Care and Normalisation Limited

Milestone House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Milestone House is a residential care home for people living with learning disabilities and/or autism and physical disabilities. The care home accommodates 11 people in one adapted building.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them. The provider told us this was because the service was originally occupied by people with more physical disabilities such as Huntington's disease and over time has come to care for more people living with a learning disability and/or autism.

Milestone house was a large service, bigger than most domestic style properties and was clearly identified as a care service. It was registered for the support of up to 13 people and 11 people were using the service. This is larger than current best practice guidance. Whilst the provider had supported a growing number of people living with a learning disability, one person living with a learning disability and characteristics of autistic spectrum disorder had lived in the service since 1989

People's experience of using this service and what we found
People were at risk of harm. Allegations of abuse had not been reported in line with local procedures and CQC regulations and staff were not up to date in their training for safeguarding people. However, staff could tell us how they kept people safe. People's risk assessments were not reflective of the care provided and whilst we have no evidence that harm had occurred, this placed people at risk of harm.

People were at risk of being cared for by unsuitable staff as not all the required safe employment checks were completed. There were not always enough staff available to meet people's needs. The provider had recruited new staff and tried to ensure staff consistency. We have made a recommendation about management of staff recruitment. Medicines were not managed safely as there was not effective systems in place to ensure this. The service was not kept clean and food was stored at unsafe temperatures. The provider has since employed a cleaner.

The provider had not implemented best practice in caring for people with behaviour that challenged. People's care plans did not include the guidance staff needed to support people in line with their needs. Staff were not given the training, supervision and support needed to ensure they were competent to support people effectively. Staff had received an induction to their role and were knowledgeable about people's needs and told us they felt supported. People were supported to eat and drink enough and associated risks with eating were managed. However, monitoring records for this were not fully completed. We have made a recommendation about this. People were enabled to eat independently where possible.

People were supported to stay well, and staff worked with other health care professionals to ensure this. The provider worked within the principles of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service did not apply the full range of the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, lack of choice and control and limited inclusion, for example people could not choose to go out when they wanted to.

Staff were caring and there were positive interactions with people. However, the provider had not sought people's views on their care. We have made a recommendation about this. People's relatives were involved where possible. People's confidential information was not always kept private. People's dignity and independence with their daily living skills within the service was promoted.

People did not receive person centred care and a good quality of life as there were not enough staff to support people to go out when they wanted to. People were not given as much choice as possible and enabled to have meaningful activities to do. Staff knew how to communicate with people. There had not been any complaints.

The provider had not ensured they had good oversight of the safety and quality of the care. Systems were not used to identify improvements needed. Incidents were not analysed for further learning and feedback was not sought as a means of learning and improvement. The provider listened to our feedback following their inspection and has told us they will implement an improvement plan.

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

Rating at last inspection
The last rating for this service was Good (published 16 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches at this inspection in relation to the following - care was not person centred; people were at risk of harm, medicines were not managed safely; the management of the service had not ensured the safety and quality of the service; and there were not enough qualified staff.

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

Since the last inspection we recognised that the provider had failed to notify CQC of allegations of abuse; and had not displayed their inspection ratings on their website and in clear view at the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Milestone House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Milestone 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered provider was also the registered manager.

Notice of inspection
This inspection was unannounced on the first day. We let the registered manager know that we would be returning for the two other days.

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

During the inspection

People living at Milestone House were not able to fully share with us their experiences of living at the service. Therefore, we spent time observing staff with people in communal areas during the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the provider (who was also the registered manager) and eight members of staff including; assistant manager, team leader, assistant team leader and care workers. We received feedback from people's relatives and health and social care professionals who work with the service.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including rotas, training data, audits and incident records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at various care planning documents.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The provider had not always ensured people were protected from the risk of abuse. Systems and policies were in place to protect people from abuse and avoidable harm. However, these had not been followed as one incident had not been reported to the local safeguarding authority. This included an incident of physical aggression between people. This meant people were at risk of not being protected from further abuse as the local authority did not have oversight of what action had been taken.
- Staff training in safeguarding people was not always completed or up to date. The provider's policy was for an annual refresher and some staff had not had an update in over five years. At least two staff had not completed safeguarding training.

The provider did not effectively operate their systems to ensure people were protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff could describe the types of abuse and the process to follow if they witnessed or had an allegation of abuse reported to them. Staff told us senior staff would listen and act upon any concerns.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of receiving inappropriate care or a failure in care. Individual risks to people were not always identified, assessed and managed safely. Risk assessments were in place to provide guidance to staff about how to reduce the risks to people. However, these were not always kept up to date or did not always reflect the care provided.
- There was no risk assessment for smoking for one person despite the fact there had been a previous incident where they had burnt themselves with their cigarette and the burn had become infected. Whilst staff present could tell us how they reduced this risk to the person, there was the potential that new or agency staff would not know this. At the time of the inspection, the provider was using agency staff and were recruiting new staff to join the service. Therefore, this put the person at risk of further harm. This incident had resulted in a safeguarding alert raised by the minor injuries unit and the local authority had placed a sanction on the service. However, there were still no guidelines for staff to detail how this was managed.
- There was no risk assessment and care plan for the management of one person's diabetes. Whilst there was reference to the person having diabetes, there were no guidelines for staff to detail how this was managed, and staff were unclear how often they needed to test the person's blood sugar level. This put the person at risk of receiving inappropriate or lack of care.

● Environmental risk assessments were in place to ensure the environment was safe and all the necessary health and safety checks were identified, for example around fire, water temperatures and equipment. However, these were not always completed. People were at risk of serious harm or death if there was a fire. The fire risk assessment was overdue for review and the fire system had not been tested weekly in line with the provider's policies and procedures. There were no records of fire drills and some staff told us they had never had one.
● The provider had not analysed incidents and accidents for any trends to identify any learning. For example, there had been no analysis around falls, the number of falls, times and locations to see if anything could be learnt from this.
● Accidents and incidents were recorded, individual needs had been identified and acted on. For example, following incidents of falls for one person their sensor mat was moved closer to their bed and linked to the call bell system to alert staff they need to support them. However, their risk assessment had not been updated to reflect this. Records were not consistent as there was no accident form where one person had fallen and had a body map to show injuries from this.

The provider did not have robust systems in place to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They updated the person's risk assessment to include the risk of smoking. They requested a review for one person with their diabetic nurse. They reviewed the fire risk assessment and their procedures around the fire system testing and fire drills.

● People had personalised emergency evacuation plans to provide guidance on the support people needed in these circumstances. Laminated grab cards were pinned to the wall near the fire panel to ensure people's needs were known in the event of a fire.
● Staff could tell us how they kept people safe. For example, how they monitored people to prevent falls.
● Staff could describe the process for reporting incidents and accidents and knew what to do in the event of incidents, such as a fall.

Using medicines safely
● Medicines were not always managed safely as people did not always receive their medicines as prescribed. For example, there were unexplained gaps in people's medicine administration records which included medicines for epilepsy. This put people at an increased risk of having a seizure.
● There was no effective system in place to ensure people had their medicines as prescribed, therefore medicines errors had not been identified. For example, medicines were not counted, and medicines audits had not been completed since January 2018.
● There were appropriate systems in place to store and dispose of medicines safely. However, these were not always followed, and one senior staff was not aware of the procedure for returning medicines to the pharmacy.
● Prescribed nutritional supplements were not always treated as medicines. For example, these were not stored securely and recorded when given.
● Staff administering medicines had not had their competency in doing so checked as per the provider's policy.
● There were no guidelines in place for 'as required' medicines for agitation to ensure staff knew when to administer these. This meant that staff may not have all the information they need to identify when the person may benefit from these medicines

The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they have reiterated to staff and provided guidance around the safe disposal of medicines. They have sought clarity around the prescribed food supplement for one person and implemented records for this. They told us they planned to reinstate medicines audits, to hold running balances of medicines daily and to assess staff competencies.

● There was some good practice in medicines management, for example regular checks were done that medicines were stored at the right temperatures and creams were dated on opening. Guidelines were in place for some 'as required' medicines such as for pain relief which ensured staff knew when people needed these medicines.

Preventing and controlling infection

● The service was not kept clean. There was visible dirt on skirting boards and food stains on some walls. Two bedrooms had a strong smell of urine or faeces. A staff toilet was dirty and clearly had not been cleaned for some time. The service was not deep cleaned regularly and staff told us they did the best they could and that most of the cleaning was done by the night staff. One staff said, "I've never known it to have a proper deep clean."

● Staff had received training in food hygiene and infection control. However, some staff, including senior staff were more than two years overdue for an update on these. Staff could tell us what they did to prevent and control infection, such as wearing gloves and not coming to work if they are unwell.

● People were at risk of food poisoning as food in the fridge had not been kept at safe temperatures. Some staff, including senior staff did not know the correct safe temperature ranges. This had resulted in a failure to identify incorrect monitoring of fridge temperatures. Records showed fridge temperatures were consistently recorded as between eight and 10 degrees and as high as 12 degrees which was considerably above best practice. The food standards agency states the coldest part of the fridge should be below five degrees. Where there was guidance for staff on fridge temperature this was incorrect as it was stated as between five and 15 degrees.

The provider did not ensure the prevention of infections was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They employed a cleaner. They implemented a new tool to provide guidance for staff around safe food which included guidelines around fridge temperatures. They added new signage to identify correct temperature ranges and new monitoring forms.

● Information about how to prevent the spread of infection was present in the service and personal protective equipment was available around the service for staff to use. There was handwashing equipment and information in the kitchen and staff used gloves when needed.

Staffing and recruitment

● People were at risk of being supported by staff who were not suitable. Staff were not always recruited safely as not all the appropriate pre-employment checks were completed by the provider to protect people from the employment of unsuitable staff. There were no references for one senior staff for their previous

employments within care. This was an area for improvement. The provider was responsive to these concerns immediately during and after the inspection. They informed us they would seek missing references.

● Staffing levels during the inspection days were appropriate to meet people's needs. However, there had not always been enough staff to keep people safe and meet their needs. Staff and senior staff all told us there had been times during the summer months when there were not enough staff. The provider told us they should never go below four staff to ensure people's safety, but staff consistently told us they had.

We recommend the provider seeks advice from a reputable source on their employment strategies.

● Regular agency staff were used where possible to help with staffing levels and there was on-going recruitment to improve the staffing levels. Five staff had been employed recently and were being inducted to the service.

● The provider had assessed the required staffing levels for people's dependency needs although there was no formal method for this. Staff told us if people's needs changed, additional staff were deployed. For example, if someone went into hospital, the provider would ensure staff went with them.

● The provider tried to ensure people were supported by a consistent staff team. For example, where people had recently moved to the service from another service, staff who knew people well came with them and were employed by Milestone House.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not receive person centred care that was appropriate and inclusive for them and which focused on opportunities to gain new skills and independence. People's outcomes did not reflect the promotion of choice, control and independence in line with the principles of registering the right support.
- People did not always achieve the best quality of life. For instance, staff deployment had significantly impacted on the amount of activity people could do within and outside of the service. There were not always enough staff or drivers available to enable people to go out if they wanted to.
- People with behaviour that challenged were not always supported in line with current best practice. For example, there was a general lack of staff understanding as to the reasons why people may have behaviour that challenged and how to manage this positively. This was evidenced in incident records. The provider was not aware how often 'as required' medicines were used to manage people's behaviour. There was no oversight of this and when these medicines were administered people were not monitored for their effectiveness.
- People's needs were fully assessed before they moved to the service. However, people's care plans were not kept up to date or included all the information needed to inform staff how to support people. For example, one person wore a helmet due to their risk of falls, but this was not recorded in their care plan. This presented a risk that new or agency staff would not be aware of this.
- Health and social care professionals had identified in March 2019 that care plans were generic and not person centred. Senior staff had started to review people's care plans, but the large majority were still not completed. This meant that new or agency staff were not given the information needed to provide person centred care.
- The provider used a well-known assessment tool to help them understand distress in people with severe communication difficulties. However, these had not always been completed.
- People's rooms were not always personalised with their own belongings. For example, one person's room was very bare considering they spent large amounts of time in their room and had lived at Milestone house for over 18 months. This meant they did not have their own homely and personalised environment.

The provider had failed to ensure the care and treatment of people was appropriate and met their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They updated one person's support plan with the issues we identified, and they told us they planned to review all care plans urgently. They also

planned to introduce more behaviour analysis, positive behaviour support strategies with guidelines in people's care plans and guidelines for 'as required' medicines for agitation.

● People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments. This included for example, people's needs in relation to their culture, religion or disability. Staff completed training in equality and diversity, although most staff were overdue for their training update on this.

Staff support: induction, training, skills and experience

● Staff had not always received appropriate training and regular refresher training to support people living at the service. This included training in manual handling, first aid, safeguarding, food hygiene, infection control, fire, health and safety, equality and diversity, mental capacity and medication. At least five staff had never completed manual handling training, at least two had not completed safeguarding training, two had not completed health and safety training and five had not completed mental capacity training. One senior care staff was overdue for all their mandatory refresher training except for medicines. This meant the provider could not be assured that staff had the skills and qualification to fulfil their role and meet people's needs. However, gaps in training records had been identified by the provider and there were training sessions booked.

● Staff had not received appropriate training around service users' individual needs in diabetes and epilepsy. At least two staff had not completed training in diabetes and at least nine staff were overdue for a refresher. There were no records to show staff had received training on epilepsy. This meant the provider could not be assured that staff had the skills and qualification to fulfil their role and meet service users' needs.

● Staff told us they were supported by senior staff and the registered manager. However, they had not received regular supervision, appraisals and competency checks. One carer had not had supervision in over two years. The provider had identified a lack of supervision and had started to ensure staff had supervision meetings with their line manager.

● Staff were not effectively supported when they were involved in incidents with people with behaviour that challenged. For example, staff were not given the opportunity to debrief and reflect on incidents where they had been physically assaulted.

The provider had failed to ensure staff were suitably qualified, competent and skilled to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they planned positive behaviour support training, and staff support including debriefs around incidents where staff have been physically assaulted. They reviewed staff training compliance and have sourced the required training.

● Staff were supported to complete nationally recognised qualifications in health and social care.

● New staff and agency staff had an appropriate induction to the service and people's needs.

● Staff were knowledgeable about people's needs. For example, staff could tell us how they met people's needs in relation to moving and handling, eating and communication.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutrition and hydration needs were assessed. People at risk of weight loss had achieved positive outcomes. For example, it was noted for one person they had gained weight and their dietician was pleased

with the progress they had made. However, there was no consistent and effective monitoring of people's dietary intake, fluids, nutritional supplements and weight where people were at risk of dehydration, malnutrition and weight loss.
● One person's fluid chart was not totalled against a target amount to ensure enough fluid was taken. Another person with a weekly weight chart was not weighed consistently and had only been weighed four times since January 2019. We spoke with the provider about this and they acted quickly to rectify these concerns.
● Staff told us people were informed of the menu by pictures on a noticeboard in the dining room. However, on both days we visited these were not used.
● There were positive interactions between staff and people during lunchtime. However, people could not always choose where they ate and who with, whether in the dining room, lounge or in their bedroom. Lunch was held in the dining room in two sittings due to the size of the room and the support people needed.

We recommend the provider consider current guidance on monitoring peoples nutrition and hydration needs.

● There was information and guidance to follow in the kitchen around any food allergies and people's dietary needs. For example, who needed their meals provided in a pureed form.
● Staff were aware of people's needs in relation to risks associated with eating and drinking and followed guidance from people's care plans and healthcare professionals in relation to these. For example, where people needed soft diets due to the risk of choking, staff followed guidance from speech and language therapists.
● People were given adapted plates and cutlery to enable them to eat independently.

Adapting service, design, decoration to meet people's needs
● The environment was accessible and met people's basic needs. For example, there were communal areas in the service where people could eat their meals, could watch television, listen to music or engage in activities. People could choose to spend time together or meet their visitors in communal spaces or spend time alone in their room.
● Where needed, people had specialised equipment, for example around their mobility needs. The second floor was accessible via a stair lift. People had their own specialist armchairs and wheelchairs.
● The provider had adapted the environment to meet the needs of people where possible. For example, one persons en-suite bathroom layout had been adapted to enable them to access the toilet using their walking frame.
● People could be supported to go out into the community in the company vehicle and one person had their own vehicle.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The senior team and provider had recently worked closely with local commissioners to support people to move urgently from another care service. They told us, "Staff from Milestone were inordinately helpful with the assessments and move processes and worked well certainly with the first two clients from the residential service, to ensure they were settled and happy."
● People had 'healthcare passports' in place. These ensured other healthcare professionals were aware of people's needs and how they communicate, for example in the event they were in hospital.
● People were supported to maintain good health and were referred to appropriate health and social care professionals as required. For example, occupational therapists.
● Records were maintained for all health appointments, for example with their GP, dentist, optician and

physiotherapist.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
● Where people were deprived of their liberty the provider worked with the local authority to seek authorisation for this. However, they had not ensured any conditions were met. For example, one condition was to personalise one person's bedroom, but this had not been done. This is an area for improvement
● Staff were aware of the principles of the MCA and clear guidance was provided to them within people's care records. Care records promoted people's rights, documented consent and the involvement of people's relatives in decisions about their care. For example, consent had been sought for the use of CCTV in the service.
● Decision specific mental capacity assessments were completed, and a best interest process followed in relation to decisions about people's care and treatment. For example, around the use of bedrails.
● Staff who knew people well could understand their verbal communication, body language, gestures and behaviours to establish whether consent to care was given and their day to day choices, for example when providing personal care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff opinion as to whether they would be happy for their loved ones to live at Milestone house was mixed. This is an area for improvement. One staff said, "No. They wouldn't have any quality of life, it's like a rest home." Another staff said, "Yes, but I find we don't meet their needs at the moment because there is not enough staff to take people out." And another said, "Yes, I think a lot of our staff go above and beyond their job role…staff come in on days off and take people out, spend that bit of extra time with them."
- One relative told us how their loved one had lived at Milestone house for many years and they felt they were well cared for and were happy with all that the service had done for them. Another relative said, "I have found Milestone quite good, the staff seem most helpful and they seemed to be caring. They have a pleasant room and they have made great effort for them to be happy." The provider had received compliments from relatives which included how well their loved one looked.
- Staff were patient and caring with people and showed compassion. We viewed positive, calm and respectful interactions throughout the inspection. For example, one person was upset by spilling some food onto the table, so staff were quick to reassure them and to clear up the spillage.
- Some staff knew people well and could recognise how people were feeling. For example, they knew if people were happy or not by the sounds they made.
- The provider had considered people's needs around equality and diversity, no one had identified with a certain religion or showed any interest in their cultural background.

Supporting people to express their views and be involved in making decisions about their care

- There was no evidence that people were asked about their views on their care, for example through care plan reviews.
- Information was not gathered formally on people views of the service and their care, for example through surveys.

We recommend the provider seeks advice from a reputable source on involving people in their care.

- People were supported to access advocacy services if needed. Advocacy services offer trained professionals who support, enable and empower people to speak up.
- There were pictures of staff on a board in the dining room so that people knew who was on duty.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always respected as information about people was not always held securely. A

downstairs office which held people's care records on an open shelf was not locked and the door was left open. We reported this to the provider and they rectified this immediately.

● Staff promoted people's dignity. Staff told us how they upheld people's dignity when providing personal care. For example, knocking on bedroom doors before entering, asking people's permission before doing something, covering the person up and explaining what they are going to do.

● People were encouraged to maintain their independence where possible. For example, one person used a frame to enable them to walk independently and people used adapted cutlery and plates to enable them to eat their meal independently. Staff could tell us what people could do for themselves.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not always person centred. Whilst their care records included information about promoting choice, who was important to them and where known their life history, care plans were not always up to date and accurate. The local authority had previously informed the provider care plans needed to be more person centred.
- People's care had not been regularly reviewed and updated in their care plans to reflect their changing needs. For example, how people were supported to manage their diabetes or risk of malnutrition in line with their current health needs.
- People were not always given as much choice as possible, for instance a choice in what they ate, there was one meal choice on the second day of our inspection and people were not informed what it was as the picture system in place for this had not been used. We did not see any evidence of the use of picture communication systems used by people during the inspection.
- Some people were given a choice if they wanted to engage in an activity in the service. For example, staff asked one person if they would like to have their nails done. However, people could not choose to go out into the community when they wanted. Some people had not been out for months. Therefore, people were not supported in line with the principles of registering the right support. People were not always enabled to take part in activities they liked, especially if this involved going out.

The provider had failed to ensure the care and treatment of people met their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans provided staff with some guidance to promote people's choice, for example one person's care plan instructed staff to offer the person a choice between a bath and a shower and to encourage them to choose the clothing they want to wear.
- Technology was used to support people's needs. For example, sensor mats were used to alert staff if some people moved to prevent them falling and to keep them safe. Email was used to send pictures to peoples relatives to involve them in their care.
- People's relatives and other health and social care professionals were involved in people's care and information was shared about people's care appropriately to support their best interests and promote positive outcomes for people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Activity monitoring records were in place but had not been analysed. The only activity which had been recorded over a three-month period for some people was watching television.
● Staff told us that people were stuck at home as they couldn't go out as there wasn't enough staff and that they didn't do a lot. Staff said that the senior staff and provider was aware of this and were trying to improve staffing levels. One staff told us there used to be a good activity timetable but that a lot has been on hold since the activity co-ordinator left a couple of months ago. One staff member described how the service used to be 'bustling' but how the staff team are all down now as they are not able to do more for people.
● One person was knitting, other people were watching television or just sitting in the lounge. Some people had sensory objects to hand for them to use. One person went to a day centre. One person was being supported to go out to buy a gift for their relatives' birthday.
● People were supported to maintain relationships that were important to them. Friends or family could visit at any time and staff knew when people's relatives' birthdays were. One relative told us they had received pictures of their loved one enjoying activities such as hydrotherapy and music. Another relative told us they raised concerns that their loved one was not getting the opportunity to converse with other people but was reassured by staff they were taken out on regular trips.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were known and understood by staff. People's care plans included details which helped new and unfamiliar staff learn about how people expressed their needs, for example if they used pictorial aids.
● The senior staff and provider had worked with speech and language therapists to ensure staff had the information to support people effectively with their communication needs.
● Information was shared with people and where relevant, available to people in formats which met their communication needs, for example the use of pictures in care plans.
● There were some visual aids around the service, for example informing what staff were on duty.

Improving care quality in response to complaints or concerns
● A complaints procedure was in place for people, relatives and visitors. This was in an easy read pictorial form for people, however most people would need to be supported by their relative to make a complaint. Where people didn't have close relatives, they had an advocate to speak on their behalf. The provider told us there had not been any complaints.

End of life care and support
● The provider was not currently supporting people at the end of their life. People's wishes and arrangements for their end of life care were not always known. Therefore, staff did not have the guidance they would need to support people in line with their wishes should an unexpected death occur. This is an area for improvement. The provider had identified the need to determine the wishes of one person with a life limiting condition.
● A relative had sent the provider a thank you card which complimented the care given to their loved one at the end of their life and commended the dedication of the staff.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The governance framework had not ensured the delivery of high quality and safe care. The provider had not ensured they had good oversight of the quality of the service. They had relied on the experience and qualifications of a manager previously employed and had assumed the service was well managed without maintaining the necessary quality oversight.
- Where improvements needed had been identified by the local authority in March and April 2019, the provider had not taken timely or appropriate action to ensure these were done. For example, they had not carried out a regular review of people's care to empower people and staff to ensure the process was more person centred.
- Quality assurance systems, such as audits, checks, observations and daily monitoring were not used effectively to monitor all aspects of the service. Health and safety monitoring records were not always completed. Whilst a quality compliance system was in place, some audits had not been completed since 2016. Finance and medicines audits had not been completed since 2018. Where improvements had been identified there were no formal action plan for improvement in place to monitor progress.
- There was no clear drive on improvement by the provider based on continuous learning. There was a lack of feedback sought to learn from. There was a lack of analysis of incidents and other activities or outcomes to identify areas for improvement from lessons learnt and therefore no formal improvement plan to improve people's care. However, both the provider and the assistant manager told us they were committed to making the necessary improvements following the feedback at the end of the inspection and started to do so immediately following the inspection.
- People were not fully engaged with the service. There were no systems in place to seek feedback from people and their relatives on their views on their care and the service.
- We received feedback from commissioners and health and social care professionals they found the service to be more responsive and had noticed improvements whilst there was a manager in post and were concerned that they left. The provider was a regular management presence in the service since the previous manager had left and had restructured the senior team. They told us they had learnt not to rely on one senior manager and had therefore created a management team which consisted of an assistant manager, a team leader and two assistant team leaders to support them in the management of the service.

The provider had not operated effective systems and processes to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider had not met all their regulatory requirements as they had failed to notify CQC of allegations of abuse.

The provider had failed to notify CQC of allegations of abuse and therefore had failed to comply with their legal duties. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their ratings but not in easy view for people and visitors at the service. The provider had also failed to display their previous inspection ratings clearly on their website in line with the regulations.

This was a breach of Regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Some staff told us they could raise any concerns or ideas and that they would be listened to. Other staff told us engagement with them had reduced since the service had been short staffed. There was a suggestion box in place for staff to raise ideas. However, the provider told us this was rarely used because staff had the opportunity to talk to their seniors and the provider daily.

● The senior staff and provider worked in partnership with other agencies to ensure people's needs were met in a timely way. For example, they had worked closely with health and social care professionals, commissioners and staff from another service to ensure a smooth transition for people to Milestone house.

● The provider had organised a fundraising event for Huntington's disease for the local community.

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

● The provider's values were based on the belief that everyone can, despite their disability lead a meaningful life. One staff told us, "It's about people living the best life they can without limiting them. We try and encourage people to do as much for themselves and when they come across barriers we let them know they can be overcome." However, it was difficult to see these values in action as the service had gone through a difficult period of low staffing levels and management restructure and had therefore been unable to achieve their aims.

● Staff told us that the morale of the staff team was low due to low staffing levels and the fact they couldn't take people out. One staff said, "No-one wants to see people just sitting around a room."

● The provider told us they wanted to provide a person centred and high-quality care service and were responsive to feedback during our inspection. However, there was a lack of recognition of the need to work within the principles of registering the right support and understanding of good practice when working with people living with a learning disability and/or autism; and in particular when supporting people with behaviour that challenges.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The law requires providers to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The provider understood their responsibilities in respect of this. They had informed relatives of any incidents or accidents and worked closely with other healthcare professionals.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not effectively operate their systems to ensure people were protected from the risk of abuse. Regulation 13 (1) (2) (3)

This section is primarily information for the provider

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of allegations of abuse and therefore had failed to comply with their legal duties. Regulation 18 (2) (e)

The enforcement action we took:

The CQC has decided that it is not in the public interest to proceed with this investigation given the current Covid-19 pandemic. The CQC has therefore decided that in this case there will be no further action taken in relation to the alleged offence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care and treatment of people was appropriate and met their needs and preferences. Regulation 9 (1) (a) (b) (c)

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Regulation 12 (1) (2) (a) (c) (d) (h) The provider had failed to ensure the proper and safe management of medicines.

	Regulation 12 (2) (g) The provider did not ensure the prevention of infections was effectively managed. Regulation 12 (1) (2) (h)

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the safety and quality of the home and ensure it was effectively managed. This placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (c) (e)

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitably qualified, competent and supported to meet people's needs. Regulation 18 (1) (2) (a)

The enforcement action we took:

Warning notice issued