National Society For Epilepsy(The)

Milton House

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 9 and 10 January 2018. It was an unannounced visit to the service.

Milton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Milton house accommodates 12 people in one adapted building. It is registered for people with epilepsy, learning and or physical disabilities. At the time of this inspection six people lived there.

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

At the previous inspection in January 2017 the provider was in breach of Regulation 18 of the Health and Social Care Act. 2008. This was because sufficient numbers of suitably qualified staff, competent, skilled and experienced staff were not consistently provided. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe and well-led to at least good. At this inspection we found systems had been put in place to ensure the minimum staffing levels were always maintained. However people's needs had increased and changed since the previous inspection. As a result sufficient staff were not available at key times of the day to enable staff to safely meet people's needs. The nominated individual immediately agreed to review the staffing levels and confirmed after the inspection that a third staff member would be rostered from 8am till 18:00 to provide an extra staff member at peak times. We have made a recommendation for the provider to keep the staffing levels under review in response to changes to people in line with best practice and dependency levels.

The people we spoke with and relatives were very happy with the care provided. Relatives commented "I am really grateful, I feel very lucky [person's name] is there. I really can't fault them." Another relative commented "Staff have time for [person's name} and they always show genuine concern and understanding. "

At this inspection the service was providing caring and responsive care. Improvements were required to ensure safe, effective and well- led care was maintained.

People were safeguarded from abuse but risks to people were not identified and managed. Staff were proactive in referring people on to the relevant professionals when people's needs changed. However the service was slow to act on recommendations and advice from those professionals to promote a person's safety.

Systems were in place to promote safe medicine administration. However the service failed to ensure they had an adequate supply of one person's medicine and failed to seek medical advice to ensure the person's health and well- being.

People consented to their care and staff worked to the principles of the Mental Capacity Act 2005. They were provided with information on how to make a complaint and this was reinforced to people at residents meetings.

People had care plans in place which outlined their needs and the support required. Their nutritional needs were identified and met. People had access to activities and keyworkers were looking at ways of developing more person centred activities in conjunction with the activities team.

The home was clean and homely. People were provided with equipment to promote their safety and independence. Systems were in place to ensure the environment was kept clean and prevent cross infection. The equipment provided was serviced and safe.

Staff had the required recruitment checks prior to commencing work at the service. They were inducted, trained and supported in their roles.

Staff were kind, caring and had a good knowledge of the people they supported. They worked well as part of a team but communication needed to improve to ensure all aspects of people's care were met.

The provider had systems in place to audit the service and get feedback to improve practice. However aspects of auditing were ineffective in picking up issues and acting on them in a timely manner. Some aspects of people's records were not suitably maintained and up to date.

The service had a registered manager who had responsibility for managing two locations. Relatives, staff and professionals were complementary of the registered manager. In view of the findings of this inspection and the failure to improve the overall rating from the previous inspection, the provider may wish to review their management arrangements for this location.

The provider was in breach of three regulations and was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of the report.'

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

People were not provided with sufficient staff in the morning to promote their safety.

People were protected from potential abuse and the risk of infection. However people's individual risks were not always identified and risks were not managed.

People were supported by staff who were suitably recruited.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were met. They had access to other health professionals. However the outcome of health appointments and follow up appointments were not routinely recorded and in some occasions follow up appointments were cancelled without explanation.

People were supported by staff who were suitably inducted, trained and supervised.

People were supported and enabled to make decisions about their day to day care. The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were complied with.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring, helpful and inclusive.

People's privacy, dignity, independence and respect was promoted.

People were provided with support to promote communication

and involvement in their care

Is the service responsive?

Good

The service was responsive.

People had care plans in place which outlined the care required to promote consistent care.

People were supported to pursue their interests and activities were provided, although people's involvement in them had decreased.

People were provided with the information on how to raise a concern or complaint.

Is the service well-led?

Requires Improvement

The service was not always well -led.

The registered manager had failed to inform the commission of an incident which they are required to notify us of.

People's records and other records required for the running of the service were not suitably maintained and up to date.

Systems were in place to monitor and audit the service. Those audits were not effective in picking up issues that needed addressing in a timely manner.

People, relatives and staff were given the opportunity to feedback on the service.

Milton House

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 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.

This inspection took place on 9 and 10 January 2018 and was unannounced. It was carried out by one inspector.

Prior to the inspection we requested and received a Provider Information Record (PIR) on the service. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed other information we held about the service such as notifications and safeguarding alerts. We contacted health care professionals involved with the service to obtain their views about the care provided. We have included their written feedback within the report.

Some people who used the service were unable to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with the registered manager, the deputy manager, three care staff and two people who used the service. We spoke with three relatives by telephone after the inspection. We looked at a number of records relating to individual's care and the running of the home. These included four care plans and medicine records, shift planners, handover records, two staff recruitment files, staff training and five staff supervision records.

We asked the provider to send further documents after the inspection. The provider sent us documents which we used as additional evidence

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in January 2017 the provider was in breach of Regulation 18 of the Health and Social Care Act 2008. This was because we found occasions where the minimum levels of staff per shift were not provided. As a result the provider introduced a daily audit of staffing levels which included checking that sufficient staff were provided for the following 48 hours. They had reinforced the on call procedure to staff to remind them to inform a manager on call and a risk assessment was in place in relation to safe staffing levels.

At this inspection people raised no concerns about the staffing levels. Relatives told us they could see staff were under pressure at times. One relative commented "Staff work hard to cover everything." Another relative commented "Staff seem stretched at times."

We reviewed the rotas and the shift planners. We found the minimum staffing levels were maintained. Staff confirmed they were aware of the process for contacting the on call manager if the staffing levels fell below two staff per shift. Two staff were provided on the day time shifts and a third staff member worked from 10am till 18.00 hours to provide three staff during this time. A waking night and sleep in staff member were provided at night. Since the previous inspection people's needs had changed and their dependency levels had increased. Staff told us they felt two staff from 7am till 10am was no longer sufficient to enable them to meet people's needs safely. This was because two people required two staff for moving and handling. As a result they felt a person's safety was compromised whilst two staff were supporting people to get up in the morning. This was due to an increase in the person's risk of falls and the delay in staff being able to respond to the person's pendant alarm or chair sensor going off. Staff told us they had raised it with management but that they were informed there was no money in the budget to increase the staffing levels. This was fed back to the nominated individual who immediately acted on it and requested that extra staff were provided. They confirmed after the inspection that the 10 to 18:00 hour shift had changed to 8am to 18:00 to enable three staff to be available to support the increase in people's dependencies and risks.

The home had three staff vacancies that they were attempting to recruit into. Regular staff, bank staff and agency staff were used to cover gaps in the rota. Regular staff told us they worked overtime but it was their choice whether to take on the extra shifts or not. At the previous inspection In January 2017 staff were working over the maximum hours recommended by the provider. At this inspection we saw this was being monitored by the administrator and acted on.

The registered manager was registered to manage two locations. They spent half a day in each service. The service had a deputy manager and a team leader to support the registered manager. We were told they had allocated administration days each week to carry out management tasks. They told us sometimes they had to assist on shift on those days to support staff. We saw on the rotas from the 18 December 2017 to 7 January 2018 no administration time had been provided for the deputy manager or team leader to enable them to have the time to fulfil management tasks.

It is recommended the provider keeps the staffing levels under review in response to changes in people's

needs in line with best practice guidance and dependency levels.

Systems were in place to promote safe administration of medicines. Staff were trained, assessed and deemed competent to administer medicines. People's care plans outlined the support they required to take their medicines. One person was self-administering their medicines. Risks around this were identified, addressed and managed. Staff carried out spot checks to ensure the person was managing their medicines safely. Medicines were stored appropriately and temperatures were checked of the cupboards in which medicines were kept to ensure a safe temperature was maintained. Documents recorded the medicines received into the home and disposed of. No controlled drugs were in use. We looked at a sample of medicine administration records. We found no gaps in administration in the records viewed.

In November 2017 we had received a notification to inform us that a person missed a number of doses of their anticoagulant medicine. Anticoagulants are medicines that help prevent blood clots. They are given to people at a high risk of getting blood clots, to reduce their chances of developing serious conditions such as strokes and heart attacks. As part of this inspection we reviewed the incident and subsequent actions.

The anticoagulant medicine was a new medicine that the person had come from hospital with. However staff failed to communicate that effectively to all staff. The service carried out daily audits of medicines to enable them to pick up any discrepancies in medicines in a timely manner. The audit showed that the number of anticoagulant medicine in stock was depleting but this failed to alert staff to it. As a result the service ran out of the person's anticoagulant medicine resulting in the person missing eight doses of their prescribed anticoagulant medicines.

When staff realised the medicine was out of stock they failed to seek medical advice. This was not in line with the provider's guidance on medicine errors. As a result of the incident the registered manager spoke with the staff involved and noted a conversation with the team leader. They reminded staff of the purpose of the daily audit and introduced a weekly more thorough audit and stock check. The provider agreed to further investigate this incident to satisfy themselves that appropriate action was taken in response to the mismanagement of the person's medicine and prevent reoccurrence. They also introduced a protocol and checklist for when people are discharged from hospital to ensure key changes are acted on, in particular changes in medicines. This was implemented on day two of the inspection.

Some risks to people's personal safety had been assessed and plans were in place to minimise these risks. These included risks associated with epilepsy, personal care, eating and drinking, community activities, mobility, moving and handling and finances. Risk assessments were kept under review.

For one person their risk of falls had increased. This had been noted and acted on. They referred the person to physiotherapy, occupational therapy and the falls clinic. They had obtained a personal call alarm and sensor mat for the person and the person was supported to wear their protective helmet. However this was not reflected in their mobility and falls risk assessment.

An occupational therapy report dated 19 October 2017 made a recommendation that the level of supervision was to be increased when the person was mobilising. Whilst staff were aware the person needed to be observed the care plan and risk assessment made no reference to the level of supervision required.

The Occupational Therapist report also raised concerns about the flooring between the person's bedroom and hallway and the shower they used. They had asked for this to be reported to the works department and addressed. At the time of the inspection the flooring still had not been made safe. This was discussed with the nominated individual during feedback. They confirmed after the inspection the works department had

been informed of the request on the 14 December 2017 but as a result of our inspection the nominated individual had reinforced the urgency of this and the work was scheduled to be carried out on the 22 January 2018.

Another person was taking anticoagulant medicine which is considered a high risk medicine. The person had a risk assessment in place in relation to medicine. However the medicine risk assessment failed to make reference to the anticoagulant medicine the person was taking, or the risks around taking that medicine such as if a person had a cut and was bleeding.

Staff were aware of risks to people in relation to risks around meal times and mobility however all staff were not aware of the risks associated with taking an anticoagulant medicine. The risks associated with the medicine was not communicated to staff in the communication book and it was not recorded as being discussed in the clinical review meetings that took place either.

This was a breach of regulation 12 of the Health and Social Care Act 2008. This is because safe care and treatment was not always provided.

The PIR indicated the service had introduced reflective practice meetings. The registered manager confirmed there was no guidance in place for those but they would be carried out in response to incidents to ensure lessons were learnt and practices changed or improved. There was no evidence that a reflective practice meeting had taken place following the medicine error in November 2017. The nominated individual confirmed they had a policy in place in relation to serious incidents. They advised that across the organisation, they are embedding a culture of "lessons learnt". They had done this in response to medicine errors, safeguarding concerns, accidents and incidents, complaints and compliments. They shared these with the registered managers and requested that the registered managers share good practice and lessons learnt with their teams during staff meetings. They confirmed that the outcome of the investigation into the above medicine error would be fedback to managers as a "lessons learnt exercise" to improve practice.

The provider confirmed they were made aware of national safety alerts and shared them with the registered managers. The organisation had a policy in place on drugs alerts and hazards notifications which provided guidance to staff on managing and acting on such information. This was reviewed and updated in December 2017.

Environmental risk assessments were in place. They outlined risks to people, staff and visitors such as risks associated with moving and handling, medication administration, driving the company vehicle, cooking and cleaning. A fire risk assessment was in place. People's files included a Personal Emergency Evacuation Plan (PEEP) which provided guidance on how people were to be evacuated in the event of a fire.

Health and safety checks took place which promoted a safe environment for people. Food, fridges and water temperature checks took place and records were maintained. Staff carried out regular checks to ensure the fire equipment was in good working order. Fire drills took place. The fire equipment, gas safety, water supply, electrical appliances and fixed lighting were regularly serviced. The administrator had a record in place to highlight when the servicing of equipment had taken place and when servicing was next due. A contingency plan was in place. This provided guidance for staff on what to do in the event of an emergency at the home. Staff were trained in fire safety, health and safety and first aid and had an emergency folder and bag in place to enable them to respond appropriately in an emergency.

People told us they felt safe. Relatives felt their family member got safe care. Staff were clear about their responsibilities for reporting and responding to concerns, accidents and incidents. They were trained in

safeguarding vulnerable adults and had access to guidance and policies to promote safe practice. A flow chart on what to do in the event of an incident of abuse was on display on notice boards throughout the home. Accidents and incident reports were completed. They were reviewed, action taken and signed off by the registered manager. Safeguarding and accident and incidents were reported to the nominated individual on a monthly basis. This enabled them to identify trends, reoccurrences and act accordingly.

Staff were trained in equality and diversity. They were observed to treat people equally and enabled people with disabilities to access facilities, follow their interests and have involvement in the home.

Systems were in place to manage infection control. Staff were trained in infection control and had a good awareness of their responsibilities in relation to infection control to prevent cross infection. They were provided with gloves and aprons. Appropriate protection such as hair nets and aprons were used during food preparation and cooking. At the previous inspection there was confusion as to who the infection control lead was. At this inspection staff spoken with were aware who the infection control lead was. This information was highlighted on the staff board on display at the entrance to the home. This ensured staff, visitors and people who used the service were aware who to report any infection control issues to.

The service had a cleaner who took responsibility for the cleaning of communal areas. Staff were responsible for cleaning people's bedrooms and ensuring that equipment was clean and maintained. Cleaning schedules were in place which outlined tasks to be done and when. These were dated and signed off when completed. The home was generally clean and free from odour. A refurbishment plan was in place which showed areas scheduled to be decorated and items due to be replaced.

Systems were in place to promote safe recruitment practices. The provider had obtained confirmation from the agencies that the required checks were carried out on agency staff that worked at the service. Staff employed by the organisation completed an application form and attended an interview. They completed a written assessment as part of the interview process. The service had two staff members employed since the previous inspection. Their files included an application form, record of interview and references. Records showed that a check had been made with the Disclosure and Barring Service (criminal records check) to make sure the staff members were suitable to work with vulnerable adults. A risk assessment had been completed for one staff member whose criminal record check had not yet been received. They worked on induction in a supervised capacity whilst they were waiting the outcome of the criminal records check. We saw for one staff member there was a delay of five months from when the required pre-employment checks were completed to them starting work. The registered manager and administrator told us there was personal and health reasons for the delay. However there was no record of a conversation with the staff member to support this to enable them to consider whether a criminal check update was required. This was fed back to the nominated individual to act on and consider if any further action was necessary.

The provider had processes in place for managing disciplinary issues and for enabling staff to raise any grievances they had.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in January 2017 we made a recommendation for the provider to ensure staff were suitably inducted, including staff who were promoted internally. At this inspection we saw the deputy manager who had a break from her role was working through an induction. A new staff member had been appointed. They had completed an in house induction and had enrolled on the Care Certificate training, which was completed subject to some observations of practice. The Care Certificate training is a recognised set of standards that health and social care workers adhere to in their daily work. This involves observations of staff performance and tests of their knowledge and skills.

Staff told us they were aware of their roles and responsibilities and felt suitably trained. They had access to training the provider considered mandatory such as epilepsy awareness, first aid, health and safety, infection control and safeguarding. Staff had access to specialist training such as Non-abusive Psychological and Physical Interventions (NAPPI), support planning, pressure area care and dementia. Training was audited and reported on monthly. This enabled the provider to address any gaps in training by prompting staff to complete their on line training or be booked on a training course. We saw gaps in training were highlighted and booked.

Staff told us they felt supported in their roles and received one to one supervision with members of the management team. We reviewed a sample of supervision records. We saw formal supervisions were taking place, some more frequently and in line with the organisations policy than others. The administrator had a matrix in place to indicate when supervisions were due and had taken place. This was audited and reported on monthly. Staff had annual appraisals of their performance and new staff completed probationary reviews.

The training department told us "The registered manager is a great advocate for his service and team and will always ask about development opportunities for the staff at Milton House."

The home had systems in place to promote communication within the team. Handover meetings took place and records were maintained. A professional involved with the home commented "When I gave verbal handovers I found that care staff consistently handed it over correctly and efficiently to their colleagues."

A shift planner was in use. This outlined the staff on duty, tasks to be completed and who was delegated for tasks and supporting individuals with their care, appointments and activities. The home had a communication book in use. Monthly team meetings and clinical review meetings took place. However we saw key changes in individuals were not recorded in the communication book, handover record or in the clinical review meetings which meant communication within the home was not always effective to safeguard people.

Relatives felt people's health needs were met and they had good access to other specialist services. A professional involved with the home told us the home was effective in the management of people's changing health needs. They gave examples where they felt staff were pro-active and considerate of

people's safety and quality of life. They commented "Importantly, they considered first the personal opinions and wishes of these residents whilst initiating changes to support their needs."

People's care plans included guidance around support with health needs and a record was in place to record the outcome of appointments with professionals such as the GP, opticians and podiatrist. People had access to therapy services on site such as an occupational therapist, physiotherapist and speech and language therapist and a consultant reviewed people's epilepsy and protocols. A health appointment record dated 16 September 2017 showed a person was to have a follow up appointment and scan at the hospital on the 20 October 2017 following an injury to their hand. There was no health record and no entry in their daily notes to say they had attended for the follow up appointment or scan. The scan was rescheduled for the 4 December 2017. This appointment was cancelled by the home and rescheduled for the end of January 2018 without any justification or explanation. This meant the scan was delayed by four months from the point when it was first requested. This was fedback to the nominated individual to investigate further.

A person was having their blood pressure monitored at the request of the GP and a follow up blood test was requested. The frequency at which the blood pressure was being monitored changed without any indication as to why and there was no evidence to suggest they had attended for the blood test which the GP requested. During the inspection the provider established that the first line nurse employed by the organisation had taken the blood test and had changed the frequency of the blood pressure monitoring in agreement with the GP. However they had failed to record this in the person's health appointment record or daily diary. The provider addressed this during the inspection and a protocol was agreed with the first line nurse in relation to recording their interventions with people on the health appointment record kept at the service and communicating this with staff.

Each file contained a hospital passport. One of the hospital passports on file was not updated since 2015, another in 2016. Staff told us hospital passports were available electronically to ensure they were current.

It is recommended the provider look to further improving communication within the team to ensure health needs are met in line with best practice guidance.

The service had no new admissions since the previous inspection and none were planned. The organisation had a process in place for assessing potential new referrals to ensure their needs could be met.

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. Staff were trained in the Mental Capacity Act 2005 (MCA) and demonstrated they had a good understanding of the act. Mental capacity assessments were carried out in relation to specific decisions. Best interest meetings took place in relation to those decisions.

People can only be deprived of their liberty so that they can 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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been made to the Local Authority for people who required it. Staff had been trained in DoLS. They had a good understanding of DoLS and how it related to the people they supported.

People had access to call bells, pendants, chair sensors and specialist crockery and cutlery to promote their safety and independence.

Staff were responsible for cooking the meals. They used an external company who provided ready prepared meals for the main meal of the day. At the previous inspection this arrangement was under review but had not changed. People had access to cereals and toast for breakfast and sandwiches, soup or a lighter meal of choice in the evening. One person chose not to eat the pre- prepared meals and was supported to have alternatives which staff cooked for them. People were given a choice of meals and menus were planned weekly. A record was maintained of meals eaten.

People were happy with the meals provided. One person told us "The meals are good and I get to have curry." People's care plans outlined their nutritional needs, risks and support required with meals. The meal time was relaxed and appropriate support was given to the people who required it.

Good

Is the service caring?

Our findings

People and relatives told us staff were caring. They described staff as kind, genuinely caring, understanding, helpful and inclusive. A relative commented "I am really grateful, I feel very lucky [person's name] is there. I really can't fault them." Another relative commented "Staff have time for [person's name] and they always show genuine concern and understanding. "

Professionals involved with the home were very complementary of staff and the positive relationships they had with people. They described staff as understanding, compassionate and caring. They told us residents and staff appear happy. The trainer told us they observed staff speak in a friendly manner at the service user's pace and if they are sitting down they will always get down to their level and make eye contact.

Professionals commented "All staff I saw communicated clearly and respectfully with me and the service user, and paid attention to his rights for privacy, and dignity. Key staff paid attention to his needs for safety and freedom." "I have found when I have worked with residents in Milton House or dealt with staff that they have always come across as a very caring group whose main focus has always been with the residents they work with." "The staff have a really good understanding and care about the individuals needs of each person .I believe the team really want to do the right thing for each person and they deeply care about the six residents who live there .The residents are very diverse and are equally respected perhaps they need much more support than we realise.". "The house has a warm and friendly atmosphere."

People appeared happy and content. They had positive friendly relationships with staff. Staff were friendly, welcoming, kind, caring and gentle in their approach with people. They offered people choices and gave them time to make a decision on what they wanted to eat or drink. Staff used appropriate touch and good eye contact when engaging with people. For people who required support with their meals staff gave them explanations as to what was on the spoon prior to putting the spoon in their mouth. They gave people time to eat their meal and the meal time was relaxed and calm

Staff had a good knowledge of the people they were supporting. They were aware when people needed support or intervention and responded appropriately. They treated people equally and responded appropriately to their needs and wishes. Some people had limited verbal communication. Staff had a good awareness of their needs and used signs, gestures and short sentences to communicate with people and promote their involvement.

People were encouraged and enabled to be involved in their care but due to the frailty of people their involvement within the home was limited. People were provided with written information in an easy read format to promote their understanding of procedures relevant to them.

The provider operated a dignity in care champion programme where a named staff member was trained as a dignity champion. The staff member who was the named dignity champion told us they had not been active in the role as they had been working nights. However now that they were working days they were committed to attending training and developing the role, to promote people's dignity in all areas of

practice.

People's care plans outlined relatives and friends that were important to individuals. Relatives told us they could visit at any time and were always made to feel welcome.

People's privacy and dignity was protected. People had their own bedrooms which were personalised. They shared the bathroom and toilet facilities. During the inspection staff asked people if they could go into their bedroom when they were not in there. People's clothes were protected at meal times and staff supported people to look clean and nicely presented.

The home had no advocacy involvement at the time of the inspection. The registered manager was aware how to access advocates for individuals when required. A leaflet on how to access advocates was displayed on the notice board and available to people.

The provider had policies, guidance and systems in place to promote people's confidentiality in line with the data protection act. People's paper records were kept secure and computers were password protected to ensure they could only be accessed by staff authorised to.

Good

Is the service responsive?

Our findings

People and relatives felt staff were responsive to people's care. They told us staff had a good knowledge of the people they supported and knew when something was wrong. A relative commented "Staff have picked up on [person's name] unique ways and [person's name] has responded positively to that."

People had care plans in place. Care plans were detailed and specific as to the care to be given. Care plans included guidance from professionals, some of which were pictorial to better promote staff's understanding. People's care plans included epilepsy descriptions and protocols. People had access to annual reviews which their funding authority was invited to. Relatives told us they were invited to reviews and felt happy with the outcome of them.

A key worker is a named member of staff who supported the person to coordinate their care. People had a named keyworker. The two people we spoke with knew who their keyworker was. One of those people indicated they had a positive relationship with their keyworker and was very complimentary of the staff member and the support they gave them. Relatives too described the same staff member as motivating, attentive and inclusive. Keyworkers were aware of their role and responsibilities. They completed a monthly keyworker report on individuals which outlined changes and progress over the month and supported the person to maintain contact with their family and people important to them.

A professional involved with the home commented "I think what works exceptionally well in Milton house is the system of keyworkers. They build up a great rapport with the resident, and are really responsive to changing need, both physical and emotional. One support worker who joined the team has stood out for me, in that they are very enthusiastic, supportive, encouraging and shows a genuine interest in the person rather than the task at hand, I think they have played a significant role in enhancing the resident's quality of life. "

Another professional commented "On the whole, I find Milton house staff to be responsive to the changing needs of their residents." They gave examples where staff had engaged with them in response to changes in individuals. They told us "The high level of responsiveness and initiative has contributed to a house I feel is safe for the people who live there."

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Management were aware of the Accessible Information standard and the NHS guidance on it was displayed on the staff notice board. People's care plans included guidance on how the person communicated their needs to enable staff to understand and be responsive to them. Staff had a good awareness of people's communication needs. They treated people equally and understood their verbal communication, gestures and responded appropriately to them.

A person told us they were happy with the range of activities provided. Relatives told us activities were available although people choose not to always participate in them. A relative told us a staff member was

looking into specific activities for their family member such as going to football matches.

People had individual activity programmes in place, which incorporated activities provided on site at the centre. People's attendance at activities on the site had reduced. This was due to a decline in their health and reluctance on their part to attend.

The home had a named activity coordinator attached to the service. Staff had been responsive and liaised with the activity team to look at what they could do differently to improve access to activities for people to meet their changing needs. The activity manager commented "The house and its staff have been working very hard to support the increased and ever changing needs and they have along with manager reached out and asked for help from the activity team .The manager is open to suggestions and is keen to make sure that the residents of Milton get the same opportunities as all others across the site. Prior to the inspection I had arranged a meeting with the manager on his return from leave to discuss activities for the residents at Milton House. Together, I hope that we can measure how affective these interventions are given the changing needs. Plus what can we do when residents aren't well and what do the staff need from my team for the residents across the week."

The home had no one on end of life care. People's care plans included an end of life care plan and advanced wishes. Some people had a Do Not Attempt Resuscitation (DNAR) order in place. These were signed by the GP and relevant others. The end of life care plans made reference to the DNAR, where this was relevant.

The people we spoke with told us they would talk to staff, keyworker or their family if they had any worries or concerns. Relatives told us they felt able to raise issues and that any issues they had raised were addressed. They confirmed they had been provided with a complaints procedure. Staff were aware how to respond to concerns or complaints. Information on how to make a complaint was displayed on notice boards throughout the home. This was in a user friendly format and accessible to people. There was a suggestion box and leaflets at the entrance to the home to enable people and others to give feedback anonymously if necessary. Systems were in place to acknowledge and investigate complaints. The home had no complaints in the previous 12 months. They had one recent compliment on file from a relative on the care and support provided to their family member.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was aware of their responsibilities under the Health and Social Care Act 2008 to notify CQC about significant events. We used this information to monitor the service and ensure they responded appropriately. The registered manager had informed us of the recent medicine error however they had failed to notify us of a DoLS approval, which had been approved in September 2017.

This was breach of Regulation 18 of the Health and Social Care act 2008 (Registration) regulations 2009. This was because the provider failed to make the required notification to us.

People's charts such as a standing chart, blood pressure monitoring charts, falls and epilepsy charts were generally well completed. Other aspects of people's records were not kept up to date, accurate and suitably maintained. Care plans and risk assessments were not updated to reflect changes in people's needs and the level of risk. The review of care plans was brief. They indicated the care plan was reviewed and no change, despite there been changes in some individuals, increase in risks and the level of care and support they required.

People's health appointment records were not routinely completed. Where they were completed some lacked detail as to the outcome of the appointment and actions required. Daily records did not reflect if people had attended for appointments or not and why appointments were cancelled. Clinical review meeting minutes showed discussion on people. However the minutes did not always reflect all of the changes in individuals, such as change in their medicines and well-being and actions required.

People's files contained mental capacity assessments which were not decision specific. They were not properly completed or signed. This had been picked up as part of a quality compliance visit and it was established they were older ones which had been superseded by the more up to date ones on file. These had not been archived as requested by the quality compliance manager.

The provider had systems in place to monitor and audit the service. The service carried out monthly audits of infection control, health and safety, catering, finance, medicines and a percentage of care plans were audited. They completed monthly reports to the organisation on complaints, compliments, safeguarding's, training, supervisions and appraisals. Alongside this they carried out daily audits of the rota and stock checks of medicines. However these audits failed to pick up issues in a timely manner in relation to medicines running low, sufficient staff not being available to take people for appointments and gaps in care plans and risk assessments. The provider carried out compliance monitoring visits. Three visits were carried out in December 2017 which rated the service as "Requires improvement." We saw issues in relation to staffing levels and records were identified and some actions were still outstanding at subsequent visits. The home had a home development plan where all actions from audits were logged. These were updated and reviewed at subsequent monitoring visits and the registered managers one to one supervision meeting.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. This was because people's records were not accurate and complete. Systems and processes were not effective in monitoring the

service.

People, relatives, staff and professionals felt the home was well-managed. Relatives told us they felt the service was well managed. They described the registered manager as pleasant, approachable and professional. A relative commented "Good manager and happy team."

A professional told us the manager was initially slow in responding to an email but then responded quickly and efficiently to procure relevant recommended equipment for a person. They commented "My impression has been that Milton house has had its struggles but under the present manager there has been a general improvement."

Another professional commented "With regards leadership, I think that this has been a challenge, I do think that staff feel that they would benefit from a manager that is there on a full time basis. And although I think that the current manager is doing a great job, it is very difficult to manage from a distance as you are not there to deal with issues as they arise."

A third professional told us they had a high regard for the house manager. They commented "I have no doubts regarding his ability, skill set and managerial approach. Because of his experience and high level of skill, he has been asked to manage two separate and distinct houses. Not only is the client group in each house quite different, the houses are separated by considerable distance. Whilst he is capable of such a challenge, the team in Milton house have informally expressed the desire to have a manager who is dedicated to them on a full-time basis. His immediate attention to a crisis may not be necessarily guaranteed, and this is a concern for them."

Staff described the registered manager as approachable, understanding and caring. However they felt disadvantaged that they had to share the registered manager with another location. They felt this impacted on the way the service was managed as things got missed.

The registered manager confirmed they worked half a day in both locations but was available by telephone during the time they were at the other location. The registered manager had a deputy manager and a team leader to support them in their role, however they did not get regular administration time scheduled on the rota to enable them to carry out those management tasks. The registered manager told us they felt supported in their role but that the other service they managed had staff vacancies too which made management of the two locations more difficult. This was fed back to the nominated individual for them to review.

Systems were in place to get feedback on the service. Monthly resident meetings took place and the minutes of the meetings were provided in pictures to enable people to understand them. Monthly staff meetings took place to enable staff to raise any issues or concerns they had about the service and the care people received. The registered manager had introduced further opportunities for staff to speak with them. They offered staff "A weekly staff surgery session". They told us the uptake on this had reduced and no minutes were taken.

An annual survey was completed which sought feedback from relatives, staff and other professionals. Relatives confirmed they were asked to complete surveys. The resident survey and relative survey was completed in August 2017. The results of the surveys were positive which indicated people and their relatives were happy with the care provided.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to make the required notification to us.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not always provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not up to date and accurate. Systems and processes in place to monitor the service were not always effective in picking up issues in a timely manner.