, drink and maintain a balanced diet.

We observed the lunchtime period. Staff wore protective clothing and assisted people appropriately. For example, staff sat next to people who required assistance with eating and patiently encouraged them to eat. Staff also asked people what they wanted to eat and drink. There was quiet music playing in the background and the meal was unhurried and a positive experience for people.

Nutritional assessments had been completed and were up to date. People's weight was regularly monitored and action taken when people lost weight.

There were systems in place to meet people's on-going health needs. Records showed referrals were made to health professionals including opticians, chiropodists, GPs and specialist health professionals.

Good

Is the service caring?

Our findings

Throughout the inspection staff were caring and supportive to people. People were free to move around the home and staff were available to support them. The staff were kind and patient with people and took time to listen to what they had to say. Everyone was clean and well-groomed with attention paid to their personal appearance.

People's privacy was respected. We saw staff knock on people's bedroom doors before entering. The person seeing their legal representative on one day of the inspection had the privacy of the conservatory with the door closed.

People were referred to by their preferred form of address. This was recorded in their personal file as well as information about their life history, which was used to support people in a person centred way. The staff said this information was also used so that they knew of people's preferred routines, such as the times that they preferred to get up and go to bed. For example one person stayed much of their time in bed but got up for a few hours over the lunchtime period. Another person was very private wishing to spend the majority of their time in their bedroom.

Good

Is the service responsive?

Our findings

The relative we spoke with felt their relative was looked after in the manner they would have wished. They also told us that they were always kept informed and had no concerns about the way care was planned and delivered.

There were assessment procedures in place to make sure that the home could meet people's needs such as a preadmission assessment of their needs being carried out before a person was accepted for a placement at the home.

When a person was admitted to the home further assessments were carried out using a range of assessment tools and risk assessments to aid development of a care plan. Care plans we looked at were up to date with hand entries and a date recorded when people's needs had changed.

People had been provided with specialist equipment where this was needed, such as an air mattress. Staff ensured people's mattress settings corresponded to their weight with a record of this being maintained on a recording chart. People who required the use of a hoist for their moving and handling needs had their own slings to minimise the risk of cross infection.

An activities coordinator was employed for 12 hours a week providing individual and group activities with people. Pictures of activities carried out were on display within the home.

People knew how to make a complaint if they needed, as the complaints procedure was detailed on the notice board in the home. The complaints log showed that no complaints had been raised since the last inspection.

There was information within people's care files should people need to go into hospital or be moved to a nursing home to ensure that consistent, planned care could be provided to that person.

Good

Is the service well-led?

Our findings

Since the last inspection a new manager had been appointed. The staff we spoke with were positive about the changes that the new manager had brought about and their leadership. There had been changes in the staff team with new members of staff 'on board' with the new management. One member of staff told us, "We are in a much better place than we were at the last inspection." One of the new members of staff said, "There is good morale and a good staff team; I enjoy working here."

Staff meetings had been held regularly and minutes showed that staff were kept informed of the home's progress as well as their being able to raise issues about the running of the home.

Surveys had been sent out to relatives as part of quality assurance by the manager to seek views of people in developing the service.

The registered manager had notified the Commission of significant events, such as deaths, serious injuries and applications to deprive people of their liberty under the Deprivation of Liberty Safeguards. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

People's records were generally up to date and the office was more organised in a way that made information easy to access than on our previous inspection.

There were a variety of checks and audits the manager had put in place to monitor the quality of service provided. These included a spot check on night staffing, an audit of care files and record keeping, a health and safety audit and regular audits of medicines and MARs.