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| **Details of visit** | |
| **Service address:** | **Millreed Lodge Care Home** |
| **Service Provider:** | **Millreed Lodge Care Ltd** |
| **Date and Time:** | **17th November 2015** |
| **Authorised Representatives:** | **Alan Walsh, Charles Gate, Rosemary Hedges** |
| **Contact details:** | **Healthwatch Calderdale** |

## Purpose of the visit

- To engage with service users of care homes and understand how dignity is being respected in a care home environment
- Identify examples of good working practice.
- Observe residents and relatives engaging with the staff and their surroundings.
- Capture the experience of residents and relatives and any ideas they may have for change.
- Review changes made since the CQC Report of 12th October 2015

## Strategic drivers

- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

## Background

Millreed Lodge Care Home provides accommodation, nursing and personal care for 36 people and people living with dementia. At the time of our visit there were 26 people in residence. The accommodation is arranged over two floors and there is a passenger lift. All of the bedrooms have en-suite toilet facilities. The lounge and dining areas are on the ground floor.

In October 2015 Millreed Lodge received an 'Overall Inadequate' rating from a CQC Inspection. It was placed in 'Special Measures' and will be reviewed six months from the last inspection. The poor ratings related to a number of areas of concern and there were five breaches of the Health and Social Care Act 2008 Regulations 2014 noted.

The concerns were in the following areas – there were not enough staff, that staff training, appraisals and supervision were not up to date. Practices were observed that showed a lack of respect, and some residents said they had to wait too long for assistance to go to the toilet. Few activities were observed to be on offer and the only interaction between staff and residents was around care needs, or when staff were called. Some residents did not have a Care Plan and other Care Plans were not up to date. Care was being delivered based on the staff's perceived knowledge of the residents. Risk Assessments were not always done and Risk Managements plans not completed.

The legal requirements of Deprivation of Liberty Safeguards (DoLS) were not being met and some residents were being prevented from leaving without the necessary authorisation. A lack of provider oversight was noted and few checks were carried out on the overall operation and quality of the home. The manager had not kept up with internal audits and records were not up to date. Feedback from residents and relatives was not consistently sought or acted upon. The medication system was not well managed. Some areas of the home were noted to be shabby and unsafe, and infection control issues were observed.

On the plus side the report said that staff were being recruited safely, and they felt supported by the open door policy of the manager. Residents said they felt staff respected their privacy and dignity, and that their health care needs were being met. They felt happy with their care and support most of the time. The meals were described as good and plenty of drinks and fresh fruit were observed. The kitchen had a 5* rating for hygiene. Visitors said they felt welcome and were invited to stay for meals. They felt they could raise any matters with the manager.

**Methodology**

This was a semi announced Enter and View visit, conducted by two representatives of Healthwatch Calderdale over a period of 3 hours.

Interviews were conducted with the Manager and two members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored. The findings of the CQC Report were examined in some depth.

The Enter & View Authorised Representatives also spoke to one resident at the care home informally to ask them about their experiences of the home. One relative was also spoken to as they were visiting a resident at the time.

The representatives explained to everyone they spoke to why they were there and took minimal notes. The representatives were also present at lunchtime and were able to observe the mealtime arrangements.

A proportion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works and how the residents and service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

**Summary of findings:**

1. At the time of our visit we saw evidence to indicate that the Manager and staff team had accepted the points in the CQC report and were working to rectify them.
2. Parts of the home looked newly decorated and re-carpeted, and we saw new sinks, flooring and locks.
3. We saw staff interacting positively with residents and meeting their needs respectfully.
4. We heard about new protocols and systems that were being implemented to modernise the care process.
5. We were told that four extra staff were being recruited.
6. We heard favourable reviews of the home from staff, residents and visitors.
7. We heard that a Relatives Meeting had been booked for the following week, where people could compare notes and suggest solutions.

**Results of Visit**

**Environment**

On entering we noted that the letter from Healthwatch Calderdale about the visit was displayed on the wall and there was a hand gel dispenser by the front door. The home is in a converted mill and has long narrow corridors with a number of twists and turns round corners so is rather difficult to navigate unaided. The nurse's observation office is beside the front entrance which is where the phone is situated consequently, it is a busy area. Staff constantly had to squeeze past us, and each other, as we stood in the hall in order to get into the room. The manager's office is at the far end of the building, so we used the nurse's room for our conversation with her, but as described above, we suffered some interruptions. The main reception rooms are near the front entrance and comprise a lounge with a large conservatory attached, and dining room.

The environment in the main areas looked to be adequate, as did the flooring, and the Manager told us that four areas of the home had recently received new carpeting, she said there was more work planned. Further back in the building there were still areas that we noted needed refurbishment. Apart from the conservatory the building has small windows and felt quite dark and gloomy, although it was a grey day outside which did not help. There was a wooden ceiling support post on the main corridor which we felt was a hazard. However, the manager pointed out to us that it had never been a problem. There were no noticeable odours in the home which suggests the hygiene standards are good. Some residents were being nursed in bed in their rooms with the doors open, are held open using magnetic closures that are linked into the fire alarm system.

Outside there is a small raised garden area with a bench which can be accessed from either the steps or by wheelchair from off the drive. This area is very close to the main road and could potentially be dangerous for any residents who may manage to get out there, both in terms of falls or risk from traffic. The manager told us very few residents ever go out there unless they are supervised.

**Manager's response to the CQC Inspection Report**

The manager told us that the CQC report had been very distressing for her and the staff and immediate steps had been taken to improve all the areas of concern. She acknowledged that the care plans were not up to standard but this did not reflect on the care given. Physical improvements to floors and decor were being carried out as an ongoing process.

Extra sinks for dirty water were being installed, and a new floor in the sluice room. Some shower trays have been replaced, all the extractor fans have been replaced and locks and a code key lock had been put on doors at the rear of the building, where wandering residents could have got into difficulties. She is planning steps to deal with some damp patches.

Four extra staff posts were being advertised and admissions were suspended until the posts were filled. A staff member with responsibility for activity co-ordination is one of those posts. An extra cleaner has also been recruited. Although the owner does not allocate a training budget for staff the Manager had been told by the owner that staff could go on any training she recommended and there were lists of future training up on the wall. The Infection Control Policy and the Medication Control Policy have been re-written. All nurses have been signed up for level 3 Medication Training updates. Millreed Lodge has been involved with the 'Quest for Quality for Quality Care Homes' service for the last 18 months within its pilot scheme. 'Quest for Quality' is now supporting the home with expert advice. (This is a multi –disciplinary peripatetic support team).

The Manager agreed that the audit system had got behind in the summer, and told us that there is no commonality regarding procedures and resources across this home and the seven others in the same ownership group. The manager was in touch with the manager of the Burnley care home, within the group, and sharing expertise around paper work. Not having common best practice across the group (allowing for individual resident needs) seems wasteful. This means each home has to devise its own programme of protocols, record keeping and audit. The clinical lead in Millreed Lodge has now been allocated extra time to carry out the audits which are being progressed, and the first relatives' meeting had been arranged for the following week to elicit feedback. Help also received from the groups Area Manager with updated audits and supervision records.

The manager told us there was a complaints and compliments book, but it is not left out for visitors to use as she felt that anyone could come to her and say what their concerns may be. We suggested the book should be left out so that visitors have immediate access to it.

**Promotion of Privacy, Dignity and Respect**

The manager told us that a temporary care plan is drawn up prior to admission and a full care plan is then written seven days after admission when full assessments and observations have been made. The Care Plans were being rewritten along new guidelines, and would all be up to date by the New Year. The Manager had also received help with care plans from a staff member from the local CCG. 3 senior care staff are dignity champions, 3 care staff work alongside 1 nurse as infection control champions and 2 senior care staff are dementia champions, these staff are to receive further training to assist them with their roles. The manager told us she was considering having some kind of colour coding for the corridors and rooms as they all look very similar and they are replacing the curtains and bedspreads in the bedrooms to break up the similarity. The manager also stated: 'We will be repainting the bedroom doors in different colours to help the residents identify their rooms.' All the residents we saw appeared well dressed and clean.

**Promotion of Independence**

Apart from seeing people feeding themselves we did not actually observe any efforts at promoting independence. It appears that many of the residents are very disabled by their conditions. We noted the difficulty in reaching an outside seating area, and the hazards in the garden.

**Interaction between Residents and Staff**

We saw evidence of staff interacting with residents in a friendly, positive and respectful way. Residents sitting in TV rooms were spoken to, to check whether they wanted anything. Some were given their meals to eat in their seat in the conservatory if they wished. We noticed a member of staff sitting for a lengthy period with an elderly man stroking his back and talking quietly to him. She also fed him his lunch.

**Residents**

We only spoke to one resident as most are not able to communicate, although we exchanged pleasantries with one or two other residents when the occasion arose. We spoke to him in his room although the door was left open. He told us that he had been there for 2 years and that he likes the home; that the staff and food are 'top hole' and he has no complaints. He also said 'the girls are good at helping' and 'I know you've got to bide your time'. This latter comment suggested he might have had to wait for a response from staff. He has bad arthritis and has to be helped to move around. He said his son was happy with the care given by the home.

**Food**

The menu is displayed on a white board as well as pictorially. All residents can choose to have all their meals where they like be that in their own room, the lounge, or dining room. The menu choices are rotated 4 weekly. Residents could choose to have their breakfast in their bedroom. They are offered the choice of two main courses for lunch in the morning. Drinks were available regularly through the day. The kitchen hygiene rating is 5*. A number of residents were being helped to eat their meals. Most others were noted to be eating on their own or not really eating very much. We observed an elderly lady who did not touch her cooked meal. A staff member offered her an alternative and brought her a small sandwich. The lady ate one of the three sandwiches she was given so she was able to feed herself, although she was not assisted to eat any more. We noticed that her first meal had a large piece of liver in it which may have presented some difficulties for cutting up. We were told one lady insists on feeding herself even though she spills a lot down her apron. She then scrapes the dropped food up and eats it and apparently gets very cross if anyone tries to help her.

The Manager told us:

'We pride ourselves on knowing our residents and the help they will accept/need with their meals. We also have some residents with very poor appetites at the moment who are on food diaries, supplements and weekly weights.'

**Recreational activities/Social Inclusion/Pastoral needs**

We were told there is a new activity co-ordinator who will be arranging activities most afternoons, and in the afternoon of our visit there was a guitarist in the conservatory playing old tunes to the residents. Previously one of the kitchen staff has helped out running activities. There were televisions in one area of the conservatory and most bedrooms. We noticed that where residents were being nursed in bed their TVs were often turned on. A hairdresser attends the home one morning a week, and was indeed there on the morning of our visit.

**Involvement in Key Decisions**

We were not told about any residents meetings, but we heard that the first Relatives Group Meeting was planned for the following week. It is difficult to know how much most residents are able to contribute to their own care or the running of the home. The manager informed us that All residents are asked on a day to day basis when they would like to get up, what they would like to eat. Most are able to make simple decisions about their day to day care but not about more complex decisions.

**Concerns/Complaint Procedure**

The home confirmed that they have a complaints/compliments book although there is nothing in it perhaps because it stays in the Manager's office. The Manager told us she is happy to receive any complaints and will always deal with them.

**Staff**

There are 34 staff employed at the home, many are part-time. There appears to be a very low turnover of staff which suggests good relationships in the team.

All the staff we saw were smartly dressed in uniform, they were all polite and friendly to us and to the residents with whom we saw them interact. We spoke to two staff members both of whom said they were very happy working there and felt very upset about criticisms in the CQC report. They acknowledged that there were deficits in some areas but felt the staffing levels had a lot to do with omissions and failings reported by the CQC, the immediate

care of the residents was always their priority. Both believed the necessary changes were being made and said they felt they could go to the manager for help with anything. Neither had noticed any disrespectful attitudes towards residents in their colleagues.

**Visitors and Relatives**

We spoke to one relative who appears to spend most of each day with her husband who is nursed in bed. She told us 'the care here is lovely, fantastic'. She said that the staff are very good with her husband and give him lots of attention. The visitor said there is nothing she is unhappy with, however, she pointed out that the owner of the home could give the manager more support and financial backing so that she can plan ahead. This relative was planning to attend the relatives meeting the following week and hoped the owners would be present so she could speak to them. She felt there were 'things that need doing' in the home and that the report might be 'a wake-up call for the owners'. She also commented that there was no wifi in the bedrooms.

This relative was in the building when the CQC visit took place. She told us it was 'a disgusting visit'. She said one of the team was 'loud, bullying, hostile and racist' and that she 'had a go at' a foreign member of staff, within earshot of residents and staff. She said this created a 'toxic atmosphere' and 'spoiled the whole day'. She said she also heard the same member of the team trying to 'force a sound-bite' from a resident in the room next to her husband's, and she was tempted to go in and remonstrate with her.

**Additional Findings**

The manager told us that she was finding the input of the Quest for Quality support team very helpful and was now able to get a GP appointment for residents through the Team, much more easily than previously. She was also using the local Pharmacist to check the MAR charts, and be the second signatory in booking the drugs in. Another new protocol is that the duty nurse has to sign off on all medical interactions and jobs at the end of their shift as a safety measure before they can leave. This suggests that the Manager is keen to accept help from all sources and to improve the quality of the home.

**Recommendations**

There are a number of aspects of care home management that we are not allowed to observe or examine, such as Care Plans and Risk Assessments, Drug protocols and MARs. However, from what we observed and were told it appeared to us that the Manager and her team were making every effort to rectify the deficits and weaknesses identified by the CQC Inspection. There is an ongoing programme of refurbishment and redecoration, and new systems are being established to ensure legal requirements and care standards are being met. Staff training and appraisals are being brought up to date.

We would add the following recommendations:

- That the owners take a greater role in supporting the Manager and her team, and encourage the sharing of expertise, systems and protocols across their portfolio of care homes. Staffing levels must also be kept up to a safe and satisfactory level.
- A budget for staff training should be allocated to the home
- We recommend that the owners attend the Relatives Meetings on a regular basis and provide ongoing consultation.
- That the complaints and compliments book is kept out for residents and visitors to use.
- That the nurse's office and area around the front door is kept clear and that staff leave their property elsewhere in the building so that visitors can have interruption free meetings.
- Install wifi throughout the building for residents and visitors to use.