First For Care Limited

Mill Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 18 June 2015 and was announced. At our last inspection on 1 August 2014 the provider was meeting all of the regulations reguired by law.

Mill Lodge Care Home operates as a residential home and as a domiciliary care agency. This inspection was of the domiciliary care agency known as First for Care at Home. As the service is registered with us under the name of Mill Lodge Care Home this is the name we shall use throughout this report. We have published a separate report for the residential home that was inspected on 16 and 17 June 2015.

Mill Lodge Care Home provides personal care for people in their own homes. At the time of our inspection there were 16 people using the service.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

People were not always protected from harm due to inadequate management of risk by the provider. Accidents and incidents were not recorded formally or reviewed by a manager. People's health and well-being was not protected through the effective use of care planning and the assessment of risk. We found that areas such as ensuring people's skin remained healthy and intact and safe moving and handling of people were not managed effectively.

People were being exposed to risk of harm as their medicines were not managed safely. Staff were administering medicines without their training or competency in this area having been checked by the provider. Staff were not keeping records of the medicines people needed and their administration to ensure that people received their medicines as prescribed and were kept safe.

The provider was not using safe recruitment practices. We were unable to find evidence that all of the required pre-employment checks to ensure that only suitable people were employed had been completed as required. Background checks such as ID checks and referencing were insufficient.

Relatives told us that there were insufficient numbers of care staff to effectively meet people's needs. Staff told us that they needed more staff within the care team in order to provide the support people needed.

We found that people's human rights were not being upheld as they were not being supported to consent to their care, if they were able to, in line with current legislation and guidance. Decisions that were made on people's behalf were not recorded and there was no evidence that decisions were made in people's 'best interests'.

People were not supported by a staff team who were trained and whose competency in their role had been fully checked. Training records showed that staff had not received all of the training the provider deemed as essential to keep people safe from harm. Staff had not received regular one-to-one meetings with a manager to ensure that they were competent and fully supported in their roles.

We found no evidence that people were involved in decisions about their care or that their choices were taken into account in their plans of care. Insufficient records were kept within the service to allow us to review how people's preferences were reflected in the care they received. The care records that we reviewed did not reflect the care that was given to people. The provider had not reviewed the care people received to ensure it met their needs and preferences.

Relatives told us that the staff team were caring in their approach. We were told that staff took time to talk to people and developed effective relationships with them. There was insufficient documentation kept to provide evidence to show that people's dignity and independence was supported.

There was no system developed by the provider to record or monitor complaints to the service. Relatives told us that they felt frustrated when they tried to raise a complaint. They told us that they did not feel listened to nor did they feel their complaint had been addressed.

The provider had failed to ensure that there was a robust management structure in place. Staff and relatives were unsure as to who the current manager of the service was. During the inspection the staff running the service were unable to produce evidence to show that the service was meeting all areas of the regulations. People were not supported by staff who were motivated and working within an open and transparent culture where they were supported to question and improve their practice.

People were not supported by a service with robust quality assurance procedures in place. No systems were in place to identify, analyse and monitor issues and areas of improvement within the service. Management meetings and reviews had not taken place. There was no action plan to show that the provider had identified issues and areas of improvement with any aspect of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The overall rating for this provider is 'inadequate'. This means that is has been placed into 'special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made
- Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Following our inspection, we were informed by the provider that they have decided to remove rhe regulated activity of personal care. This means they intended not to continue a domiciliary care service from 5 July 2015. We have received an application from the provider to cancel their registration and this was being processed at the time this report was published. The provider has informed us that they have submitted this cancellation in order to focus on driving improvements within their residential home in order to ensure they are meeting the regulations.

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?

Inadequate

The service was not safe.

People were not protected from harm by effective risk management within the service. Accidents and incidents were not recorded effectively or monitored to ensure that risks to people were managed and minimised. People were not protected by safe moving and handling practices or management of their health needs such as skin integrity.

People were exposed to risk through unsafe practices regarding medicines management. People were not supported by sufficient levels of staff to safely meet their needs. Robust systems were not in place to ensure that the provider had checked to ensure only suitable staff were providing support to people.

Is the service effective?

Requires improvement

The service was not always effective.

People were not supported to consent to the care they received. Their ability to consent had not been assessed in line with current legislation and guidance.

The provider had not ensured that people were supported by staff with appropriate skills as they had not taken steps to fully train staff and to check their competency in their roles.

Is the service caring?

Requires improvement

The service was not always caring.

The provider did not ensure that people's choices about the care they received were fully understood and respected. Sufficient evidence was not available to demonstrate that people's dignity and independence was promoted.

People were supported by a staff team who were caring in their approach and built positive relationships.

Is the service responsive?

Requires improvement

The service was not responsive.

The provider did not ensure that people's preferences and needs were reflected in their plans of care. There was insufficient evidence available to demonstrate that people were involved in discussing their preferences and needs.

People were not supported to make complaints about the service they received. There was no system in place to record and respond to people's complaints

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

People were not supported by a service with a clear and robust management structure. The provider had not developed systems to ensure that the quality of care was assessed and improvements in the service were identified and implemented. Staff were not supported to deliver high quality care in a culture that was open and transparent for them to review their practice.

Mill Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 June 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection was carried out by two inspectors.

Prior to our inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us by law to inform us of certain events. We also contacted the local authority for information they held about the service. We used this information in the planning of the inspection.

During our inspection we spoke with one person who used the service and six relatives. We spoke with the care coordinator, the provider and two members of care staff. We reviewed the care records of five people who used the service, four staff records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not always protected from harm due to the inadequate management of risk by the provider. Staff told us that one person had a fall that resulted in emergency services being called. This accident was not recorded and we found no evidence of other accidents or incidents having been recorded. It was confirmed by staff that accidents were not recorded formally but a note would be made in a person's daily record. One member of staff said, "Last time there was an accident on my call I called [the office] and asked if there was a form and they said no. I just wrote in the daily reports." We found that daily records were not monitored or audited, therefore accidents were not being monitored by the manager.

Risks to people's health and well-being were not protected through the effective use of care planning and the assessment of risk. One person's care plan said that they should be moved with the use of a hoist, assisted into their chair and their pressure areas checked for any skin damage each time care staff visited. Care staff confirmed that the hoist was not used, this person was cared for in bed and their pressure areas were not formally checked. We asked staff what systems were in place for pressure area management and we were told there were none. Staff were unable to explain why this person was being cared for in bed. One member of staff told us that they thought it might be due to the person having dementia and not being able to walk. One member of staff told us that there was insufficient equipment to move this person safely and told us, "There's no slide sheet so we have to use the loose bed sheets to slide [name of person] up [their bed]." This practice increased the risk of injury to the person being supported. We saw that risk assessments were in place in people's care records however, staff told us that they did not reflect the person's current needs.

One person's care records identified that they had not accepted a drink for a number of consecutive days. We found no evidence that staff had monitored why this person had not had a drink and what steps had been taken to ensure that this person's health and well being was protected. The staff that we spoke with were unable to provide an explanation for this.

People were being exposed to risk through unsafe practices in relation to the management of medicines. We found that staff were assisting people with their medicines although only two of the seven training records that we checked showed that the appropriate training had been provided. We were told by staff that their competency in administering medicines safely had not been checked by the manager. The medicines policy clearly stated that staff who supported people with their medicines must have appropriate training. There was no evidence available to confirm that staff were safely administering and recording medicines as records had not been completed. Staff were unable to produce records relating to the medicines that people should received and their administration records. We were told that some records about people's medicines were kept in people's own homes. Staff were unable to tell us where historic records were kept. We were told by staff that records kept in peoples' homes were not checked for accuracy or reviewed. We discussed these concerns with the provider who could not provide an explanation and was unaware of the systems in place for managing peoples medicines.

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

We found that the provider did not have systems in place to ensure that safe recruitment practices were adhered to. The provider was unable to supply evidence that all of the required pre-employment checks to ensure that only suitable people were employed had been completed as required. The provider was unable to provide evidence that Disclosure and Barring Service (DBS) checks had been completed for staff. We asked to see these checks but the provider was unable to produce them. We found that the employment history of staff, including gaps in their employment had not been checked. References were sometimes obtained after the staff member had commenced employment and some references were personal references and therefore did not check the staff members competency for the role. We found that some staff files did not contain satisfactory ID checks. We asked the provider to forward evidence that these checks had been completed within 48 hours of the inspection. We did not receive any further evidence.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that they felt there was not sufficient numbers of care staff to meet people's needs. One relative told us, "I would not recommend this service to anyone, they have an amazing turnover of staff and sometimes do

Inadequate

Is the service safe?

not turn up." A relative told us, "There have been a couple of occasions where [person] hasn't been able to get up or go to bed due to missed calls". Another relative said, "I do not think the staff have enough time to administer care, I can see that the staff are stretched and it shows in the high turnover of staff." A third relative told us, "You tell them to come at one time and they come another, they give you a number to call and no one answers it. I then have to call the care home, it is very frustrating."

Staff told us that they were overstretched and were covering a lot of care visits due to the number of staff who had left the service. We were given an example of one member of staff who had been getting up to start work at 5am and returning home at 10pm at night due to staff shortages. On the day of the inspection the care coordinator had to leave the office in order to cover care visits due to insufficient staffing levels. We found one care record that stated a person's personal care needs had not been met due to insufficient staff numbers being available for their care visit.

We spoke to the provider about the shortages of staff within the team and they confirmed that they had found it challenging to recruit suitable people to provide personal care within domiciliary care. The provider told that they were working to increase the number of staff working in the domiciliary care agency, by two additional staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us that they felt people were safe. We found that staff were not confident in describing what abuse was. They were uncertain how to raise a concerns about people's safety or well-being to the local authority who lead in investigating such matters. Staff told us that they would contact the provider if they had any concerns about people. The provider confirmed that they were unsure of the processes for escalating a concern to the local authority. The staff and the provider were not able to provide an evidence of concerns that had been passed on to the local authority. Due to the lack of records kept regarding people's care we were unable to confirm if any referrals had been required.

Requires improvement

Is the service effective?

Our findings

We found that people's human right's were not being upheld and their right to consent to their care was not being followed in line with current legislation and guidance. We found that people who staff told us were able to consent were not signing their own plans of care and representatives were routinely doing this on their behalf. There was no evidence that people's capacity to consent for themselves had been assessed. There was also no evidence that in the absence of someone's capacity that decisions were being made in their 'best interests'. We were told by staff that some people did not have the capacity to make decisions about their care but this was not recorded anywhere. We found no evidence that staff had been trained in the areas of capacity and consent and the current legislation and guidance in this area. The staff members that we spoke to knew that people needed to provide their consent to their care but were unable to explain the requirements of current legislation in this area and how the provider was applying this within the service.

When seeking the views of people who used the service we were provided with the contact details of people's relatives. We spoke to one person directly as they were with their relative at the time we made the call to them. We asked for two further contact numbers to speak to people directly and we were told that they were not recorded and therefore we were unable to obtain the views of people directly. The provider systems were set up to liaise with a family member in the first instance before liaising with people directly about their care. The provider was unable to provide evidence that people had chosen that the representative speak on their behalf or that they lacked the capacity to consent or make decisions themselves.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

One relative told us, "The staff all seem to be well trained and know what they are doing." The provider supplied a training plan which did not show all the training that had been received by all staff who were providing personal care for people. This training plan showed that staff training was not assessed for the provider to assure themselves that staff were appropriately trained and skilled to meet people's needs. For example, the plan did not indicate whether staff had received training in manual handling when there were people who required such support. Staff told us that they did not have access to sufficient training and that most of their training had been completed with previous employers. We spoke with the provider about the gaps in training and there was no explanation about this. We were told that the competency of staff in areas such as medicines had not been checked by the manager. The care coordinator had recently started to carry out spot checks on staff to ensure that their care practice was safe and effective and saw that one spot check that had been completed. In the absence of staff training, there was no evidence to show that staff were supervised regularly in order to monitor their competence and to provide sufficient support in the role.

Relatives did not raise any concerns about the food and drink provided by care staff. Care staff were not always required to provide meals for people as part of their care plans. We were told that one person had a sandwich prepared for them at lunchtime by staff. Care staff told us that they provided meals as requested by people.

Staff confirmed that they did not get involved in contacting outside health professionals as part of the care provided. We were told that all of the packages of care provided were privately funded by people's relatives. If there were concerns around people's health then relatives would make contact with the required healthcare professionals. We were not given evidence by staff that they alerted relatives to any healthcare professionals and we were unable to find evidence of this within care records due to the lack of documentation available.

Requires improvement

Is the service caring?

Our findings

We found no evidence that people were involved in decisions about their care or that their choices were taken into account in their plans of care. We were told by staff that the plans were not reflective of the care provided to people and they would ask people what they wanted. People's capacity to make decisions had not been assessed or recorded and decisions made on behalf of people had not been recorded. Therefore we were unable to view evidence to support that people were involved as much as they could be in decisions about their care.

We were unable to speak with more than one person who used the service directly in order to understand if their views were taken into consideration as people's relatives were the first point of contact regarding care and support provided. Two relatives that we spoke with told us that care visits did space not take place at the times they were requested. One relative said that they had requested a text message when care staff were not available to complete a care visit to enable them to find alternative cover. We were told that this did not happen as requested.

Not all daily records were available for us to view. Therefore there was insufficient evidence available to analyse the care that people received and any involvement and choices that they may have being reflected in their care. We were told by staff that daily care records were kept in peoples' homes however there was no system in place for these records to be brought into the service or to be reviewed by the manager. The provider was not ensuring that peoples' care given was taking into account their choices.

There was insufficient documentation available for the provider to supply evidence to support how people's privacy, dignity and independence was supported. One relative told us that personal care was carried out for people in the bathroom, out of view. Staff were able to describe how they would protect people's privacy although some staff did refer to people in an undignified way. Care plans did not identify how people's independence should be promoted. In some cases we found that the care provided to people offered a reduced level of independence to that outlined in their plan of care. For example, one person was being cared for in bed despite their plan of care stating they should be transferred from their bed into a chair.

Relatives told us that the staff team were caring in their approach to their role. One relative said, "The care is very good, the regular staff are very good at their job.". Another relative told us "[Name of family member] enjoys the conversations while being looked after". Comments from other relatives included "[Name of family member] gets on with the carers and they develop relationships". "[Name of family member] has ulcers on their legs and the carer applies cream to their feet in a caring way and gives medication regularly". One relative told us that the carers spent half an hour at the care visit showing their relative photos and making them a cup of tea.

Requires improvement

Is the service responsive?

Our findings

The provider was unable to evidence that people's preferences were taken into consideration. There was limited information in people's care records about people's individual needs and we were told by staff that the information that was present was not accurate. We looked at three people's care records with a member of staff. They confirmed that the information did not reflect the care that was provided to these three people. Staff told us care plans were not looked at and we were told that people's care needs were not recorded and reviewed. Staff told us that they got to know people's preferences by asking them directly and shadowing other members of staff. We found that the provider was not checking to ensure that the care provided by staff was effective or met their needs and preferences.

We found that people's preferences about the time they received their care visits was not recorded. Both staff members and the provider confirmed that there was no formal system in place to record people's preferences around their care or the times they received their visits. Therefore people may be at risk of not having their individual needs met.

We found that there was no complaints system in place or record kept of complaints received. One relative told us, "I have no problem in complaining, the problem is that you get no response to calls, no one follows up complaints".

Another relative said, "The admin is terrible. I always have to check my invoice". Another relative told us, "When I rang and complained I didn't get very far". We were told by staff and by one relative that a complaints policy and procedure was not supplied to families who used the service. We asked staff if there was a system in place or if people were provided with a policy about how to complain and we were told that they were not.

We asked the provider if they could show us any records of complaints that had been received and they could not provide this information. They were able to provide evidence that complaints were responded to appropriately. They were also unable to provide evidence that complaints were analysed for any common themes or trends or that changes had been made within the service as a result of these complaints.

One relative told us that they believed the provider was keen for people to share their views in order for issues to be identified and improvements made. We found no evidence to show that people's views had been heard and that the quality of care of the service provided had improved as a result. Staff told us that a survey had recently been issued to people who used the service in order to obtain their views. One relative confirmed that they had received the survey. We were unable to view any responses to this survey as the staff and the provider were unaware if any responses had been returned.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in place. There had been no registered manager employed at the service since 31 December 2015. This was a breach of the providers condition of registration with us. An acting manager was in place in the residential home who had overseen aspects of the domiciliary care agency although this person was absent during this inspection. The provider told us that it was not their intention for the acting manager to manage the domiciliary care agency in the future although no plans had been confirmed as to who would manage the service at the time of our inspection.

One relative told us, "I'm not quite sure who the manager is". One member of staff said that they were unsure as to who their line manager was. There was not sufficient management cover in place to run the care agency and this was reduced further during the absence of the acting manager from the residential home. One member of staff told us, "We don't get any support and don't know who to call". We found access to information was restricted during the inspection as the provider was not aware of all operational aspects of the service. The staff who were running the day-to-day care agency did not have managerial responsibility for the service and were unsure as to who their current line manager was.

The provider had failed to ensure that people who used the service were receiving appropriate care and support in a safe manner due to the fact that quality assurance systems had not been developed. We found that there were no systems in place to ensure that people were receiving care that met their needs. There were no audits or systems in place to monitor and analyse accidents and incidents in order to minimise risks to people in the future. There were no systems to ensure that people's changing needs were identified and care was amended as appropriate. Risk assessments were not reviewed in order to ensure that people were protected from harm. We found that people's care records were not stored securely or reviewed to ensure that staff were providing the care that people required to meet their individual needs or to identify any issues or concern.

Management meetings were not held to discuss the operation of the service and to assist with identifying areas of improvement and driving quality. The provider had failed to identify the areas where the service did not meet people's needs or requirements within the regulations which we found during the inspection. There was no action plan in place to show how the provider was addressing the areas of improvement required within the service.

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

The provider had not sent any notifications to CQC prior to the inspection. These notifications are required by law and are required when significant events arise such as serious accidents. Staff members were not certain if notifications had been required although the provider told us that they had not been. We were unable to confirm if notifications had been required due to insufficient documentation being kept on people's care records and any accidents or incidents that had arisen.

People were not supported by staff who were motivated and working within an open and transparent culture. We were told that staff had only participated in one staff meeting when a new care coordinator joined the team. They had not received one-one-one meetings to discuss their care practice or training needs. Staff told us that they were not given the opportunity to share their views regarding the service or to question practices in order to drive improvement.. Staff were not given constructive feedback in a way that developed their practice and improved the quality of care that people received.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent to their care and support was not always sought in line with current legislation and guidelines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate systems for managing medicines safely and inadequate risk management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of staff to meet peoples needs effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure that an effective quality assurance system was in place to identify risks to people and to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

The provider had failed to ensure that people were protected by safe recruitment practices.