Albany Farm Care (Havant) Limited

# Milton House

## Inspection report

18 Fourth Avenue
Havant
Hampshire
PO9 2QX

Tel: 02392480789

Date of inspection visit:
04 June 2021
16 June 2021
09 July 2021

Date of publication:
28 September 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Milton House is a residential care home providing personal care to four people at the time of the inspection. The home can accommodate up to six people in one building and there are multiple communal areas. They predominantly support people living with a learning disability and autism.

People's experience of using this service and what we found
People were at risk of harm due to poor medicines management. We could not be sure people had received their medicines safely and as prescribed.

Infection prevention and control was not always effective and safe. Staff were not disposing of PPE and LFD tests in line with government guidelines.

Care plans and risk assessments did not always contain enough information to guide staff how to support people safely and effectively.

People were not always safeguarded from abuse and incidents had not always been reported to the relevant people.

Agency staff who were used regularly, had not received appropriate training to enable them to carry out their role safely.

Staff were not always recruited safely, there were gaps in employment histories which hadn't been checked. We have made a recommendation about this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Choice and inclusion were not effectively promoted, so people using the service were not leading as full lives as possible. People were not actively involved in making decisions around their care and the environment in which they lived. The ethos, values, and behaviours of the provider and care staff did not ensure people using the service led confident, inclusive and empowered lives. People did not always receive person centred care and the lack of a consistent management team had a negative impact on people's lives.

The care people received did not always promote people's dignity, privacy and human rights. For example, we witnessed an inappropriate and unauthorised physical intervention taking place which had the potential to harm the person and did not promote dignity.

People we spoke to identified they were scared or could not relax due to the noise and behaviour of one person. The nominated individual had recognised this and planned to be working at the service full time until a registered manager could be appointed.

The provider had not displayed their rating for Milton house on their website.

Governance systems had not identified the concerns we found during our inspection. We could therefore not be assured that quality assurance processes were effective.

There was a lack of management oversite of the service, staff lacked direction which impacted on people leading confident, inclusive and empowered lives. Staff told us the lack of management oversight had impacted on people and behaviours that challenge had increased as a result.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (Published 17 November 2020). The service remains rated requires improvement. This service was been rated requires improvement for the last inspection and inadequate for this inspection.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made, and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to failure to report safeguarding incidents, financial management, medicines management and safe staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering

what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe management of medicines, management of risk, safe management of infection prevention and control, safeguarding people from abuse, assessing and monitoring risk, staffing, good governance, failure to display ratings and failure to report to CQC.

We have imposed conditions on the providers registration which requires them to submit a monthly report to the Care Quality Commission on the actions being taken to ensure improvements are being made to quality and safety of the service.

Follow up
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

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Milton 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.

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

Inspection team
This inspection was conducted by two inspectors on the first and second day and one inspector on the third day. An assistant inspector supported the inspection by making phone calls to relatives.

Service and service type
Milton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The provider was holding interviews for a new registered manager. There was a registered manager from another service overseeing Milton House. We refer to them as the manager throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and about their experience of the care provided. We spoke with seven members of staff including the nominated individual, manager, acting deputy manager, acting team leader and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included three people's care records in detail, a sample of the fourth persons care records and four people's medication records. We looked at two staff files in relation to recruitment and three staff files in relation to supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with an external professional who regularly visit the service. We spoke with three relatives about their experience of the care provided.

Inadequate

# 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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to ensure the proper and safe management of people's medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Medicines were not managed safely to ensure people received their medicines as prescribed. Medicines records (MAR) were incomplete and the medicines audits had not picked up these issues. The manager told us they had recently implemented a new medicines audit system. However, we found this new audit was limited in scope and only covered some areas of safe medicines management.
● Not all staff who were administering medicines to people, had an annual review of their competency to safely do so. For example, the acting team leader had been administering medicines despite not being assessed as competent to do so. This meant we could not be assured that people received their medicines safely from staff who had received adequate training. Following the inspection, the manager confirmed staff competencies would be checked and only those staff assessed as competent, would administer medicines.
● We found concerns in relation guidance for topical medicines administration. One person who used a topical cream, the MAR chart showed the product was made available for the person to apply themselves. However, there was no guidance available for staff to describe how they should support the person to do this, should they need to rely on it. For another person, there was no record of administration of their prescribed topical cream.
● Medicines that were prescribed 'as required' (PRN) were not managed safely. For example, where people were prescribed medicines to help manage anxiety and behaviour which could be a risk to themselves or others, there was not always a protocol to support staff to understand how and when to safely administer the PRN medicine. One person did have a PRN protocol in place for a medicine to support their behaviours. However, this did not describe how staff should use de-escalation or other techniques to support the person prior to administering medication. This is important to guide staff on what behavioural support is in place as an alternative to, or as well as, administering these medicines. This meant we could not be assured that people received their PRN medicines safely.
● People's care plans stated two staff should sign when medicines are administered. Records did not always show this had been done.
● We completed a third site visit on 9 July 2021 to check if improvements had been made. We found PRN protocols still lacked the required detail and we could not be assured safe practices had been implemented.

The failure to ensure the safe and proper management of people's medicines was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the provider had failed to ensure the correct management of infection control risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The provider's infection, prevention and control policy had been updated to reflect the coronavirus pandemic. However, we were not confident the practice in the home was in line with government guidelines and people were not always protected from the risks of COVID 19 and other infectious disease.
● The first day of the inspection was unannounced. On arrival, an agency member of staff showed us into the outside donning and doffing area. We observed a yellow clinical waste bag open on the floor containing used PPE. We observed several used lateral flow devices (LFD) from staff tests, left on the side. This meant used LFD tests and used PPE were not disposed of appropriately, there was a risk of contamination from these items. We spoke to the acting team leader about this, they told us they would arrange for a lidded bin to be in place to hold the clinical waste bags. We checked the donning and doffing garage at the end of the day and the yellow bag was still open on the floor and the used LFD tests were still left on the side.
● In addition, following our arrival, a senior staff member, who had come from inside Milton House to meet us in the donning area, looked at the LFD tests and stated, "Oh good, mines negative." We spoke to the manager about this, who told us the senior staff member had known their test result was negative prior to going on shift. However, we could not be assured that safe COVID testing practices were taking place.

The failure to ensure the correct management of infection control risks, was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● People were not safe from the risk of abuse. Safeguarding incidents had not always been reported as required to the local authority. For example, we reviewed records of an incident that had occurred where a person was extremely agitated, and had thrown objects around the home, breaking another person's property. A staff member recorded on the incident form, "I locked myself in [a person's room] with them to reassure them I would turn the alarms off as soon as safe to do so." By locking this person in their room with them, the staff member was depriving them of their liberty. There was no attempt at the time to check if the fire alarm had been set off in error or if there was a fire. A senior member of staff had reviewed the incident form and had identified that the information recorded was a, "Deeply concerning." Despite reviewing the incident, the management team had failed to recognise the deprivation of liberty to the person or the potential risk from a fire. There was no information to indicate if lessons were learnt as a result, or if action

was taken to reduce a reoccurrence. This incident was not reported to the local authority.
● People's care plans contained contradictory advice, which meant staff did not have clear information to enable them to support people safely. For example, one person's care plan described how when distressed and presenting behaviours that challenged themselves and others, staff should escort the person to their flat and lock the doors for a period of five minutes or longer if required, until the person had calmed down. There was no evidence to demonstrate that this restriction on the persons liberty was lawful. We spoke to a senior staff member about this and they told us they no longer lock the person in their flat and this practice had stopped. The nominated individual showed us a different care plan which did not contain this information. However, as regular agency staff were used, we could not be assured that staff had access to accurate information to keep the person safe. One staff member we spoke to told us when behaviour that challenges occurs, "The house would go into like a lockdown and then the PRN is administered as well." The staff member did not describe any de-escalation techniques and support used to support people prior to administering PRN medicine.
● Staff were not following people's behaviour support plans to ensure they received safe care. For example, during the first day of inspection we witnessed a person use a type of sign language to ask to go out for a drive. The senior staff member told them, "Maybe later." The person became distressed and hit the senior staff member several times. Agency staff came over and grabbed the persons arms near their wrists. The persons arms became crossed and they were manoeuvred out of the room like this. This was not a safe or approved physical intervention. There was no redirection or de-escalation techniques attempted. We spoke to the manager about this, they told us core staff were all trained in Team Teach, a safe intervention technique. However, the two agency staff involved in the inappropriate and unsafe restrictive practice, were not trained in Team Teach. We reviewed the agency staff training records and saw they had not been trained to use any restrictive practice techniques to meet the needs of people living at Milton House. Furthermore, the only staff member who was Team Teach trained, was the senior staff member who was at the time, the target of the person's behaviour that challenged. This resulted in agency staff using unlawful restrictive practice to remove the person from the situation. This meant people were at risk of being harmed while being supported by staff working in the service.
● Staff we spoke with understood their responsibilities to safeguard people and told us they would report any concerns to their manager. However, safeguarding concerns had not always been reported to the local authority by the management team. This meant the provider had not been open and transparent and external agencies were unable to accurately monitor the service.
● When asked if people were safe from abuse, relatives comments included, "Well currently I don't know is the answer, sometimes yes and sometimes no," "There have been incidents where the staffing levels are not appropriate for his and the others needs and it's dangerous for him and others," and, "I'm honestly not sure - I think the lack of senior management and the lack of experience actually on-site, is a concern they are manager less now."
● Following the first two on-site inspection visits, the manager told us they had arranged for the agency staff used at Milton House to have Team Teach training, which would take place in July 2021. They told us they would ensure there would always be three staff trained in Team Teach working on each shift, until the agency staff had been trained. However, during our third day of inspection we found dates for agency staff training were not in place and the service did not always have three Team Teach trained staff on duty. We could not be assured that people were safe and supported by staff with the appropriate skills.

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

Assessing risk, safety monitoring and management
● Care plans did not contain enough detail to guide staff how to support people safely and risk assessments

were not always in place for people's specific medical conditions. For example, one person had type two diabetes, and required support to be safe and stay healthy. However, their care plan did not identify the difference between hyperglycaemic and hypoglycaemic attacks and did not describe the action staff should take if this occurred. Hypoglycaemia is when blood glucose drops too low. Hyperglycaemia is when blood glucose rises too high. Another person's care plan identified them as having an underactive thyroid. However, there was no risk assessment relating to this condition. This meant there was a risk staff would not recognise when they needed to call for medical attention or spot the warning signs, which would place people at increased risk.

● When asked about specific risks to people, one staff member described how one person needed supervision when eating, as they were at risk of choking. However, an external professional told us they had witnessed the person eating without staff support. The lack of close supervision meant this person was at risk of choking and was not receiving safe effective care.

● Another person had behaviours that challenged themselves and others, there was a risk assessment in place which detailed, 'in an emergency situation' staff could use seat belt clips to prevent them from undoing their seatbelt when in the vehicle. The care plan and risk assessment did not describe what 'an emergency situation' would be or detail how to use these clips. In addition, there was no reference to the Mental Capacity Act (2005) being considered. We spoke to the nominated individual about this who told us they would review this care plan and risk assessment. This meant the person was at risk of being restrained without the required legal processes in place, to establish if this was safe and in their best interest. We requested capacity and best interest decisions in relation to this however, these had not been received at the time of writing this report.

● Furthermore, an incident report for one person identified they were scared by another person's behaviour. The person had repeatedly said they were scared, and their anxieties had increased to a level where they self-injured and required 'as required' [PRN] medicines to help them manage their anxieties. This meant we could not be assured safe strategies in were in place to manage risks to people. This incident was not reported to the local authority as required.

The provider failed to assess the risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Trained staff were not always available to support people safely. We observed sufficiently trained staff were not always available to support people in the service. Rota's identified that agency staff were heavily relied on. However, none of the agency staff were trained in the positive behaviour support system used by the provider, meaning agency staff could not provide safe support to people by following their care plans, as all people living at the service had identified support needs using Team Teach. This placed people at risk of harm.

The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices were not always followed. For example, gaps in the employment history of staff were not always followed up to ensure there was a satisfactory written explanation for this. This meant the provider was not always able to consider whether the applicant's background impacted on their suitability to work with people who were vulnerable. We spoke to the manager about this, they were responsive and told us they would address the gaps in employment history

We recommend the provider seeks reputable guidance on the safe recruitment and employment of staff and updates their practice accordingly.

● However, all other employment checks had been carried out and documented, including Disclosure and Barring Service (DBS) checks for all staff prior to commencing employment. A DBS check enables employers to check the criminal records of current and potential employees to ascertain whether they are suitable to work with vulnerable adults and children.

Learning lessons when things go wrong

● The provider has a history of not achieving the required standards. This was the second consecutive inspection where a rating of good has not been achieved in safe and well-led.

● Lessons were not always learnt when something went wrong in the service. For example, the analysis of incident records by a senior staff member had not resulted in any evidenced action to improve the recording made by staff or identify any learning needed. There was no evidence of improvement in the recording, and we found the records made, had missing information. This increased the risk of people not being supported in line with their care plans and risk assessments and as a result, having increased anxiety and behaviours that challenged themselves and others. We could not be assured that action to support staff learning and development, was effective. This meant people were at continued risk of harm as improvements were not being clearly identified and staff were repeatedly making the same mistakes.

● On the third day of our inspection, the provider told us they had a learning outcomes document which was completed following a review of each incident. We viewed the document, which listed concerns found with staff recording of incidents. However, this did not clearly identify what the learning outcomes were and there was no evidence that this had been discussed with staff. We found incident records remained consistently poor. We spoke to the nominated individual about this, who told us they had arranged two meetings to talk to staff about report writing and the recording of incidents.

● The nominated individual recognised that significant improvements in the service were needed since the departure of the registered manager. They had put plans in place to increase the management oversight and told us they would be reviewing all systems and processes and would complete an action plan, to ensure these improvements were made.

We could not improve the rating for Safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 requires. 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

At our last inspection the provider had failed to operate effective systems to assess, monitor and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Robust quality assurance systems to assess and monitor the service were not always in place. However, where they were in place, they were not effective and had failed to identify the concerns we found during the inspection.
● The provider's audit system was ineffective at identifying concerns, or taking action where required. For example, daily medicine audits were in place but had failed to identify the significant concerns we found in the safe management of people's medicines. We found multiple errors on audit forms when we reviewed them during our inspection. This meant we could not be assured that systems in place were effective to keep people safe. We discussed these concerns with the manager and nominated individual who told they would make improvements to their auditing process. In addition, the nominated individual told us they would be commencing monthly management audits. On our third site visit we found no evidence that their auditing process had been improved.
● Staff file audits last took place in January 2021 however, failed to identify staff full employment histories were not complete. This meant we could not be assured people had been safely recruited and the audit process in place was ineffective at identifying this.
● Infection control audits had taken place however, had not picked up the concerns we found during our inspection.
● There was no management oversight or audit of people's finances. We reviewed one person's finance records and found several discrepancies, where receipts had been incorrectly added together. We discussed this with the manager and nominated individual who told us they would address the concerns and put in place weekly and monthly audits of people's finances. On our third site visit the nominated individual told us all finances had been reviewed by head office and he had completed some spot checks, however we could not evidence this as he said, "The thing is I haven't written it down." We could not be assured the provider had a good oversite and finances were being managed safely.

● There was no registered manager in post when we inspected. The provider was interviewing for this post on the second day of our inspection and had appointed a manager by the third day we visited.
● There were no care plan or risk assessment audits, the management team did not have oversight of the care plans and risk assessments and had not picked up concerns we found during this inspection. We could not be assured people were receiving safe care and support in line with their assessed needs. The nominated individual was responsive to our feedback and told us they would be improving their auditing systems and would be completing monthly audits to ensure they had good oversight of the improvements needed.

The failure to operate effective systems to assess, monitor and improve the service, was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse and injuries to people. For example, we identified, three occasions where a person had injured their head. CQC had not been notified of these incidents. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents. We discussed the requirements of this regulation with the nominated individual and they told us they would ensure notifications were sent in as required. These incidents were reported retrospectively following our inspection.

The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People, staff and relatives were not always engaged and involved, and feedback was not always followed up on. For example, relatives told us communication was not always effective and they were not kept fully informed. One relative told us they had raised concerns about the previous registered manager with the provider over a period of several months. However, they felt no action was taken, and they were made to feel the problem was with them. However, they feel the management team have now confirmed everything the relative had previously been trying to tell them. They felt they were not listened to. A second relative told us, "It's [the service] mismanaged, if there was a different service provider in that location, it would be great."
● Other comments from relatives included, "Previously it [the service] was great however, it has changed, I felt they [management] were honest with me and approachable. I don't know about now," and, "Listened to, yes, but it's not acted upon. Every meeting we have there's a list of things that haven't been put in action. We talk to one person about it and then they leave, we spent 18 months with the last manager; This is the sixth manager in three years." On the third day the nominated individual told us they had now recruited to the registered manager post, and a new manager was starting. In the meantime, they would continue to have oversight and take on the management responsibilities in the service. Following the inspection, the nominated individual told us via email, they had three managers in the last three years at the time of the inspection.
● Staff did not have access to regular supervision and team meetings. The provider's supervision contract states, 'supervisions will be carried out every six to eight weeks.' Documents showed supervision for staff was sporadic. Staff generally had a supervision once a year. We spoke to the acting deputy manager about this who told us, "Supervisions were not happening with the frequency they should. I will now be taking this over." However, there was no supervision planner in place, so we could not be assured staff would receive supervision to support them in their roles effectively.

● Staff told us people had access to medical professionals when required. However, documents demonstrated people did not have regular access to dentists and opticians. We asked the nominated individual about this by email. He confirmed two people needed to have optician appointments arranged. We were not provided with dates of dental appointments. This meant people were not supported to access health providers to monitor their health and well-being.

The failure to seek and act on feedback from relevant persons and other persons on the services provided, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People did not receive consistent person centred care that was empowering, of a high-quality and achieved good outcomes. Significant improvements were needed. These have been reported in the safe domains of the report.

● There was a lack of leadership within the service. The registered manager had left, there was an acting team leader and an acting deputy and a manager from another service supporting the management of the service. We spoke to the nominated individual about the need for consistent strong leadership and they told us they would be based at the service and taking over the management responsibility, until the new manager was established in position.

● There was a lack of evidence to demonstrate people were supported to express their views about how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.

● A staff member told us, "I feel like it is a really nice home, I just think at the minute staff members are just unsure where they stand. Not having a manager has had a huge impact on the staff and the people that live there. You can definitely notice the tension and the atmosphere, it is reflecting on them [people] and they are having more behaviours."

● Two of the people we spoke with following an incident that happened during our inspection, used a sign language to indicate the noise was too loud. Both expressed they had sore stomachs and one was in tears and told us they were scared. We observed a senior staff member supporting the person in tears in line with their care plan however, the other person was not supported. A third person told us they couldn't sleep because another person was up a lot in the night shouting. We spoke to a senior staff member about this, who told us this person does get up in the night to use the toilet and is quite noisy. We could not be assured that the management team and staff always recognised the impact on people's wellbeing and took action to support people to live fulfilled and content lives.

● A relative told us, "There have been altercations between [person] and another service user, experience has shown they don't have the staffing levels or capacity to deal with that consistently well." Another relative told us they think their relative is bored and the activity plan is not sufficient. They said, "I have never seen a proper activity plan he's left to just ruminate quite a lot." The nominated individual told us they were committed to making improvements.

The failure to ensure dignified and respectful care was provided at all times was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual recognised the service needed to be improved and the supporting manager had started to put some things in place. They told us they will provide an action plan to address all of the areas we discussed during feedback.

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 provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. However, we found this had not always been followed. For example, safeguarding concerns were not always reported to the local authority. We have reported on this in the Safe section of this report.

● A relative told us, "There were incidents that I didn't know about immediately and, I don't think I've ever seen the incident report they send to social services, as they don't update me at the same time. I have to ask and sometimes I have to ask more than once."

● Where incidents had occurred, we could not see evidence of effective learning as a result. No duty of candour letters or investigations had been completed. For example; documents showed when a person was locked in their room with a staff member and another person's personal property was destroyed, no investigations had been completed and no apology was provided to people . In addition, the local authority safeguarding team was not alerted, family were not informed and CQC were not notified. This meant we could not be assured that the provider and management team acted in an open and transparent way and always recognised when things went wrong.

The failure to act in an open and transparent way was a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

● The provider has a legal requirement to clearly display their CQC rating overall and the rating for each location on every website maintained by or on behalf of the service provider. We looked at the providers website and saw a CCQ link and the words. "Rated 'Good' by CQC across all services. This was not accurate. Milton House was last inspected in November 2020 and received an overall rating of requires improvement. We spoke to the nominated individual about this who told us, "This hasn't been updated yet. I will arrange for that to be sorted out straight away."

The failure to display ratings on the providers website was a breach of 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We could not improve the rating for Well-Led from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse and injuries to people. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. |

| 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<br><br>The failure to display ratings on the providers website was a breach of 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The failure to safeguard people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The failure to ensure the safe and proper management of people's medicines was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>The failure to ensure the correct management of infection control risks, was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>The provider failed to assess the risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.

| 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<br><br>The failure to safeguard people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The failure to operate effective systems to assess, monitor and improve the service, was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>The failure to act in an open and transparent way was a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We imposed conditions on the provider requiring them to undertake specific audits and provide us with monthly reports.