Care Quality Commission

Mr & Mrs N Frances
Millhouse

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

The inspection was carried out on 01 and 03 July 2015. Our inspection was unannounced. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received.

Millhouse is located on the outskirts of Faversham and provides care and support for up to 24 older people with dementia. Some people had sensory impairments, limited mobility and one person received care in bed. Accommodation is set out over two floors with lift access to the first floor. On the day of our inspection there were 17 people living at the home.

The registered manager had left the service in April 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run. The provider had employed an acting manager to oversee the day to day running of the home.

At our previous inspection on 12 November 2014 we found breaches of nine regulations of the Health and

Summary of findings

Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. We took enforcement action and required the provider to make improvements. We issued two warning notices in relation to the safety and suitability of the premises and the cleanliness of the premises and told the provider to comply with the regulations by 30 January 2015. We found seven further breaches of regulations. We asked the provider to take action in relation to person centred care, suitability of equipment, records, staffing levels, support to staff, recruitment and quality assurance.

The provider sent us an action plan on 29 April 2015 which stated that they would comply with the regulations by 12 June 2015.

At this inspection we found that some minor improvements had been made but the provider had not completed all the actions they told us they would take within the timescales they had given us. In particular they had not met the requirements of the warning notices we issued at out last inspection. As a result, they were breaching regulations relating to fundamental standards of care.

People made complimentary comments about the service they received. People told us they felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Most of the relatives who we spoke with during our visit were satisfied with the service.

Work had begun to improve the premises, this had not been done in a timely manner. General repairs had not been reported or actioned in a timely manner.

Cleaning standards in the home had improved. However, some rooms had not been cleaned effectively to remove strong odours and we found dirty equipment such as commodes. The sluice machine had not been relocated away from the laundry area to ensure that laundry could be separated from clinical waste. People and staff were unable to wash their hands effectively because some bathrooms did not have soap or hand gel.

Staff had undertaken safeguarding training but they did not have access to all the information they needed about how to report abuse, including contact details for the Local Authority safeguarding team. Staff were aware of their roles and responsibilities with regards to safeguarding people.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. The provider was not aware of environmental issues in the home and had therefore not instructed contractors to carry out repairs and maintenance.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. People were at risk of heat exhaustion because the central heating was on during a heat wave and there were no fans available.

The provider did not follow safe recruitment practice. Essential documentation was not available for all staff employed. Gaps in recruitment had not been explored to check staff suitability for their role.

Medicines administration had not been recorded effectively. One person's prescribed cream had not been signed as administered for three weeks. Medicines were not monitored effectively to ensure that they had been kept at the correct temperature.

The provider did not have an effective system to assess how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times.

Staff had received training relevant to their roles such as infection control and the Mental Capacity Act 2005. However, staff had not received training in de-escalation and managing behaviours that may challenge to enable them to safely support people whose behaviours could have a negative effect on themselves or others.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had submitted Deprivation of Liberty Safeguards (DoLS) applications for most people, but had not informed CQC that these had been authorised, as they are required to do.

The complaints procedure was out of date and did not provide information about all of the external authorities people could talk to if they were unhappy about the service. Complaints had not been appropriately recorded and investigated. People told us they would speak to the acting manager if they wished to complain.

Summary of findings

Records relating to people's care and the management of the home were not well organised, adequately maintained or stored securely.

People and their relatives were involved in planning their care, although records did not demonstrate this.

People were not always provided with personalised care. They were not provided with sufficient, meaningful activities to promote their wellbeing.

People's health needs were well met. They had access to health professionals when they needed it.

Staff were cheerful and patient in their approach and had a good rapport with people. The atmosphere in the home was generally calm and relaxed and there were lots of smiles and laughter.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and were complimentary about the care their relatives received.

People who able to voice their own views and opinions were consulted through resident's meetings and their views taken into account in the way the service was run. People who were unable to voice their own views and opinions and their relatives had not been asked for their views and opinions about the home.

Most staff had received the essential training and updates required, such as food hygiene and fire safety training, to meet people's needs.

People were generally complimentary about the food and drinks were readily available throughout the day.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action

Summary of findings

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 were not always protected from abuse or the risk of abuse.

The provider had not assessed staffing levels based on people's needs. The provider had not always followed safe recruitment practice.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

Medicines had not been appropriately recorded. Medicines were not monitored effectively to ensure that they had been kept at the correct temperature.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the training and support they needed to meet people's needs.

Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority by the acting manager. However, the provider had not notified CQC of this.

People's food and fluid had not been recorded effectively to evidence that they had sufficient food and drink to keep them well. People had a choice of food and were complimentary about the food.

People were supported effectively with their health care needs.

Is the service caring?

Good

The service was caring.

People or their representatives were always involved in planning their care, however this was not recorded.

People were treated with dignity and respect. Staff respected people's privacy.

Staff were kind, caring and patient in their approach or supported people in a calm and relaxed manner.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

Not all people's views were formally recorded or gathered and feedback from relatives had not been sought.

Summary of findings

The complaints procedure was out of date and did not contain all the information people needed. Complaints were not managed effectively to make sure they were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not assessed the quality of the service and therefore failed to identify where improvements could be made. The provider was not aware of the quality concerns within the service.

The provider was not aware of their responsibilities. They had not notified CQC about important events.

Records relating to people's care had not been completed effectively. There were gaps in records.

Millhouse

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 was carried out on 01 July and 03 July 2015. Our inspection was unannounced. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received and also following concerns we had received since the last inspection.

The inspection team included two inspectors. The team also included an expert-by-experience who had personal experience of caring for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority, information from whistle blowers and our last report.

During our inspection we observed care in communal areas. We examined records including staff rotas; management records and care records for five people. We looked around the premises and spoke with six people, five staff, two workmen who were undertaking repairs, the acting manager and the provider. We also spoke with three relatives, a district nurse and a visitor.

Inadequate

Is the service safe?

Our findings

At our last inspection on 12 November 2014, we identified breaches of Regulations 12, 15, 16, 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 12, 15, 18, 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff to meet people's assessed needs. We asked the provider to take action to make improvements to their staffing deployment procedures, staff recruitment and to make improvements to the safety of the home, the cleanliness of the home and the suitability and servicing of equipment. We also made a recommendation about the safe storage of medicines. The provider sent us an action plan which stated they would meet the regulations by 18 May 2015.

At this inspection we found that some minor improvements had been made. However, we found additional concerns with the premises and staff recruitment and risks had not been effectively managed.

Some people were unable to verbally tell us about their experiences. People told us they felt safe living at the home. One person told us, "Yes I am safe. It's comfortable in here". Another person said "I feel safe. Staff are very helpful and kind". We observed that people were relaxed around the staff and felt at home.

Relatives told us that their family members were safe living in the home. One relative said, "I'm really confident she [family member] is safe".

Work had begun to improve the premises, new flooring had been laid in areas of the home and some communal areas and bedrooms had been redecorated. Some of this work had not started until June 2015, which meant that there had been a delay of seven months after our last inspection. The provider told us that some of the work started in April 2015 but this was poor quality and required redoing. Many areas of the home still required redecoration and improvement. People were at risk because parts of the flooring had become unstuck which caused trip hazards. The vine that had grown round the fire escape had been cut back, but had exposed broken glass bottles which had been cemented into the top of the wall which could be reached by hand from anyone using the fire escape. The fire escape hand rails were loose and at risk of detachment. Stocks of cleaning materials and continence pads were stored near to the exit from the kitchen and laundry room which was blocking the fire exit.

General repairs had not been reported in a timely manner. Repairs had not been added to the maintenance records when they were identified. For example, repairs such as broken electrical sockets, blocked sinks, low temperatures of hot water in sinks and the emergency call button in the lift breaking had not been added to the repairs book, therefore were not on the providers schedule of work. Staff knew about some of these issues as they told us about them during the inspection. However, no action had been taken to deal with these minor repairs to ensure people remain safe from harm.

Cleaning standards in the home had improved overall. Most areas of the home were clean. One relative told us that the home was, "Clean, especially since the decorations have been done its fine". One person told us, "The cleaner comes in every day and cleans my room". However, not all areas of the home were clean. There was a strong smell of stale urine in three people's bedrooms; the flooring within these rooms was not suitable to meet people's continence needs as it could not be easily cleaned. We found a dirty stained commode pan on a shelf above the sluice machine, and raised toilet seats were stained and dirty underneath. The mops had very dirty mop heads which needed replacing. The sluice machine had not been relocated away from the laundry area to ensure that laundry could be separated from clinical waste. The washing machine at the service was not properly plumbed in and dirty water from soiled linen was draining into an open sink. Kent Health Protection unit carried out an inspection of the premises on the 03 June 2015. The report following this inspection was given to the provider on the 29 June 2015. The report highlighted a number of actions and recommendations that were needed to improve the cleanliness of the home.

Some bathrooms and toilet facilities did not have hand gel which meant staff and people could not wash their hands effectively. Hand washing guidance was not displayed in the home to remind and encourage staff, people and visitors about effective hand washing techniques. The acting manager had ordered hand washing guidance, which had been delivered but not yet displayed.

Inadequate

Is the service safe?

This failure to clean and maintain the premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Millhouse had a safeguarding policy that was dated 2014. This was not suitable and sufficient as it did not describe the types of abuse and signs and symptoms of abuse and did not provide a link to the local authorities safeguarding adult's policy, protocols and guidance. Although most of the staff had training in safeguarding, they did not have access to all the information they needed about how to report abuse, including contact details for the Local Authority safeguarding team. The staff we spoke with had a good understanding of abuse, which included how to report it.

We inspected the home during a heat wave, outside temperatures exceeded 35 degrees Celsius. The home did not have a heat wave plan in place and had not reduced the risks to people. The central heating was still on in one part of the home, people did not have access to fans and cool areas. We spoke with the acting manager and the provider about our concerns. The provider left the service for a number of hours and returned with four fans.

This failure to safeguard people from harm was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people's care plans contained individual risk assessments in which risks to their safety were identified such as skin integrity, moving and handling, pain, medicines and mobility. The risk assessments had been reviewed regularly and updated when required. No risk assessments had been carried for one person who had just moved in to the home. Therefore staff did not have guidance and support about how to support this person safely. The acting manager confirmed that there were no risk assessments in place to reduce the risk of harm to demonstrate safe systems of work whilst contractors worked in the home to carry out redecoration and building works. The acting manager confirmed that measures were put in place to reduce the risk. They explained that tables were moved to prevent people from accessing areas. Staff reported that they had raised concerns with the provider about their own safety because they had been boiling water in a large kettle using the gas hob, because the urn had broken. The provider had not dealt with this risk straight away. The provider showed us that the new urn had been purchased on the 29 June 2015.

This failure to ensure that risk assessments were suitable and sufficient to keep people safe from harm was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The number of staff employed was not based on an analysis of how much time was needed to provide appropriate levels of care and activities for people. During the inspection, one staff member was present in the dining/lounge area at all times with the majority of people. Other staff on shift provided support to people in their own rooms, gave medicines and brought in refreshments. During the afternoons staff told us people needed more care and support. One person actively walked around the service and grounds, they were unsteady on their feet and required support to keep safe. Staff told us that more often than not this person needed one to one support in the afternoons to keep them safe. We observed that the person entered other people's rooms and had laid down in the garden. At one point three staff were outside assisting the person which left two staff inside with 16 other people. We spoke to a visiting district nurse. They told us that there were sometimes not enough staff on duty to provide support to people and that staff were often pushed for time.

There were not enough staff to keep people safe at all times. The example above was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that home did not follow safe recruitment procedures. The provider stated in their action plan that they had devised an employment checklist. We found that the provider had not improved their recruitment process. Recruitment records were not readily available. The provider had not checked reasons for gaps in employment. One new staff member who had been employed in May 2015 had a gap of 10 years in their employment history which had not been explored. Another application form only showed an employment history for a staff member back to 2010, which highlighted a gap of 12 years. Two staff files did not contain information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. None of the staff files contained the employment checklist. Two contractors had been working unsupervised at the home carrying out

Is the service safe?

maintenance and redecoration, the provider had not carried out disclosure and barring service checks (DBS) to check that they were suitable to work around people who needed safeguarding from harm.

The examples above were a breach of Regulation 19 (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Temperatures of medicines storage areas had been monitored and recorded, however no action had been taken to reduce temperatures when the storage areas had exceeded the safe and maximum storage temperatures detailed on the medicines packaging. The medicines cabinet was not clean and the new storage area for medicines which had been delivered was not monitored to check that the temperature was suitable.

We checked medicines administration records (MAR charts) to check that people had given their medicines as prescribed. MAR charts showed that most of the time people had been given their medicines as they had been prescribed. However, one person's prescribed cream had not been signed to show it had been administered for three weeks. Staff assured us that this cream had been given but had not been recorded. One person's care records showed they had diarrhoea for a period of 10 days, the MAR chart for this person showed that staff had continued to give laxatives to the person daily.

The failure to properly manage medicines was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the cellar of the building, this was empty and clean. Medicines were no longer stored here.

Inadequate

Is the service effective?

Our findings

At our last inspection on 12 November 2014, we identified breaches of Regulation 23 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 18 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to provide staff with training to effectively meet the needs of people they cared for. The home had not been decorated or adapted in a way that enabled people living with dementia to access different areas of the home independently. We asked the provider to take action to make improvements. The provider sent us an action plan which stated they would meet the regulations by 12 June 2015.

Some people were unable to verbally tell us about their experiences. People told us that they received care and support that met their needs. One person told us, "When you are ill the staff are really good. They really look after you." Another person said, "If you want help washing they will help you. They help me to my back and legs". Another person said "Staff are very good. It's like having a grown up sister looking after you. This morning I was very warm in the lounge so the staff asked me if I wanted to change they came up to my room and helped me choose something cooler to put on". One person told us, "Sometimes I feel a little sad and a carer comes and sits down beside me and talks to me which is nice".

Relatives told us that their family members received the care and support they needed to meet their needs. A relative told us, "The staff know her now and if she is under the weather they would let me know. If the doctor is needed they ring me straight away and I come round".

At our last inspection we found that all the corridors in the home were decorated in the same way and signs and symbols had not been used to inform people of where important places, such as toilets and bedrooms, were. Some bedrooms had a paper sign on the door which showed a picture of the person and their name. Most bedrooms did not have this and all the doors looked the same. People were confused by this. During this inspection we found that some improvements had been made to the decoration of the home. Some bedroom doors had signs with people's names on them, these were printed and laminated. None of the signs had photographs of people or items that people would recognise as their own. The corridors in the home were still decorated in the same way. This could make it difficult for people living with dementia to identify their rooms and to feel orientated around the service and did not follow good practice NICE guidance about design and adaptation of housing. There were clear signs on toilet doors around the home.

This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records evidenced that training had been undertaken by staff. Courses undertaken included Infection control, managing challenging behaviour and eight staff had attended training on the Mental Capacity Act. Further courses had been scheduled for the end of July 2015. Training records evidenced that some staff members were due to attend training on dementia, moving and handling training and end of life care. The staff had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The acting manager had completed a 'train the trainer' course and was able to deliver some training to staff in the home, such as moving and handling, infection control and safeguarding vulnerable adults. However, staff had not received training on how to manage people with behaviours that challenge, which included de-escalation and some staff had not attended nutrition and hydration training. The provider's restraint policy had not been reviewed since the last inspection. It was not tailored to the service provided at Millhouse and stated that staff 'Will use physical restraint only as a last resort or in exceptional circumstances'. It also said, 'Those involved in the intervention have received appropriate training'. One person became challenging and held on to a staff member, which caused them pain. The staff confirmed they had not received training to safely diffuse challenging behaviours, which meant that staff didn't have the knowledge and training to deescalate situations.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food and fluid charts were kept for 10 of the 17 people. We were told that nutritional risk assessments including consideration of weight and eating habits were carried out to determine which people's food and fluid intakes should be monitored. The charts were not accurate records of nutritional intake. In some cases, there was nothing

recorded on the charts. Where quantities of food and fluids taken were recorded, these had not been accurately measured. On the day of our inspection the weather was extremely hot. Staff were encouraging people to drink fluids and made hot and cold drinks available. However, there were no accurate records of the volumes of fluids people had consumed. People were therefore at risk of dehydration and other conditions as a result of the extreme heat. There was a nutrition policy dated 2012 that stated that people should be weighed each week. However, the records we reviewed indicated that this was not done regularly.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person needed support from staff to maintain their skin condition. Their care plan detailed that they needed support every two hours to reposition to relieve pressure on the skin. Staff told us that the person needed support to reposition every four hours. Care records evidenced that generally the person was repositioned every four hours. However, there were a number of occasions which had exceeded this. This meant that the person was not effectively supported and they were at risk of developing pressure areas.

This failure to provide appropriate care to meet the person's needs was a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received regular supervision from their line manager, during which they and their manager discussed their performance in the role, training completed and future development needs. Staff felt they received good support from the manager in order to carry out their roles. New staff had received an induction. Induction records showed that staff had read information and completed tests which had been checked by the acting manager. There was nothing to show that new staff had been monitored and assessed in their induction period following good practice guidelines provided by Skills for Care. The acting manager did not have information about the Care Certificate which should support a staff member's induction. We provided guidance about how to obtain this and the acting manager advised that they would implement this.

Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority. The local authority assessors had been to visit people in the home and had approved some of these. Some of the authorisations required the provider to complete actions which included, updating care plans to comply with the Mental Capacity Act (MCA) and be decision specific. These actions had not yet been completed, the acting manager explained that the authorisation with conditions had only been received the week before our inspection. People were not restricted unlawfully in the home.

At the last inspection we found that people received adequate food and fluids to meet their needs. We found that this was consistent at this inspection. People had access to drinks when they needed them. Staff regularly offered people hot and cold drinks during the inspection. The atmosphere at meal times was relaxed with music playing in the background. People were given the meal they had chosen. One person told us, "If you decide you want the other choice, the staff are very good at getting this for you". People were encouraged to remain independent. Staff discreetly supported people to eat their meals when they identified that people were struggling. People were asked if they wanted some more before the plates were removed. People were offered a choice of pudding and when they were finished they were offered a cup of tea which they could have either in the lounge or dining room.

People told us they enjoyed their meals. One person told us, "I have no complaints. Food is fine, plenty of vegetables. We have a good cook I am happy with the food. It certainly smells nice today". Another person said, "Meals are quite nice. I always enjoy them. You always get plenty of water and juice with them".

People told us that the staff understood their health needs. One person told us, "Here, the staff are very good at looking after you, they nurse you, they make sure you are fine, if you need a doctor they call them out for you". People were supported and helped to maintain their health and to access health services when they needed them. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. Staff responded to people's requests to see a GP when they made them. A staff member on shift contacted the GP on the 03 July 2015 whilst we were in the home. The GP visited

Inadequate

Is the service effective?

the person on the same day. Records evidenced that staff had contacted the GP, social services and relatives when necessary. The visiting district nurse told us that staff at the home were quick to refer people for treatment if required.

Good

Is the service caring?

Our findings

At our last inspection on 12 November 2014 we found that staff were kind, caring and respectful.

People we spoke with told us they were well cared for and that staff supported them to remain independent as best as they could. People were encouraged to undertake their own personal tasks when they could. One person told us, "I wash and dress myself. Staff are really helpful and kind". Another person said, "When the girls [staff] run the bath for me, they make sure that it not too hot and make sure that you can get in. They don't rush you".

Relatives told us that staff were kind and caring and respectful towards their family members. One relative told us "She [family member] always looks clean. Honestly cannot fault any aspect of her care. She is very happy here".

Staff supported people in a calm and relaxed manner. One person who liked to walk around the home removed his shirt and trouser belt which made his trousers fall. Staff calmly went over to him and stood beside him to protect his dignity from others and in a jokey manner said "I think we need go and find you a belt to keep these trousers up. Let's go and see what we can find". Staff knew peoples likes and dislikes. One person was able to watch cricket on TV. Staff allowed him to watch until the programme was over before encouraging him to have lunch. The district nurse told us that staff were very caring and knew people well.

Staff initiated conversations with people. One person was looking at her photo book taken on a special holiday, staff sat down with her and talked about the people in the photographs. Staff talked to people about special memories such as first dates, weddings and other special events.

Staff stopped what they were doing and assisted people when they identified they needed help. One person had been given an iced lolly to help them cool down, they had become confused and were holding the lolly the wrong way up, staff provided gentle prompts and support to help the person.

One person moved into the home from hospital on the day of our inspection. Staff told us that the person and their relatives had been to visit the home prior to deciding to move in and that they and their family had stayed for lunch in the home. The relatives of the person told us how they had been involved in the assessment of their family member.

Staff respected people's privacy. People told us that they were treated with respect. One person who was being cared for in bed told us, "Staff talk very nice and are very respectful. They always knock on the door before they come in". Another person said, "Staff that work here treat me nicely. They are pleasant". Staff used the office when having confidential discussions to ensure that people's personal information stayed private.

Relatives told us that they could visit their family member when they wanted and they felt welcome at the home at any time. People received visits from a befriender, this meant people who had little or no family had social visits. The befriender told us that they had been visiting people once a week for the past three to four years. One relative told us, "We are able to visit day or night, I sometimes sit in the lounge with her or in her room if she has stayed in her room".

Inadequate

Is the service responsive?

Our findings

At our last inspection on 12 November, we identified breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not have access to meaningful activities. We asked the provider to take action to make improvements. The provider sent us an action plan which stated they would meet the regulations by 14 April 2015.

None of the people we spoke with had made a complaint about their care, but told us if they had a problem they would speak with the manager or senior staff. One person said they had, "No complaint with anything. I like it here. I enjoy being here. It is an interesting experience for me. If I have a problem I would go and see the manager". Another person told us, "I like helping the staff fold up the washing. We chat at the same time. I always have a daily paper and like to read it and also library books". Another person said, "I like people coming in, we now have a lot more people coming in and we have more music".

Relatives told us that they had been involved in assessing and planning their family member's care. One relative told us "Before she [family member] moved in staff came to her flat to assess her needs and discuss what help they would offer. They asked her questions about her background, what music and activities she liked to do. They also asked how she liked to wash and if she preferred a bath or shower. They discussed the care plan with us. I am fully involved when there have been changes to the care". Another relative said, "I have no complaint about (family member's) care. Cannot praise the home enough. Staff definitely listen. Senior staff are always available if I had an issue". One relative told us that they had seen their family member doing exercise class with a balloon".

At our last inspection we found that that people did not have activities planned to meet their individual needs. During this inspection we found that this had not improved.

There was no structure to people's day, activities were not planned or scheduled. Although one staff member had been allocated as activities person for the day, the staff member stayed in the lounge area and supported people who were using the lounge and dining room. Activities records showed that the activities undertaken most days were; staff read the newspaper to people and quizzes. People and staff said a music man visited the home weekly to play and sing songs. People did not access activities in the community where they could develop their social network and meet other people, other than when their family took them. Activities records evidenced that some days no activities were recorded and on other days, activities such as 'Sleeping', Resting in lounge', 'Watching TV' and 'Listening to radio' were recorded.

One person received care in bed. They received little stimulation and activity to keep them engaged. Their records showed that staff read them the paper twice in one week and staff sat with them and chatted. Staff told us that they often didn't have time to facilitate activities as they were often busy in the afternoons. One person actively walked around the home and could become confused and disorientated. They often had to provide one to one support to keep the person safe. Relatives felt that Millhouse had missed activity opportunities, as much more could be done to support people to participate in activities they used to enjoy such as gardening and knitting. Care plans detailed what activities people used to enjoy. Millhouse had not used this information to inform the activities schedule. The acting manager told us that they were in the process of arranging and planning activities and they were doing this with a relative who had a keen interest in improving the range of activities.

This failure to provide activities to meet people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a policy for writing care plans which stated that people would be involved in planning their care where possible. People and relatives told us that they had been involved in planning their own care. One person said, "I have a care plan. We discussed if I needed help to wash and dress. I prefer to do this myself". However, we did not see evidence in people's care records to show that they (or their relatives) had been involved in planning their care.

At our last inspection we found that people's views were not formally recorded or gathered. This had improved. 'Residents' meetings had taken place which the provider had attended. However, the meeting records did not show how many people had attended. People who were unable

Inadequate

Is the service responsive?

to participate in the meeting had not been asked for their views or feedback. The provider had not carried out surveys of people, relatives and health care professionals since 2013 to gain feedback about the service.

This was a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a complaints procedure which was displayed on the wall in the dining room. The home's records showed that they had not received any formal complaints from people or their relatives since the last inspection. However, we are aware that one relative had complained. They had made contact with us before we inspected. This complaint had not been appropriately recorded or responded to. The complaints policy did not give people full details of who to contact if they were unhappy with the outcome of their complaint. The policy did not list the contact details for the Local Government Ombudsman (LGO).

This failure to follow the provider's complaints policy and failure to record, investigate and respond to complaints effectively was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 12 November 2014, we identified breaches of Regulations 10 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems. We asked the provider to take action to make improvements. The provider sent us an action plan which stated they would meet the regulations by 29 May 2015.

People told us that there had been improvements at the home and they were happy the way the home was led. People said, "More things going on now, more music, more people coming in and visiting"; "The lounge has been painted recently, it looks much better, not sure I like the pink". Another person said there was "Lots of decorating happening it looks much nicer here". People told us that the acting manager listened to their views. One person said, "She is always walking about, stops and chats". Another person told us, "We see her [the acting manager] everyday, always asks how everything is going".

Relatives told us the service was well led. One relative told us, "Senior manager always available. I cannot praise the home enough. They definitely listen to your views. So happy with staff. They are always happy, no moods. The home is so relaxed. The owner's son told us what improvements they were making to the home. Decorating and repairs in the hall and lounge. New TV. The decoration in the lounge has changed the atmosphere it is a lot lighter and brighter". A visitor added, "There have been improvements in management and care. I wouldn't have minded my mother coming in here".

The positive views people and visitors had about the care and management contrasted with some of our findings.

At the last time we inspected the home staff told us that the provider was slow to sort things out if there was a financial cost involved. Repeated requests had been made by staff and relatives for repairs, staff training and activities. These requests had not been responded to or acted on. We found that this had not improved sufficiently. Staff had made repeated requests for kitchen equipment which had not been ordered in a timely manner. Flooring and other equipment had also not been ordered in a timely manner.

At the last inspection we found that the provider had carried out an audit through an external contractor but had not acted on the action points. This had slightly improved. The provider had been carrying out regular audits of the home. However, they had not checked all areas of the home and had not identified the environmental issues and concerns that we found during our inspection. The provider had not acted on the concerns found during the inspection in November 2014 in a timely and coordinated manner to ensure people were safe and their wellbeing was promoted.

The acting manager and senior staff on shift carried out a number of checks and audits. However, these had been treated as a tick box exercise and did not demonstrate what in particular had been checked. For example, the 'Senior daily bed and room checks' form only evidenced that bedrooms had been checked and did not evidence that communal rooms and the garden had been checked.

At out last inspection we found that records relating to people's care and the management of the home were not well organised, adequately maintained or stored securely. This had not improved. One person's care records showed that they should be repositioned every four hours. The records made by staff did not evidence that this was always the case. Sometimes that the person had not been repositioned for in excess of five hours.

The majority of policies and procedures had been purchased from an organisation. Whilst some of them had been tailored to reflect the service provided at Millhouse, others had not. The policies and procedures had not been reviewed and updated. This meant that staff did not have up to date guidance and support to follow while delivering care.

Records were not securely kept. People's care files and personal information had been stored on shelving in the office. We observed a number of periods when the office was unmanned and not locked which meant that visitors, relatives and people could access files. The provider told us that they had ordered a secure lockable cabinet for confidential files, however this cabinet had not been ordered until the end of June 2015.

Inadequate

Is the service well-led?

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records and store them securely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in November 2014 was not displayed on the walls of the home. We spoke with the acting manager and the provider about this. They told us that the reason why this was not displayed was because a person who lived at the home had torn in down. The rating had also not been displayed on the provider's website.

The failure to display the rating was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had not notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The acting manager was not aware of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on the 01 April 2015. The provider had not given the acting manager appropriate support and guidance for them to carry out their role effectively.

Staff told us they felt free to raise any concerns and make suggestions at any time to the acting manager and knew they would be listened to. However, some staff were not confident about raising concerns with the provider. Staff told us that they were aware of the home's whistleblowing policy and that they could contact other organisations such as the Care Quality Commission (CQC) and the local authority if they needed to blow the whistle about concerns. After our last inspection CQC received information of concern from whistle blowers which we followed up and shared with the safeguarding authority.

Staff told us that communication between staff was effective and that support from the acting manager was good. One member of staff told us that the acting manager was very good. They said, "If things go wrong, she [acting manager] looks at what we can learn from it". They also said the acting manager provides praise and thanks when things have gone well. However, we found there was a culture of blame at Millhouse. When we challenged the provider about the issues found during this inspection, they blamed the registered manager. The registered manager had not worked at Millhouse since April 2015.

Staff told us that the provider visited the service once or twice each week; the frequency of these visits had increased since our last inspection. Staff told us that improvements had been made since our last inspection. However, this contrasted with what we found during the inspection because suitable improvements had not been made. Staff told us that staff meetings were held approximately every two months and that the provider attended meetings. Meeting records evidenced that meetings had taken place.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not always receive appropriate care to meet their needs, which reflected their preferences. People did not have access to activities which met their needs. Regulation 9 (1) (a) (b) (c) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from harm because suitable and sufficient risk assessments had not been carried out. Medicines had not been managed effectively. Regulation 12 (1) (2) (a) (b) (g)

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 Systems and processes were not in place to protect people from harm. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were at risk of dehydration and other conditions as a result of the extreme heat. Records showed that people had not been weighed regularly. Regulation 14 (1) (2) (a) (i) (4) (a)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises had not been appropriately cleaned and maintained. Adaptations had not been made to support people living with dementia to maintain their independence. Regulation 15 (1) (a) (c) (e) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Complaints had not been appropriately investigated, recorded and responded to. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider has failed to operate an effective quality assurance system and failed to maintain accurate records and store them securely. The provider had not sought feedback from people, relatives and health care professionals. Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient staffing had not been deployed to meet people's needs. Staff had not received appropriate training to enable them to carry out their job roles effectively. Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had not established or operated recruitment procedures effectively. The provider had not maintained information specified in schedule 3.** Regulation 19 (1) (2) (a) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider did not have the inspection rating on display in the home or on the website.** Regulation 20A

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had failed to notify CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations.** Regulation 18 (1) (4B) (a) (b) (c) (d) (5) (a) (e) (f)