Avery Homes (Nelson) Limited

Milton Court Care Home

Inspection report

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Date of inspection visit:
31 May 2023

Date of publication:
11 July 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Milton Court is a care home providing personal and nursing care to up to 148 people. The service provides support to older people who are living with physical disabilities, mental health, and dementia. At the time of our inspection there were 98 people using the service.

The service comprises of 6 units, 5 units were in use at the time of the inspection, 2 of these provided nursing care. Each unit has its own communal areas which includes a lounge, dining room and kitchenette. All bedrooms have en-suite shower rooms.

People's experience of using this service and what we found
The provider did not always support people to follow their interests or provide sufficient engagement opportunities. Records were not always person centred. At times staff were task led. People's communication needs were not always fully met. Complaints were managed appropriately.

Systems to assess and monitor the service were not always effective. When things went wrong the provider ensured appropriate actions were taken in line with the duty of candour. There was a positive attitude to learning from mistakes.

There were enough staff to keep people safe. People were protected from the risk of harm and abuse. The provider had suitable risk assessments in place to keep people safe. Medicines were managed safely. People were protected from the risk of infection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 08 December 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Milton Court care home on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified a breach in relation to person centred care at this inspection. We have made a recommendation in relation to the providers governance systems.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our safe findings below	**Good**
Is the service responsive? The service was not always responsive Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our well-led findings below	**Requires Improvement**

Milton Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The Inspection was carried out by 3 inspectors, a nurse specialist advisor and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Milton Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Milton Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post, the manager had been in post for 3 months and had submitted their application to register with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and 15 relatives of people using the service. We also spoke with 16 staff members, including the managing director, home manager, regional support manager, deputy manager, unit managers, nurses, care assistants and kitchen staff.

We reviewed a range of records. This included 9 peoples care records and multiple medication records. We looked at 4 staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance records, policies and procedures, training records, meeting notes, governance information and risk assessments.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

- We observed mixed responsiveness of staff during the inspection. Whilst there were enough staff to keep people safe, we found people in their rooms were often left alone for extended periods of time outside of any direct care being provided. We have reported on this further in the responsive part of the report.
- Staff, people, and relatives told us the staffing levels had improved and they felt there were sufficient staff on duty. One person said, "I do use the buzzer when I need, staff come fairly quickly, maybe 5 minutes max to wait."
- The provider ensured staff were recruited safely by undertaking robust pre-employment and identity checks. These included a full employment history, employment references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm and abuse.
- Staff received training and were aware of the signs of abuse and how to report this. One staff member said, "I understand what abuse is and signs to look for if I suspected someone was at risk. I have a duty of care so would have no worries about reporting."
- The provider had policies and procedures in place to safeguard people from abuse. The manager had referred safeguarding concerns appropriately and promptly to the local authority and other stakeholders as required.

Assessing risk, safety monitoring and management

Risks to people were assessed, monitored, and regularly reviewed. This included risks associated with falls, malnutrition, skin integrity and diabetes.

- Risk assessments were in place and provided staff with enough information to manage risks and keep people safe.
- The provider had carried out robust risk assessment of the premises, relevant safety checks had been completed and any remedial action taken.

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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely
● Medicines were administered, stored, and disposed of safely. Safety related Information about people's medicines was recorded in care plans to further ensure people received their medicines correctly.
● People using 'as required' (PRN) medicines had a detailed 'PRN protocol' in place. This gave details to staff about what the medicine was used for and what signs and symptoms the person may display in the event the medicine was needed.
● Staff received medicines training which included regular competency checks.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
There were no restrictions on visiting. The provider was working in line with current government guidance. There were clear processes in place in the event of an outbreak of infection to ensure visits could still take place safely.

Learning lessons when things go wrong
● Processes were in place for the reporting and follow up of any accidents or incidents.
● The manager held a weekly clinical risk meeting with senior staff to review a number of areas, for example, falls, infections and pressure sores. These were analysed for themes and trends and learning was shared with the wider team to reduce risk of reoccurrence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Peoples care was not always personalised. Care plans lacked personal detail. We found limited information about people's life history or social needs to help staff understand them better as a person and be able to personalise their care.
● One person's care records stated they would need staff to intervene in the event they became distressed. Although we found there had been no recent periods the person had experienced an episode of distress, the care plan did not give detail about the techniques that should be used in this situation and there was no evidence that possible triggers for the persons distress had been considered.
● The provider did not always ensure people had sufficient opportunities to do the things they wanted to and spend their time in the way they preferred. For example, a person told us, "I used to like doing lots of things, not now though, I don't like bingo." Another person told us, "I know that there is a lot of things going on, my wife goes all the time, I prefer to stay [in my room] and take it easy."
● There were limited choices and opportunities for people who remained in bed to participate in activities. For example, a person who was cared for in bed told us, "I'm bored, there is nothing to do here." and, "I feel lonely, sometimes I am here for a long time." Furthermore, we observed minimal engagement from staff outside of direct caring tasks such as to provide personal care or deliver meals particularly for those people remaining in bed. This meant people were at increased risk of social isolation.
● The provider did not always ensure peoples communication needs were being met. One person we spoke with had difficulty communicating verbally. We raised this with staff and were told they previously had communication boards to aid in this area, however they were removed during the COVID-19 pandemic and had not been reinstated. This meant the person was left unable to communicate effectively, placing them at risk.
●Although care plans contained information about peoples sight and hearing needs, information was not always presented to people in ways they could understand. For example, around the service where people lived with dementia, there was no consideration to appropriate signage or use of colour for people to use as a point of reference and to support with wayfinding.

The provider did not always support people to follow their interests or provide sufficient engagement opportunities. Care records were not always person centred. This placed people at risk of harm. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were offered and encouraged to join in with group activities. We saw an activity planner for the upcoming week. During the inspection the well-being co-ordinator was on duty and had arranged a group darts activity for people to attend if they wished to. Relatives told us they felt there were a variety of activities scheduled for groups to attend.
● The provider had started asking for people's views around engagement opportunities and people had been asked to contribute to a 'wishing tree', where people could add their wishes and aspirations. One person wanted to reconnect with their former job in the police force. The provider worked with them to rebuild their confidence and they had enjoyed a day out at their old police headquarters and met with colleagues at their local police force.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place so complaints could be addressed in accordance with the provider's policy. Recent complaints had been addressed by the manager and we saw that these had been resolved to the complainant's satisfaction.
●The provider shared any lessons learned from complaints with the staff team and wider organisation to prevent recurrence.
● People and relatives knew who to contact if they had anything they were concerned about.

End of life care and support
● The provider held discussions with people to discuss their end of life wishes as part of the initial assessment and ongoing care plan review process.
● Following a concern with a recent hospital visit, 1 relative told us, "after a traumatic experience in hospital, [manager] suggested we add a new document [to the care plan] now my relative's wishes will be honoured if they need an ambulance in the future. I was glad they advised me to add this."
● Staff received training in end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to assess and monitor the service were not always effective. Audits failed to identify shortfalls related to care planning and the provision of activities for people. This resulted in care plans lacking personalised detail and records did not always provide staff with sufficient information to support people. For example, with their anxiety or distressed behaviours.

We recommend the provider review their governance systems.

- The manager had been in post for 3 months; people staff and relatives were positive about the changes they were already introducing. They were supported by 2 knowledgeable deputy managers as well as the provider. There was a clear management and staffing structure, and staff were aware of their roles and responsibilities and had confidence in the management team.
- The provider and manager were supportive of the inspection process and keen to take on board any suggestions and feedback offered. They were keen to drive improvements of the service to achieve good outcomes for people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a mixed culture within the service and people did not always receive person centred care. Some staff were dismissive of people's needs. For example, 1 person was calling out, we reported this to staff who said, "[person] has dementia, they're always like that." We also saw positive interactions between staff and people, for example, one person had become disoriented, a staff member spoke with them with kindness and patience, supporting them to their bedroom.
- People, staff and relatives described a recent positive change in the culture of the service and spoke highly of the new manager. A staff member said, "I feel supported and I'm excited for the changes that will come. I have faith in the new manager."
- The manager had started a culture change process within the service and was working alongside staff to embed best practice which was well received by staff, people, and their relatives. A relative told us, "[Manager] works well with staff, they're not shy to show them they have high standards to follow."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● When things went wrong the provider ensured appropriate actions were taken in line with the duty of candour. There was a positive attitude to learning from mistakes, action plans showed how incidents, feedback and complaints were used to make improvements to the service.

● Relatives and people told us the service contacted them when something went wrong and took action to put things right. One relative said, "[Manager] is honest and speaks directly with families without hiding anything. They would say openly if something was not right and admit mistake and try to correct it."

● The provider had up to date policies and governance arrangements in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider sought feedback from people and those important to them and used the feedback to develop the service. Questionnaires were sent to staff, people, relatives and professionals. Actions were implemented in response to the feedback gathered.

● One relative told us, "We receive information in newsletters and the office sends surveys, I know that my relative is also invited to attend meetings with other residents."

Working in partnership with others

● Staff worked well with other professionals and made appropriate and timely referrals where needed. People were supported to attend medical appointments.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to design care or treatment with a view to achieving service users' preferences and ensuring their needs are met.