Care UK Community Partnerships Ltd

Milner House

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?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 23 November 2017 and was unannounced. Our last inspection was in September 2016 where we found no breaches of the legal requirements, but we rated the service as Requires Improvement as recent improvements had not become embedded and sustained.

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

Milner House accommodates up to 46 people across two floors, each of which have separate adapted facilities and some shared facilities. People living at the home had a variety of medical conditions and healthcare needs. Most of the people at the home were living with dementia. At the time of our inspection there were 24 people living at the home.

There was not a registered manager in post, one of the provider's operational managers was in the process of registering with CQC at the time of 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 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 did not always receive their care safely. We observed two instances in which staff used inappropriate moving and handling techniques when supporting people. Prescribed equipment was not used which placed people at risk of injury. Where risks were identified, we found that staff were not always implementing plans to keep people safe.

Where incidents and accidents had occurred, the measures put in place to reduce the risk of them happening again were not always implemented robustly. There were not sufficient numbers of staff present to safely meet people's needs. We observed that where people required supervision as a part of their risk management plans, staff were unable to provide this due to being busy elsewhere.

Care was not always delivered in a dignified way. Half of the people that we spoke with told us that they had encountered staff that appeared reluctant to provide support to them. People said this was a particular

problem at night time and this impacted on their wellbeing significantly. There were high numbers of temporary agency staff employed at the home and they did not always know people's needs well. People reported that staff did not take due care with their belongings and there weren't effective systems in place to ensure people's belongings returned from the laundry. The laundry lacked organisation and we found that linen was not stored in a way that guaranteed it would not become contaminated.

There was a lack of good practice in relation to infection control. Where infection control risks were known about one person's medical condition, a plan was not recorded to guide staff on how to prevent cross-contamination. Staff were also observed failing to follow good practice when supporting this person. Areas of the home were not clean and systems to prevent cross-contamination were not implemented correctly.

People's medicines were not always managed safely. Discrepancies in medicines records had been identified in an audit by the provider, but had not been addressed. We also found shortfalls in the way that medicines were stored and monitored. Nursing staff did not receive the clinical supervision that they needed and there was a lack of leadership at the home. Staff were not held to account for work that they completed and there was a lack of oversight from the provider.

People did not always receive person-centred care. Care plans contained person centred information, but we identified occasions where things that were important to people were not documented in their care plans. People told us that the activities they were offered did not cover the whole week and they often felt bored at weekends. We observed some activities taking place and saw evidence of good practice in this area, however people fed back that there was a lack of consistency.

There was a lack of leadership and governance at the home. We identified information missing from records and the provider's audits had not identified or addressed the numerous concerns we found during our inspection.

Checks had been undertaken on new staff as well as agency staff to ensure they were suitable for their roles. Staff understood their roles in safeguarding people from abuse, however we found people were not always comfortable raising their concerns. Where complaints or concerns were raised, the provider responded to them. We recommended that the provider reviews their record keeping of complaints.

People were offered a choice of foods that reflected their dietary needs. We identified some shortfalls in the record keeping in the kitchen and recommended that the provider reviews their systems for involving people in choices about their meals. We saw evidence of people being supported to access healthcare professionals when required.

Staff followed the guidance of the Mental Capacity Act (2005). We observed times where people's privacy was respected by staff and we received some positive feedback about staff at the home. There was a contingency plan in place to be implemented in the event of an emergency. The provider had systems in place to reduce the risk of fire and to respond in the event of an emergency. The provider had developed links with the local community that had impacted positively on people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Staff did not use safe moving and handling techniques and known risks were not managed safely.

People were at risk of the spread of infection because infection control processes were not implemented correctly. The provider did not always follow best practice in medicines management.

There were not enough staff at the home to keep people safe.

The provider carried out checks on new staff to ensure they were suitable for their roles.

Staff understood their roles in safeguarding people from abuse but we found that people did not always seem comfortable raising their concerns. We recommended that the provider reviews their processes for enabling people to raise concerns.

Plans were in place to keep people safe in the event of an emergency.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a lack of clinical supervision and competency-based practice in place for nursing staff. Improvements to staff training and supervision had not been fully implemented.

People liked the food that they were served but we recommended that the provider reviews food records in relation to people's needs and to involve people more around menu choices.

The home environment was tailored to people's needs and people had regular access to healthcare professionals. Staff followed the guidance of the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring.

People told us that the staff that supported them were not always kind and caring. We heard examples of staff not providing care in a respectful or dignified way. People's belongings were not always treated with care.

Staff that supported people were not consistent which meant people did not always receive care from staff that they knew well and felt comfortable with.

Staff were observed respecting people's privacy and people's independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were activities in place, but this was not always the case at weekends. We recommended that the provider reviews their scheduling of activities.

The provider documented and responded to complaints. We recommended that the provider reviews their record keeping in this area.

Is the service well-led?

Inadequate

The service was not well-led.

Known concerns were not always addressed and audits had not identified numerous issues identified at this inspection.

There was a lack of leadership of staff and oversight was lacking. There were multiple gaps in records that affected the care that people received.

The provider had developed links with local community groups.

Milner 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.

The inspection team consisted of four inspectors.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

As part of our inspection we spoke with twelve people and two relatives. We also observed the care that people received and how staff interacted with people. We spoke with the home manager who was also the provider's the operational support manager, another of the provider's operational support managers, the deputy manager, two nursing staff, three care staff, the housekeeper, the chef and a visiting healthcare professional. We read care plans for seven people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at six staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records of menus, activities and minutes of meetings of staff and residents.

Inadequate

Our findings

People were at risk of harm because staff did not practice safe moving and handling techniques. We observed staff supporting people in a way that increased the risk of injury to them. We saw that the moving and handling method used to support two people was not in line with recommended best practice. Both people had equipment that staff should have been using to make moving them in bed easier and safer. Staff did not use the equipment and therefore placed the person at risk of injury. After the inspection, a healthcare professional told CQC that they had recently raised similar concerns with the provider. Following the inspection the provider informed us that they had arranged refresher training in moving and handling for all staff. However, we will require further actions from the provider to identify how they will ensure people's individual risk management plans are implemented safely.

Risks to people were not always managed safely. We observed that actions in risk management plans were not always implemented. Staff were not aware of every risk that people faced and how the risks were managed. For example, one person moved in a particular way that could cause pressure damage to their skin. Their risk assessment said that healthcare professionals had recommended protective pads for the person to wear. On the day of inspection, two staff members were not aware that the person used this equipment. The person was not wearing the protective pads and we did not see them in the person's room. This showed that information recorded to manage risks was not always being used. The impact of these gaps in record keeping was heightened because the home used high numbers of temporary agency staff. Where these staff had not supported people before, they would require detailed information on risks to keep them safe.

Responses to accidents and incidents were not always followed through. Records were kept of accidents or incidents, such as falls. Records showed that staff provided first aid where necessary and risk assessments were updated when necessary. However, we observed that the actions identified to reduce the risk of further falls were not always taken. One person had fallen four times in the last month. Their risk assessment had been updated in response to the falls. It stated that staff should remind the person to use a walking frame when mobilising. During the inspection we observed the person not using their frame when walking. A staff member spoke to the person whilst they were standing and the staff member did not remind them to use their frame. This showed that the lack of effective risk management in place increased the risk of falls happening again. Analysis of incidents took place to identify any lessons learnt from them, however these were not always responded to in a timely manner. For example, the analysis identified a high frequency of skin tears that were potentially caused by poor manual handling. This had not been addressed by the time of our inspection where we observed poor practice.

We identified serious concerns with how the provider controlled the potential spread of infection. Staff told us that one person was being cared for in their room because they had an infectious disease. There was no personal protective equipment (PPE) in place at the person's room, such as gloves and hand sanitising gel. We observed staff going into the person's room and supporting them and leaving the room without washing their hands. The person's care plan did not mention the fact that they had an infectious disease and it contained no guidance for staff. When we asked staff how they minimised the spread of infection when providing care to this person, they told us that they washed their hands and used gloves and aprons. However, we observed two staff members not doing so at separate times of the day. One staff member told us that the person was cared for in their room and later another staff member asked the person if they wanted to go downstairs for lunch. This showed that staff were not aware of how to manage a known risk of cross contamination.

Good practice in infection control was not always observed and audits did not identify shortfalls. The most recent infection control audit had not picked up on issues that we found during our inspection. Soiled laundry was stored in red bags, but we found them kept amongst non-soiled linen which posed a risk of cross-contamination. Red bags containing soiled linen were hung on the wall, with no clear system in place to keep soiled linen separate. A toilet door near the kitchen had visible stains on it and toilets did not contain information on good hand washing practice for staff. This was significant as we also observed staff not washing their hands after providing care to people or after the member of staff took a cigarette break. A staff member said, "They need to refurbish the home. Not all staff are good at infection control but it's so important. I have had to remind them about wearing gloves. Bad habits are hard to change."

Areas of the home were not kept clean and well maintained. The kitchen environment was in need of repair and equipment in there had become very old. A visit from environmental health in February had identified a number of actions required to ensure a clean and safe kitchen area. Not all of these actions had been completed by the time of our inspection. For example, there were cracks and holes in tiles that had been identified by environmental health and had not yet been fixed. Staff told us that they had asked for the kitchen to be deep cleaned some time ago but this had not taken place. We also found laundry cupboards were not locked and linen was not stored in line with good practice. In one cupboard linen was found alongside an old sink and some pipes. This showed a lack of organisation and heightened the risk of people's linen becoming contaminated.

Equipment used to support people was also not always clean. One person used a pressure relieving cushion and this had become frayed, which meant it could not be easily cleaned and it could also have reduced the effectiveness of the cushion in managing the risk of pressure damage. Staff had been working with the person on a daily basis and had not identified this and addressed it.

There were shortfalls in medicine management practices and therefore not always safe. We found that people's medicine administration records (MARs) were up to date and contained important information about their allergies. However, there were three medicines where the provider's recent count did not match the observed numbers of tablets stored and as such it was not clear whether people had received their medicines as prescribed. An audit of medicines had identified inconsistencies in staff counting a week before our inspection but it had not been addressed by the time of our visit. We also found one person's medicines stored in a container that had not been sealed and another person had dressings stored that were also unsealed and exposed to the air. Some syringes used to administer medicines had passed the manufacturers expiry date and an audit carried out after that date had not identified this. We also found dressings for use in an emergency that had also passed their expiry date which showed a lack of oversight of medicines and equipment.

The unsafe moving and handling practice and lack of management of known risks, poor practice in relation to infection control and the shortfalls in medicines management practice were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014).

There were not sufficient numbers of staff present to meet people's needs safely. Whilst staff told us that they felt there were enough staff to meet people's needs, we received mixed feedback from people about staffing levels. One person told us that staff arrived, "Fairly quickly" when they called them. However, another person told us, "They've got too many people to look after, they are short staffed." Throughout the day, we noted times in communal areas where there was limited staff supervision. This meant that in some cases, known risks were not managed as outlined in people's care plans. For example, one person's care plan said that they needed 'supervision' from staff due to risks relating to their behaviour. We observed the person left on their own in a lounge for five minutes. Another person's risk assessment stated, '[Person] is at high risk of falls, needs supervision', but we observed this person left in the communal area for a long period of time without staff present. Later in the day we observed two people sitting unattended in the lounge area for twenty minutes. This showed that staff were not able to provide the supervision required to keep people safe. We also noted that incident records showed that there had been six unwitnessed falls in the last month. This was a high number for a home of this size and indicated that staff were often not around when people suffered falls.

The provider had a tool in place to calculate staffing numbers and rotas showed that the calculated staffing levels had been maintained over the last three weeks, apart from one day when a staff member had called in sick. However, based on our observations and people's feedback, the calculated number of staff was not sufficient to safely meet people's needs. The provider was using high numbers of temporary agency staff and the manager told us that they found recruiting permanent staff challenging. Work was underway to recruit permanent staff. However, we identified this concern at our inspection in September 2016 and it had not been addressed by the time of our visit.

The lack of sufficient numbers of staff present to meet people's needs safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014).

The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, right to work in the UK and DBS. DBS is the disclosure barring service. This is used to complete a criminal records check and identify potential staff who would not be appropriate to work within social care. Staff told us that they did not start work until these checks had been completed.

Staff understood their roles in safeguarding people from abuse. Staff had been trained in safeguarding and knew who to contact if they suspected abuse had occurred. "First I would tell a senior and record it. If I wasn't happy I'd go to CQC or whistle blow. There's a phone number we can ring." Records showed that staff were raising concerns when appropriate. There had been six safeguarding concerns at the home in the last 12 months and we saw evidence of the provider working with the local authority safeguarding team where required. We noted that some people made negative comments to us regarding the staff that supported them, which we have reported on in the Caring domain. These concerns had not been raised with the provider which showed that people did not have confidence to speak up when required. This meant the provider could not guarantee people could raise a safeguarding concern if they needed to.

We recommend that the provider reviews their systems for enabling people to provide feedback and raise concerns in confidence.

People were kept safe in the event of an emergency. The provider had assessed the risk of fire to the building

and had equipment in place to reduce fire risks. Equipment, such as fire extinguishers and fire doors, were regularly checked and issues were addressed. There was a plan in place for evacuation and each person had a personal emergency evacuation plan (PEEP) that informed staff on how to evacuate people, based on their needs. Staff had been trained in fire safety and the provider had drawn up a plan to ensure people's care could continue in the event of the building becoming unusable.

Requires Improvement

Our findings

Clinical staff did not have the support that they needed to meet people's healthcare needs. Staff files showed that nursing staff were not having clinical supervision. Clinical supervision is a meeting where nurses can discuss their skills and keep up to date with current practice. Staff told us that not having this in place impacted negatively on the care that they delivered. A staff member told us that they had less opportunity to discuss practice and find ways of improving the way they worked. We also noted that all the nurses apart from one who worked on shift in the last three weeks were from an agency. There was no evidence of a system in place to ensure agency nurses had opportunities to discuss their practice and for the provider to assess their competencies. It also meant that the provider did not have a system in place to ensure that nursing staff continued to meet the professional standards they needed for their registration to the Nursing and Midwifery Council (NMC).

Staff told us that there was a lack of clinical support when they needed advice about people's health needs. One staff member told us, "There is not enough clinical support. [Deputy manager] is here Monday to Friday and we have an on-call manager, but sometimes you need an answer quick. We don't have a clinical lead." Staff told us that it was often quicker to telephone a person's GP due to a lack of clinical support in the home. This showed that there was a lack of support in place for staff to ensure that people's healthcare needs were met.

Staff had access to training to carry out their roles, but our observed practice showed that this was not always effective. For example, we observed poor moving and handling and infection control practice despite staff having had training in these areas. The high use of agency staff also meant that the provider could not always be assured that staff training was up to date. The provider kept a record of training which showed that permanent staff training was up to date. Training covered important areas such as health and safety, dementia and infection control. Staff told us that they received regular supervision and the provider's records confirmed this. Staff said supervision was an opportunity to discuss people's needs as well as any training or areas of knowledge that they wished to develop.

Although the provider often ensured they often used regular staff from agencies, this was not always guaranteed. We saw evidence of the provider keeping records of agency staff training and the provider had started to introduce one to one supervision for agency staff. However, this had only been introduced very recently and had not become embedded by the time of our inspection.

The lack of support and ongoing training for clinical staff and shortfalls in staff training was a breach of

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014).

People told us that they liked the food that was prepared for them, but we noted there wasn't a clear system to involve people in writing menus. One person said, "The food is good." Another person told us, "There's a choice up to a point. There's usually four or five things to choose from." Another person said, "If you want something different, you ask and they'll get it for you, they're very good." People were offered a choice of meals each day and the kitchen held records of people's preferences.

People's dietary needs were met but there were inconsistencies in records. We observed that people were served food in line with their dietary requirements. Daily records showed that people's dietary requirements were met as staff recorded what people had eaten each day. For example, one person had been seen by a speech and language therapist (SALT) as staff noted that they had difficulties swallowing. The SALT recommended soft textured food to reduce the risk and this was added to the person's care plan. The kitchen also had this information in their records and the staff were aware of this person's dietary requirements. However, we found kitchen records were not up to date and still kept records for people that no longer lived at the home. The inconsistent records was significant as the home used kitchen staff from an agency. We also noted that there was not a system in place for people to give feedback on the food that they received.

We recommend that the provider reviews the records kept by the kitchen to ensure they are accurate and people's choices and feedback are regularly updated.

People were supported to access healthcare professionals when necessary. People's care files contained evidence of input from healthcare professionals and records showed that people saw the GP or community nurses as required. For example, staff had noted one person's mobility had worsened. The person was referred to an occupational therapist and a physiotherapist. The person was given a frame to walk with and we saw that they had it in their room on the day of inspection. People's records also showed evidence of appointments with opticians, dentists and GP.

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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the guidance of the MCA. People's records contained evidence of mental capacity assessments being undertaken to establish whether people could make decisions. Where people were unable to make these decisions, best interest decisions were recorded that involved relatives and healthcare professionals. For example, one person who was living with dementia did not want to take their prescribed medicines. A mental capacity assessment was carried out and the person was assessed as unable to make the decision to take their medicine. A best interest decision was documented that involved relatives, staff, the person's GP and a pharmacist. It was decided that it was in the person's best interests to receive the medicine covertly. Where people had restrictions placed upon them, applications had been made to the local authority DoLS team.

The home's design catered to people's needs. There were people at the home that were living with dementia and there were clear signs with pictures throughout the home to help orientate people. A number of people living at the home used mobility aids and wheelchairs and we observed that people's rooms and communal areas were spacious to allow room for people to manoeuvre. People's bedrooms had adjoining wet rooms and toilets which allowed spacious facilities for people to wash in that was suited to their needs.

Inadequate

Our findings

People told us that they were not always supported by kind and compassionate staff. Six people gave us negative feedback about the staff that supported them. One person said, "I find them (staff) very brusque." Another person said, "Most of the carers are kind and do their best but a couple at night aren't." People described to us how some of the staff supporting them did not appear committed or compassionate. Whilst six people gave us positive feedback about the caring nature of staff, six people also told us that some staff did not seem as caring as others. In particular, we received feedback that people did not always feel comfortable pressing the call bell at night due to the attitude of the staff that responded. This meant that people did not always receive their care in a dignified way. For example, one person told us that they requested a snack at night time. They said that the night staff were reluctant to do so and threw a bag of crisps onto the person's bed in an uncaring manner. Another person told us that they had been afraid to ask for help to use the toilet, which had caused them to have accidents on three occasions in one week. This showed that people did not feel comfortable with the staff supporting them and did not receive dignified care. During our inspection we observed a person ask a member of staff for a drink. They told them that they would arrange this but twenty minutes later the person had not had their request fulfilled. We fed back our concerns to the manager and they started to do spot checks of people's care at night.

People did not feel that their belongings were treated well by staff. Three people told us that items of clothing regularly went missing when they went to laundry. People told us they would regularly find other people's clothes in their wardrobes or drawers. One person told us that they felt staff did not take care when returning laundry to their room and they would often find clothes left in their drawers in a mess. They also said staff did not ask for permission before opening their drawers. This impacted on the person's wellbeing as well as their confidence in staff and the care that they received.

People were not supported by regular staff that knew them well. The home regularly used temporary agency staff and this impacted on the care that people received. One person told us, "We're familiar with some of the agency staff but you do suddenly get new faces, which can be disconcerting, especially when they stand and watch you shower." The provider did try to ensure consistency when recruiting temporary agency staff and rotas confirmed they were often able to achieve this, reducing the impact of inconsistent staff on people. For example, an agency staff member that we spoke to was able to tell us about one person's needs, including their favourite music and what calmed them down. However, the turn-over of staff remained high and the provider did not have systems in place to ensure sustained consistency for people. We identified and reported on this concern at our inspection in September 2016 and the provider had started to try and

recruit more permanent staff. However, people still had a lack of consistency in the staff that supported them. People fed back to us that there was uncertainty about staff that would be supporting them and that staff changed frequently. This prevented people from building a rapport with staff.

Staff did not always have a good understanding of people's needs. We identified inconsistencies in records that prevented staff from getting to know people. The shortfalls in recording had added significance due to the high use of agency staff at the home. Whilst some staff that we spoke with had a good understanding of people's needs and backgrounds, other staff did not know the needs of the people that they supported. For example, a staff member told us that one person was blind and could not use sign language. When we checked the person's care plan it stated they did have some vision and staff were to get close to them. We confirmed this with the person but staff were not aware and as such had not been communicating with them in their preferred way. We did also speak with staff who were able to tell us people's needs. The provider had been working to recruit new staff and when we spoke to permanent staff they knew what people needed support with and what was important to them. The provider will need to take further action in this area to ensure the improvements are embedded.

We observed times where staff did not communicate effectively with people. One person had a hearing impairment and there was guidance for staff on how to communicate with them. Their care plan stated this and they had pictures in their room showing staff sign language that the person used. Staff were observed supporting the person by raising their voices, which was not effective in helping the person to understand them. A healthcare professional told us that they had advised staff of how to communicate with the person and that what we observed was not in line with this guidance.

People were not always involved in their care. Whilst people were involved in some aspects of their care, we did not see evidence of consistency in this area. For example, people did not have regular opportunities to give feedback on meals and people told us that they did not get to do activities that interested them at weekends. People did have regular reviews and we saw evidence of meetings taking place for people to feedback their views. However, people were not supported by staff that knew their interests and preferences so the extent to which people were involved in their day to day care was limited. The new manager had started work to meet with people and speak to them as part of their daily walk around, but we will require action from the provider in this area to ensure people are routinely involved in their care.

The lack of dignified care, the lack of consistent staff that knew people well and the failure to routinely involve people in their care was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014).

We observed that some staff were caring and there were some kind and pleasant interactions between people and staff. In the morning, a staff member was observed discussing a television programme with two people who were both smiling. Another person enjoyed music and staff were observed asking them about their favourite song. At times staff demonstrated a good understanding of people's needs. One person really liked music as it calmed them down when agitated. An agency staff member was able to tell us about this and who their favourite musical artist was.

Staff understood how to promote people's independence. One staff member told us, "We do activities and where people need help to walk we encourage them. With [person] when we talk to her she gets confidence." We observed staff supporting this person by providing them with encouragement when walking, as this was identified as something they were able to do. At mealtimes, we observed that people were encouraged by staff to eat independently.

At other times than previously mentioned, people's privacy was respected by staff. Staff were seen knocking on people's doors and waiting for permission before entering. Where people required support with personal care, this was done discreetly in people's rooms. Staff demonstrated a good understanding of how to promote people's privacy when we spoke with them.

Requires Improvement

Our findings

People told us that they didn't always have access to activities that interested them. One person said, "I go to a few things. I like the bingo and crosswords." However, another person said, "There are some (activities) but maybe not as much as we could enjoy." Another person said, "[Activity co-ordinator] arranges things but they're never on duty at weekends."

The home employed an activities co-ordinator but they were not available every day. One person said, "The weekends are horrible. None of us like the weekends. It's lonely and nothing ever goes on." The provider was in the process of recruiting an additional activities co-ordinator as the current one did not cover weekends. People spoke positively of the activities co-ordinator but said that the lack of activities at weekends impacted on their wellbeing. On the day of our inspection the activities co-ordinator was on leave. We observed staff were able to provide cover as games took place and we observed staff listening to music and watching television with people. There was a timetable in place that included games, quizzes, arts and crafts as well as outings and visits from local schools. However, people fed back that they found weekends boring because there was less happening at the home. One person told us they often just sat in their room at weekends. They said, "I get really tired looking at that wall."

We recommend that the provider reviews the way that activities are scheduled to ensure people have access to activities when they need them.

Information about things that were important to people was missing from their care plans. The provider kept detailed and comprehensive care plans but we found examples where important information was missing. For example, we observed that one person liked to wear their glasses in a unique way. When we checked the person's care plan, the information about this was missing and staff were not sure about how this person liked to wear their glasses. Another person's records stated that they had a history of depression but there was no information for staff about how to support this person if they became depressed. This showed a lack of planning in place to ensure people received person-centred care. Whilst we noted that reviews were recorded as having taken place, they had not resulted in this information being updated on the person's care plan. This showed that reviews were not always robust and person-centred.

We observed times where people's specific needs were not met. One person had a hearing impairment and there was guidance for staff on how to communicate with them. Their care plan stated this and they had pictures in their room showing staff sign language that the person used. Staff were observed supporting the person by raising their voices, which was not effective in helping the person to understand them. A

healthcare professional told us that they had advised staff of how to communicate with the person and that what we observed was not in line with this guidance.

The lack of regular and consistent activities for people and lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014).

In other cases, we found examples of where people did receive person-centred care. One person had an interest in art and records showed staff supported them to engage in creative activities. Another person used facial expressions and gestures to make choices. There was guidance in the person's care plan about this and a staff member was able to describe to us how they supported this person to choose what they wished to eat or what they wished to wear. Staff noted that another person used to be a teacher and worked with children. In response, they had been encouraged to become involved in recent activities involving a local school and we saw photographs of this. The school were due to visit the home again after our inspection for a Christmas activity.

Complaints were responded to appropriately. A relative told us, "I am sure if I had any problems [manager] would deal with them straight away." There was a complaints policy in place and it was clearly displayed within the home. The provider kept a record of complaints and actions that had been taken. Responses showed that the provider was addressing people's concerns and checking that people were satisfied with their response. For example, a relative had complained about a lack of garden furniture at the home. This had been documented and addressed and the provider had bought garden furniture. We did note that the provider did not keep a record of the original complaint, which made it harder to track concerns and actions taken.

We recommend that the provider reviews their systems for logging and tracking complaints to ensure a clear audit trail is in place to follow up on people's concerns.

Inadequate

Our findings

At our inspection in September 2016, we rated the service as 'Requires Improvement' in Well-led. We identified a lack of consistent staff and we noted that improvements to leadership and governance at the home required a period of time to become embedded and sustained before we would give the service a 'Good' rating in Well-led. At this inspection, we found that the service had deteriorated and the improvements had not been sustained. The lack of action following the concerns we highlighted at our previous inspection showed a lack of learning and a lack of improvements in response to our concerns.

There was not always clear leadership at the home. One of the provider's operational support managers was in the process of registering with CQC as the home's registered manager at the time of inspection. The feedback we received about the new manager was positive, but they had not had time to implement many of their planned improvements by the time of our inspection. We also received feedback that the provider did not ensure that people and their relatives had access to management at all times. A relative told us, "There never seem to be any management on site at weekends. I think there should be management around at all times. I often wonder who is in charge (at weekends)."

Staff were not always held to account by management. For example, we observed staff having frequent cigarette breaks. The manager told us that these should make up part of their normal break time. Management were not aware of how often people had been leaving the building for breaks until we pointed this out to them. This impacted on people significantly due to the concerns we identified with staffing levels. This also showed a lack of oversight and leadership at the home and lack of accountability for staff.

Staff meetings did not always result in improvements to people's care. Regular meetings were conducted and staff told us that they found staff meetings useful. However, the identified actions following staff meetings were not always implemented. For example, a recent meeting had been used to discuss the importance of putting people's clothes away neatly. The minutes stated that staff should 'carefully put away' people's clothes and check that they were in the correct room. Despite this having been discussed a month before, people told us their clothing was still going missing and it was not stored in their rooms neatly.

Quality assurance processes were not addressing known concerns. Where we found shortfalls in medicines management, an audit had also identified a lack of recording and accounting but this had not been addressed. Where we found significant information missing from people's records, audits of documentation had not found these. The lack of robust infection control practices had not been identified in an audit.

Further to this, recommended actions from the local environmental health team had not been fully actioned despite being made nine months before our inspection. We received concerns about the quality of care at night time but no audit had taken place to measure the quality of care overnight. This was despite the provider using mostly temporary agency staff on night shifts, which increased the need for additional checks. Where people told us that they waited a long time for responses to call bells, the provider had not audited this so was unable to give us information in relation to response times.

The provider failed to maintain accurate and contemporaneous records for people. Where one person had an infectious disease that required specialist support from staff, this was not in their care plan. Inconsistent record keeping with regards to people's communication needs, preferences and medical conditions meant information for staff was lacking. As previously mentioned, this was particularly significant due to the frequent use of agency staff at the home.

The lack of robust quality assurance, the information missing from records and the inconsistent leadership and governance at the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Staff told us that they felt supported by management. A new manager was in the process of registering with CQC and staff told us that they were already causing improvements at the service. Staff said they had confidence in the new manager as they had already identified areas to improve and change. For example, they were in the processes of implementing increased supervision at the time of our inspection.

People and their relatives were given opportunities to feedback on the care that they received. We saw evidence of meetings taking place in which people and their relatives were encouraged to give feedback. A recent meeting had been used to discuss changes to the dining arrangements and to gather people's feedback. A regular relative's survey was carried out and the most recent survey showed a drop in relative's satisfaction with the care that they received, which was in line with our findings. There were low satisfaction levels with activities and satisfaction levels in how people's safety and dignity were promoted had also fallen. Following this inspection we will require the provider to implement an action plan of improvements. We will measure the improvements against people's experiences at our next inspection.

The service worked in partnership with other agencies. We saw evidence of regular contact with healthcare professionals and social services to meet individual care needs. The provider had also built links with a local school that were involved in activities at the home. We received positive feedback from people on these activities and more activities of this type were planned.
The provider understood the responsibilities of their registration. Providers are required to notify CQC of important events such as serious injuries or deaths at the service. We found that where required, the provider was notifying CQC appropriately.

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
Treatment of disease, disorder or injury	Care plans did not always reflect people's needs and what was important to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Staff did not always support people in a kind and caring way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Staff did not use appropriate moving and handling techniques. Known risks were not managed safely. There was a lack of safe medicines management. Infection control risks were not managed safely.

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of leadership and governance at the home.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to meet people's needs safely. There was a lack of clinical supervision and support in place for qualified staff.

The enforcement action we took:

We issued a warning notice