National Society For Epilepsy(The)

Milton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 June 2016. It was an unannounced visit to the service.

Milton House is a care home which provides accommodation and personal care for up to twelve people. At the time of our inspection eight people were living there.

Milton house provides accommodation on the ground floor. The first floor is out of use.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' A manager had been appointed and was in the process of applying to the Commission to be the registered manager.

We previously inspected the service on the 4 February 2014. The service was assessed against five outcome areas at the time and found to be compliant.

At this inspection we found people's medicines were not safely managed. Their care plans were not up to date and reflective of their current needs. Risks to people were not managed and put people at risk of injury. Staff were not working in line with the principles of the Mental Capacity Act 2005.

Staff were suitably inducted, trained but were not adequately supported and supervised in their roles. They were generally kind and caring but some staff practices did not promote people's dignity and respect. Staffing levels had not been reviewed to take into account the change in people's needs. Staff were not recruited in line with the organisations policy on recruitment and staff felt they lacked guidance and management support. People were asked to make choices and decisions on day to day care but aids and props were not routinely used to promote people's involvement and communication. People's records were not suitably maintained and fit for purpose. We have made recommendations to address these shortfalls.

The provider had systems in place to monitor the service but the auditing was not effective in picking up the issues and shortfalls we found.

People had access to a range of health professionals to meet their needs. They had individual programme of activities and some people were keen for the activities to be improved to promote more community based activities. People and their relatives knew how to raise a concern/ complaint and they were able to give feedback on the care and support provided.

People and their relatives were happy with the care provided. They described staff as being knowledgeable, kind, caring, committed and supportive.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's likelihood of experiencing injury or harm was increased as risks to people were not properly managed.

People's medicines were not given as prescribed.

People were not protected by safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to make decisions about their day to day care. However staff failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice such as the Deprivation of Liberty safeguards.

People were supported by staff who were suitably inducted and trained. However staff were not adequately supervised and supported to ensure they provided effective care.

People had access to a range of health professionals to promote their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People's privacy was promoted however people were not always provided with the aids, objects and props to enable them to be involved in their care.

People had end of life care plans in place but the end of life care plan did not take account of "Do not attempt resuscitation" forms which were included in people's files.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not reflective of their current needs.

People had access to activities but were keen for more community based activities to be made more accessible.

People had access to information on how to raise a concern or complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had no registered manager although a manager had been appointed and was applying to be registered. The service lacked management input to provide guidance and support to staff to promote safe care.

The service was audited and monitored but monitoring failed to pick up the issues we had identified to promote safe care to people.

People's records were not maintained and fit for purpose.

Milton House

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 June 2016.It was an unannounced inspection which meant staff and the provider did not know we would be visiting. The inspection was carried out by one inspector.

At our previous inspection on the 4 February 2014 the service was meeting the regulations inspected. This inspection was a comprehensive inspection to provide a rating for the service.

Prior to the inspection we reviewed the Provider Information Record (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports of the home and other information we held about the home. After the inspection we contacted health care professionals involved with the service to obtain their views about the care provided.

The inspection was facilitated by the Operations Manager for the service. During the inspection we spoke with two people living at the home. We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to other people in the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke to six staff which included two team leaders, three care workers and the administrator. We spoke with three relatives after the inspection. We looked at a number of records relating to individuals care and the running of the service These included three care plans, medicine records for all eight people, two staff recruitment files, ten staff supervision records, accident/incident reports and audits. We observed staff practices and walked around the service to review the environment people lived in.

Inadequate

Is the service safe?

Our findings

People told us staff supported them with their medicines. Some people were self-administering their medicines whilst others required staff support to take their medicine.

Medicines were not administered as prescribed. We saw one person was prescribed new medicine on their discharge from hospital. Staff had recorded the medicine into the home but failed to recognise that only a short supply of the person's new medicine was provided. It was recorded on the medicine administration record that 43 doses of one medicine and eleven doses of another medicine were not administered. We saw staff at the home put a request in for repeat prescription to the GP but only the day after the medicine had ran out. This meant the person did not get their prescribed medicines.

A person was prescribed a food supplement to be administered via a Percutaneous Endoscopic Gastrostomy feed (P.E.G). This is where a tube is passed into the person's stomach to provide them with supplements. The medicine administration record indicated that 1500 millilitres of the food supplement was given for a period of 27 days and on two occasions it was signed as being administered twice. The hospital discharge letter and guidance from the Dietician services indicated the person was prescribed 1000 millilitres per day. The medicine administration record was handwritten and unsigned and it was not known who had completed it. We saw from the 2 June 2016 the person was given the prescribed amount however the medicine record was not properly completed to outline the name of the feed and again was unsigned. This meant the person could have had the wrong supplement administered and potentially overload the person with fluids.

A person was prescribed medicine for constipation. Their care plan highlighted they were at risk of constipation. There was two occasions where this medicine was not signed as being administered. Another person's medicine records indicated three gaps in administration of their prescribed medicine. There was no indication this had been picked up by the provider and investigated as to whether it was missed signatures or missed medicines. The communication book made no reference to it and an incident report for missed medicine was not completed. This should have been completed according to the providers guidance on missed medicines.

One person's care plan indicated they were on a specific prescribed medicine for managing their epilepsy. The medicine was not prescribed on the person's medicine administration record and their epilepsy emergency protocol made no reference to it. The care plan had recently been updated but failed to pick up that change which we were told had occurred some years previously.

The service had new medicine administration records which had been introduced. We saw one person's medicines were handwritten and there was no signature to indicate who had done that. Staff used an O code for medicine not administered. However no explanation was provided as to what the O code meant and why prescribed medicines were not given. We saw as required medicines were also handwritten. We were told this was because the software used did not allow them to print as required medicine. The provider confirmed they were aware there were issues with the medicine administration records and were working

on improving it.

Staff told us they had been trained in the new medicine administration records however their practice would suggest they were not fully aware of how to administer medicines safely and take action when medicine was not given as prescribed. We asked to see a copy of the medicine training programme which was delivered. This was provided after the inspection. The training outlined how staff should manage out of hours medicines. It indicated two staff should write and sign any medicines added to the medicine administration record. Staff's practice demonstrated the guidance and training was not followed.

We were provided with a copy of the medicine policy. The medicine policy made no reference as to how medicines into the home should be handled and did not provide guidance on whether medicine records could be handwritten and how this process should be managed. We were told the medicine policy was being updated to reflect current practice.

People were not being protected against risks and action had not been taken to prevent the potential of harm. People's files contained a series of risk assessments and management plans. However not all risks identified were managed. One person was identified as being at high risk of pressure sores. There were no risk management plans or care plan to outline how the risk should be managed. Staff were aware this risk existed and told us how they cared for the person to prevent a pressure sore developing. However the lack of guidance could mean staff were not consistent in managing the potential risk. One person had a moving and handling risk assessment in place which outlined they were able to mobilise independently. However the person's needs had changed and they were no longer mobile. People had personal evacuation emergency plans (PEEP) in place. One person's PEEP was not updated to reflect they were no longer mobile and they would require full assistance to evacuate in the event of a fire.

One person's medicine record indicated they had an allergy to a food product. The person's care plan made no reference to it. There was no risk assessment in place to identify and manage the potential risk. The operations manager informed staff of the allergy but staff were unable to inform us of the details of the allergy, how it presented or how it was treated. This had the potential to put the person at risk of eating the product they were allergic to.

We were told one person required 30 min checks. Staff told this was to promote their safety and gave us differing accounts of what they were checking. There was no risk assessment in place to indicate the potential risks to the person's safety and why the checks were necessary. The person's daily records made no reference to the checks either. There was inconsistent recording of the checks on the shift planner. On occasions it was recorded the 30 min checks were maintained. On other occasions it was recorded regular checks were maintained but it was not clear what were considered regular checks. On other occasions there was no reference to any checks. On day two of the inspection a check list was put in place for staff to sign and guidance was being written to ensure staff were consistent in their checking and observations of the person.

The home had a risk assessment document which identified environmental risks and how these were managed to promote people's, staff and visitors safety. This was reviewed and up to date. Fire safety and moving and handling equipment was regularly serviced and safe to use. A range of health and safety checks of the environment and fire safety checks, including fire drills took place. The home had a pregnant staff member. We saw an initial pregnancy assessment was completed for them in April 2016 but had not been reviewed since then or monthly as indicated by the organisations guidance on pregnancy risk assessments. This had the potential to put the staff member at risk.

Areas of the home were being decorated. All of the bathrooms/showers had been updated and a refurbishment plan was in place to further improve the environment. 44 degrees centigrade is considered by the Health and Safety executive to be the maximum safe temperature for water outlets in care homes. We saw the hot water temperature in the bath was recorded as 59 degrees centigrade and above from April 2016. There was no indication any action had been taken and staff did not recognise that it was above the recommended safe level. The operations manager contacted the works department during the inspection and they came to check the temperature. They confirmed the water temperature was within the safe water temperature level at that time. The team leader on duty at that time agreed to discuss it with the staff undertaking the task to ensure they knew how to do the task properly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because safe care and treatment was not routinely provided.

Staff demonstrated during discussions with us they had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. We viewed the accident and incident records. These were completed and interventions recorded. They were checked and signed off by the service manager and checked during the bi-monthly Quality Monitoring Record audits undertaken by the operations manager.

People told us they felt safe. Pictorial information was provided on notice boards to outline to them what was abuse and who to report to. Relatives believed their family members were safe. A relative commented "We know our family member is safe and feel very thankful to staff for that."

Staff were trained in safeguarding and were aware of their responsibilities to report poor practice. Policies and guidance were provided to ensure staff knew how to report any issues of concern. However we saw staff practice in relation to medicine administration did not safeguard people. An incident report and subsequent safe guarding alerts were not completed for the missed medicines and administration of double doses of medication. Risks to people were not managed which also meant staff failed to safeguard people.

People told us staff were nearly always available to support them. One person commented "Whenever I call staff they are there." Relatives thought the staffing levels were sufficient. One relative told us the frequent change in staff and use of bank and agency staff worried them. We were told three staff were provided during the day time shift. Two waking night staff were available at night. On day one of the inspection two staff were on duty when we arrived as the third staff member was on training. Staff told us this often happened where two staff were left on shift due to training or an agency or bank worker not turning up. Staff said they inform the manager who is responsible for coordinating bank and agency workers but do not routinely tell management and just cope with two staff.

Two people required one to one support at meal times and three people required two staff for moving and handling. One person was on 30 minute checks and another needed observation when mobilising due to limited vision. Care staff were also responsible for cooking the meals and medicine administration. On day one of the inspection it was chaotic at lunch time. People were not provided with staff immediately to support them with their meal and meals were served at different times. One person had two different staff support them as one staff member had to go back to their training.

The home had 85.25 support worker hours' vacancies and was attempting to recruit into the vacancies. We saw bank and agency staff were used to cover gaps in the rota, especially on the night shift often leaving two bank staff on at night. We reviewed the duty rota from the period the 6 June to 26 June. Three staff were generally maintained on shift. We saw the team leaders were allocated supernumerary days to catch up on

administration tasks but on occasions they had to cover the shift instead.

It is recommended the provider reviews staffing levels to take account of people's changing needs and dependency levels to ensure safe staffing levels are maintained.

Systems were in place to ensure staff were suitably recruited into roles. Staff files contained a photo, application form, medical questionnaire and evidence of an interview and written assessment. Records showed checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Two references were obtained by the provider to satisfy themselves that staff were suitable for the role. We saw in one file gaps in employment were not explored and references were not routinely obtained from a previous employer as was required according to the provider's policy on recruitment.

It is recommended the provider improves its recruitment practices to ensure the required checks are carried out, in line with their recruitment policy.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were trained in the Mental Capacity Act 2005 (MCA) and demonstrated they had a good understanding of the act. However staff failed to see how it related to the people they supported. People's care plans told us if people had capacity to make decisions and choices but did not outline if they had capacity to make decisions on their care and treatment. We saw best interest meetings took place for people in relation to some aspects of their treatment such as flu vaccinations.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had been trained in DoLS however they did not know who had a DoLS in place. They named people they thought should have a DoLS and why. The home had no record either of DoLS applications submitted, pending or which if any were due for renewal.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because staff failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

People told us they felt staff had the skills and training to do their job. One person commented "They all seem to know what they are doing." Relatives felt confident staff were suitably trained. One relative commented "Staff seem to know instinctively what to do in any given situation." Another relative commented "Staff seem to know what they are doing." Staff told us they had the training and skills they needed to meet people's needs. They confirmed they had completed an induction. They said they had completed the induction training and worked in a shadowing capacity alongside more experienced staff during their induction. We looked at induction records for one staff member. We saw they had worked through the induction booklet and it was signed off when completed.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff completed training the provider considered to be mandatory such as epilepsy awareness, Mental Capacity Act 2005, Deprivation of Liberty safeguards, safeguarding of vulnerable adults, fire safety, food handling, moving and handling, health and safety and infection control. Alongside this some staff had completed PEG feed training, dementia training and non-abusive psychological and physical intervention training to enable them to have the skills to deal with behaviours that challenged. The team leaders had supervision and some management training and shift leaders were trained in their role and responsibilities. Updates in training were highlighted when due and booked. Staff told us they were clear of their roles and responsibilities, felt suitably trained but felt there was a lack of

guidance, support and direction.

Care staff said they received regular one to one supervisions. They told us they felt supported by the team leaders. Team leaders felt less supported and told us they did not have regular supervisions. We looked at a sample of supervision records. We saw the care staff received supervision every eight weeks in line with the organisations policy. However team leaders were not receiving supervision in line with the organisations policy. Two team leaders had two supervisions recorded for 2016 and one team leader had only one. We were told team meetings were meant to take place monthly and clinical review meetings were meant to take place weekly. These were not taking place as required. The last team meeting minutes on file was dated 11 March 2016 and the last clinical meeting was 31 May 2016. This meant the systems in place to support staff were not being utilised.

It is recommended staff are supervised in line with the organisations policy and systems in place to support staff such as team meetings and clinical review meetings take place in line with the organisations expectations.

People were registered with a local GP surgery and had access to other health professionals such as a consultant psychiatrist, neurologist, optician, dietitian and district nurses. Records were maintained of appointments with health professionals and the outcome recorded. People had access to therapy staff on site which included physiotherapists, occupational therapists, speech and language therapists. Care plans included guidance from therapy staff and staff were seen to work to the guidance.

Relatives felt people's health needs were met. They told us they were informed if their family members were unwell or had an accident. One relative described staff as committed to their job. They commented "They persevere and don't give up easily."

A professional involved with the home commented "The safety of residents is important to staff at Milton House. They have been reviewing and updating care plans and have been pro-active in seeking expert guidance by referring to the Therapy service for recommendations. For example in dysphagia management and bathing facilities." They told us the staff can talk with knowledge regarding the needs of the residents. A resident who attends regular physiotherapy appointments was supported to attend consistently.

Another professional commented "The staff are the usual mix of new and experienced. They are always very friendly and well informed whenever I go there. Obviously mistakes get made, arguments and debates happen, but on the whole for the task in hand supporting complex vulnerable people to live life the best they can, I think they put in a great effort to make it happen."

People's care plans outlined their nutritional needs and risks. Food and fluid charts were in place for people who were considered a risk of malnutrition. The service had access to a dietitian and they were currently involved with one person at the service. We saw one person's fluids were not given evenly throughout the day and they had the majority of their drinks in the morning and little or no drinks throughout the afternoon and evening. The operations manager advised us they had picked that up and was already addressing it with staff so that people had access to regular drinks throughout the day.

Staff support was provided at meal times for people who required it. Two people were provided with full assistance to have their meals. Other people were provided with aids and equipment as required to enable them to eat safely and independently. The service used an external company to provide them with nutritionally balanced frozen meals. People told us they were generally happy with the meals provided. However one person commented "They found the meals were not as good as home cooked meals." Another

person did not like the prepared frozen meals and they did their own menu, shopping and had an alternative option to what was on the menu.

Menu plans were in place and records were maintained of meals eaten. A pictorial menu plan was provided to support people to make meal choices. A weekly menu was on display in the dining room. On day one of the inspection we saw it was not up to date to reflect the current week's menu. This was immediately addressed. Records were maintained of cooked food temperatures and fridge and freezer temperatures. These were generally well maintained.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and caring. One person commented "They are all very kind and helpful to me and nothing is too much trouble." Relatives told us staff were all very caring. One relative described staff as patient, kind, fair, tolerant and understanding of their family member which had provided them with the reassurance they needed that this was the best place for them. Another relative commented "Staff are definitely caring, my family member tells me staff are very good to them." A third relative told us staff were friendly, open, patient and they gave people plenty of time to complete tasks.

A professional involved with the home commented "Staff care and are responsive to individual needs. Many team members address the residents with terms of endearment, to which the residents respond positively. There seems to be a rapport of friendship between many of the staff and the residents."

We observed negative interactions over lunch on day one. A staff member was supporting a person with their meal. Throughout the task they were loud, constantly talking and shouting across the room to other service users and staff. They referred to people as "Mate" or abbreviated people's names. They did not complete the task of supporting the person with their meal and got another staff to do that which meant the person's mealtime was disruptive. This was fed back to the operations manager who addressed it with the staff member concerned. On day two of the inspection we observed the same staff member supporting a person with their lunch. They engaged with the person quietly and discreetly and promoted their dignity.

We observed positive interactions during the inspection too. Staff were kind, caring and gentle in their approach with people. They had a good understanding of people's needs and had a good connection with them. They listened and gave people time to make choices and decisions. They provided people with good eye contact, reassurance and encouragement whilst engaging and supporting people. The majority of staff were patient and allowed people plenty of time to complete tasks such as mobilising, eating and drinking. They promoted people's dignity and were respectful towards them.

It is recommended the provider regularly monitors staff practice to promote good practice.

People told us their privacy and dignity was respected. They told us staff knocked on their bedroom doors prior to entering. During the inspection we saw this was the case.

People's care plans outlined their communication needs and outlined how people made choices. We saw people were offered choices. However none of the suggested props/objects of reference referred to in their care plans were used to support people to communicate and make choices, decisions and promote their involvement. Information and guidance for people was available in pictures and displayed on notice boards but this was more directed to the whole group as opposed to being person centred and individualised.

It is recommended the provider promote person centred care.

People's care plans included an end of life plan of care and funeral plans. We saw the end of life care plan

did not make any reference to the DNAR's that were in place. End of life training was being accessed for staff to support them in their role and ensure people got the right support at that stage of their life.

It is recommended end of life care plans include reference to DNAR's, where this is required.

Requires Improvement

Is the service responsive?

Our findings

The service had one recent admission. The person was assessed prior to admission and the transition to the home was gradual and suitable to the person's needs. A relative told us an assessment had been completed and they were impressed with the way the assessment and admission was planned.

People had a range of care plans in place to address their needs. Care plans outlined how people were to be supported with their needs and any risks associated with that. One person's needs had changed and increased due to a change in their medical condition. This had been a progressive deterioration and change so sufficient time for care plans to be updated. There was a note to say care plans and risk assessments were being reviewed and updated and staff were to ignore the documents on file but had no other guidance to refer to. Where care plans had been reviewed and updated they were not changed to take account of changes in the person's health, ability and mobility. Other care plans were reviewed and changes suggested but the changes had not been implemented. This had the potential to put people at risk of not having their needs safely met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because people's care plans did not reflect their current needs and care required.

People and their relatives told us they had a key worker. Some relatives were not aware who their family member's key worker was. Staff were clear of the role of key worker and seen it mainly as a liaison between them, the relative and the person they key worked.

People and their relatives told us staff were responsive to their needs. One person commented "They are always there if there is a problem." A relative told us they found staff to be very intuitive to their family member's needs. They commented "Staff respond appropriately and quickly to reduce our family members anxiety." Throughout the inspection we heard staff respond quickly to a call bell and people's request for assistance. One person was unwell and the GP was called to do a home visit to review the person.

A professional involved with the home commented "The team are observant and responsive. They are keen to get the most suitable equipment for a resident's safety and comfort and proper care, in the areas of moving and handling and hygiene." They told us when there is a change in communication function, improvement or decline, the therapy team receive a referral for investigation into how they can capitalise on a positive change or compensate for decrease in function. An example is of one resident who has temporary moments of lucidity and alertness; on two occasions, the Milton team have asked for a Speech and Language Therapy review due to a spurt of 'chattiness' as they want to ensure the resident gets all the opportunities possible to regain skills and interact.

The professional commented "The same is true for eating and swallowing. The team noticed one resident was having difficulty feeding himself and 'seemed to not be able to see his food. They referred him to therapy services, and their hypothesis was correct so the therapy team advised them on the appropriate course of action."

Another professional told us staff are very proactive in the care of their patient. They commented "If they have any concerns they contact me immediately to discuss any changes to the plan of care that might be required."

Activities were organised centrally and a named activities coordinator was allocated to the home. People had an individual programme of activities. Staff supported people to attend activities on- site and some in house activities were provided such as horticulture sessions and arts and crafts. People told us they had some opportunity to go on community based activities and during the inspection one person went shopping for items for their redecorated bedroom. People told us they would like more social community based activities and hoped the change in the activities coordinator would enable this to happen more as that person could drive.

People told us they would talk to their key worker or team leader if they had any concerns or complaints. Relatives told us they felt able to raise concerns with any member of the team and could ring or email the home if they felt they needed to. The home had a complaints procedure in place. People and their relatives were provided with a copy of it. It was displayed on notice boards in a user friendly format. A relative confirmed they had been given a copy of the complaints procedure at the point their family member was admitted to the home. The operations manager confirmed they had a system in place to log, investigate and respond to complaints. The home had no recent complaints logged.

Requires Improvement

Is the service well-led?

Our findings

People told us the home had a new manager but did not see much of them as they managed two homes. Relatives we spoke with were aware a new manager had been appointed. They said they had not had the opportunity to meet the new manager and had no correspondence from them. The manager confirmed after the inspection they had sent a letter of introduction, including a photograph to relatives.

A professional involved with the home commented "It is too early to evaluate the effectiveness of the new manager but it would be hoped that the new manager will be involved in guiding the Milton team regarding what should be done to address problems and who is the most appropriate member of the Multi-Disciplinary Team (both internal and external) to consult.

Staff told us the new manager was approachable but not always available as it seemed to them they spent a lot of time at the other home they managed. They were unable to comment on whether the home was well-led as the new manager had only been in post for a month and they felt it was too soon to be able to make that judgement. The home had been without a registered manager since September 2015. A deputy manager from another service supported the home for a period of time up until April 2016. However staff felt unsupported and felt they lacked guidance and direction. They dealt with issues internally and did not inform management of issues/ difficulties they were experiencing. Staff commented "Feel unfair we are not supported, feel left in the lurch, staff support each other well but team leaders are let down by senior management."

It is recommended management put systems in place to support staff effectively and look at ways of enabling and encouraging staff to share their concerns with management when that is required.

The provider was aware of their registration responsibilities. They are required to notify CQC of significant events such as accident/ incidents concerning people who use the service. We used this information to monitor the service. However the home did not notify CQC about recent medicine omissions which they are required to do within a timely manner. This was because staff did not recognise it as a safeguarding and notifiable issue. These were received after the inspection.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The operations managers completed bi-monthly audits and an external auditor had carried out an audit in January 2016. Alongside this staff carried out infection control, health and safety, catering, medicine and they had just introduced care plan audits. We saw the audits carried out by staff did not pick up or address that the water temperature in the bathroom was recorded as too hot, the medicine omissions we saw and not all actions from audits were transferred onto the homes development plan and were completed. The provider confirmed after the inspection they were looking to further improve their quality monitoring systems to ensure that current issues in services are effectively monitored and addressed.

Systems were in place to get feedback from people and their relatives. A resident's survey was carried out in February 2016. This indicated people were generally happy with their care. An action plan was put in place

to continue to improve on activities on offer to people. Resident meetings took place but not frequently. Minutes available showed the last resident meeting took place in April 2016. A resident and tenant's committee meeting had taken place in May 2016. A relative and professionals survey was carried out in February 2016. The feedback was generally positive. Relatives confirmed they were given the opportunity to feedback on the service provided.

Records required for regulation were not always suitably maintained and kept up to date. Care plans and risk assessments were not up to date and reflective of current needs. Identified risks to people were not managed. The medicine administration record was not in numerical order and confusing. Medicine was not always signed for. Records of DoLS notifications were not available and the internal audits were not readily accessible.

It is recommended records required for regulation are suitably maintained and fit for purpose.

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 People's care plans did not reflect their current needs and care required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff failed to act in accordance with the requirements of the Mental Capacity act 20005 and associated code of practice.

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