Four Seasons (Bamford) Limited

Milverton Gate Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 14 October 2015 and was unannounced. Milverton Gate Care Home is a nursing home providing care and accommodation to a maximum of 39 older people. On the day of our inspection there were 27 people living at the home six people were living with dementia.

The provider has a history of non-compliance with regulations. At our last inspection on 16 October 2014 we found there were three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. These breaches were in relation to people's care records not being kept up to date, insufficient numbers of suitably qualified, skilled and experienced staff and the safe care and treatment of people using the service.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The home had undergone several changes in management since the last inspection. The previous manager of the service had left in April 2015. The current registered manager had been in post since April 2015, and had only recently registered as the manager of Milverton Gates. They had worked as a registered manager at two of the provider's other homes. We were informed the registered manager would be leaving the service in December 2015 and a new manager had been appointed to start in December 2015. Following our inspection the current registered manager had taken a leave of absence and an interim manager had come in from another of the provider's' homes to manage the home. The area manager was also on a leave of absence and cover was being provided by another area manager. The deputy manager had left in August 2015 and not yet replaced. The registered manager told us they felt unsupported at times by the provider and the provider acknowledged that they had not provided enough support.

The provider had a quality assurance system in order to identify areas of the service that required improvement; however these checks were not carried out consistently. Analysis of incidents and accidents were carried out to minimise the likelihood of them happening again, however issues identified from the quality assurance system were not dealt with effectively. The provider acknowledged that this needed to be improved in order to assess the quality and safety of service people received.

Staff were not always available at the times people needed them. Although the provider was in the process of recruiting more nurses, progress was slow. Staffing levels were often supported by the use of agency nurses and care workers which meant people did not consistently receive care and support from staff who knew them.

Some people and their relatives told us they did not feel the care provided was consistently safe. External healthcare professionals raised concerns regarding unsafe practice around the management of skin breakdown due to pressure. Records identifying when people should be repositioned were not always completed and pain management for wound care was not consistently managed. The registered manager told us they had addressed record keeping with staff individually and in team meetings but errors continued.

When risks were identified regarding correct positioning of people staff did not consistently follow guidelines in care plans which meant people were sometimes placed at risk of skin breakdown or choking. Call bells were not always in reach of people when they needed to request support from staff.

Care plans and risk assessments were in place to protect people but not consistently followed and specialist equipment not correctly used on occasions.

We saw some appropriate referrals were made to specialist healthcare professionals where people needed support, for example with eating and drinking and skin breakdown, however relatives told us that people had experienced lengthy waiting times. This means that people did not always have a timely response to receive support and treatment.

We observed people were offered a choice of food and supported to eat, however some relatives told us when they had visited they found food had been left to go cold and not eaten. We observed drinks were not always in reach of people and one person requiring a special overnight feed did not receive it. Some people required their fluid intake to be monitored by staff in order to maintain their health and well-being; we saw the monitoring was not consistently recorded by staff.

People did not always receive the personal care they wanted or needed. Relatives described finding their relatives in an unkempt state with their dignity not respected and personal hygiene needs not met. We saw that records were not consistently kept up to date detailing if, and when, personal care was given.

Emergency plans were in place to minimise the disruption to people's care and support and to make sure people were kept safe in the event of a fire or other emergency, however the risk assessment required updating. This meant the emergency plans available to the emergency services were not fit for purpose.

We observed, and people told us, individual staff members were caring but did not have time to interact with people outside of giving personal care and we saw some people were left for long periods with little interaction.

Summary of findings

The provider employed activities coordinators but we saw they often spent time carrying out other tasks around the home and people were not consistently supported to follow their interests and hobbies.

There were appropriate policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), to ensure that people who could not make decisions were protected. Appropriate assessments had been made but not always completed in detail.

The provider obtained feedback from people, and their relatives, about the home and care given, however where improvements needed to be made they were not sustained. People were able to make complaints or raise concerns and most of these were investigated in a timely manner. Some relatives however were not satisfied with the length of time taken to respond to their concerns.

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

The overall rating for this service is 'Inadequate' and the service will therefore be placed in 'Special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?
The service was not safe.

There were not always enough skilled and experienced staff, to meet people's needs. The provider was not delivering care and treatment that met people's individual needs and ensured the safety and welfare of people.

Inadequate

Is the service effective?
The service was not consistently effective.

People were not always supported to eat and drink and fluid monitoring required improvement so that people's health was maintained.

People were not consistently supported to access healthcare professionals to maintain their health and wellbeing.

Requires improvement

Is the service caring?
The service was not consistently caring.

People did not consistently receive personal care that met their individual needs. Individual staff members interacted with people in a caring and respectful way but did not always have time to engage with people outside of delivering care.

Requires improvement

Is the service responsive?
The service was not consistently responsive

People were not always supported to pursue their hobbies and interests.

Care and support was not always provided in a way people preferred

Requires improvement

Is the service well-led?
The service was not well led

Leadership in the home had not been consistent due to changes in the management team. The provider had not ensured that effective quality assurance procedures were in place in order to assess and monitor the quality and safety of the service people received.

People and their relatives were able to give feedback about the service but improvements to the service were not sustained.

Inadequate

Milverton Gate Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 October 2015 and was unannounced.

The inspection was undertaken by two inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us was an experienced nurse.

An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

Many of the people who lived at the home were not able to tell us, in detail, about how they were cared for and supported. However, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we also reviewed the information we held about the service. We looked at information we received from relatives, the local authority and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information as part of our inspection planning.

We spoke with five people who lived at the home, 10 relatives, six care staff, two nurses and three healthcare professionals. We also spoke with the area manager and the registered manager of the home.

We observed care and support provided in communal areas and we observed how people were supported to eat and drink at lunch time. We looked at a range of records about people's care including four care files, daily records for personal care and fluid and food records charts for four people.

We also looked at three staff files, staff training records and staff rotas. In addition we requested information from the provider about audits conducted within the home. The information was recorded on the homes' computer and we asked for details of the information to be sent to us, we did not receive this. This was requested to see what actions the provider was taking to make improvements in the home.

Inadequate

Is the service safe?

Our findings

At our previous inspection in October 2014 we found there were breaches in the regulations because there were not enough skilled and experienced staff to keep people safe. The provider was not keeping up to date care records to make sure people received the right amount of fluids to maintain their health. People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe, as the provider was not delivering care and treatment that met people's individual needs, and ensured the safety and well-being of people.

At this inspection we found that improvements had not been sustained and there continued to be a number of nursing staff vacancies. The registered manager told us to ensure there were sufficient staff to meet people's needs the service had been using agency staff.

We found a number of examples where staff were not always available at the times people needed them.

When we arrived at the home at approximately 9.30am we saw most people were still in their bedrooms. One member of staff told us, "We usually get people up between 10:30 and 13:00." They went on to say that the night staff would try to get some people washed and sat out of bed as the day staff had to assist with breakfasts and help other people who needed support.

Relatives told us people did not consistently receive care from staff they knew and who had an understanding of their needs. For example, one relative told us, "The problem is there is a lot of agency staff. Once they said 'we will bring [person] a cup of tea'. He is not allowed a cup of tea". They went on to tell us this would have been unsafe for the person because of their medical condition which made them prone to choking. Another relative told us, "There's a massive turnover of staff here, they seem to manage very well but they are always rushed. They don't have enough time to spend with residents." "The regular staff know how he likes to receive his care but the agency staff don't."

One relative told us: "I was concerned [person] looked unkempt, sometimes he hadn't had a shave and he had poor oral care. I told the manager, they said they would look to get extra staff in the next day, it's not good enough. I found it distressing and the attitude of some of the agency staff was poor. I felt I couldn't trust the staff to care for [person] properly."

A member of staff told us, "We use a lot of agency staff, one more staff on duty would make a difference; we could do with more time for personal care and feeding. Sometimes agency staff don't always know what charts to fill in; they stay with senior care workers as they don't always know the residents."

One staff member felt there were enough staff on duty, but added; "Sometimes if there are agency staff it can make it difficult if time is spent directing them."

This took the time of permanent staff who had to provide support to agency workers who were not familiar with the day to day running of the home and the people that lived there.

We saw during the day the communal areas were not always attended by staff. This meant some people did not have care workers on hand to support them if they needed assistance. A staff member told us, "We should sometimes have more [staff] on each floor. I can't give enough one to one interaction because we are so busy doing pad changes and filling in folders."

At lunchtime we saw another person in a wheelchair facing out of the window. We could see they were visibly distressed as they wanted to face the room where they could see other people; they had no call bell to summon staff. There were no care workers present to see their distress and eventually the activities coordinator came to assist.

A relative told us on visiting they had found their relative in bed in the afternoon, something they normally would not do at home. When they asked a care worker why they were still in bed, the care worker told them there was not another member of staff available to assist them getting the person out of bed. This relative told us they frequently could not find staff in the late afternoon to speak with and ask for help.

One relative told us, "They assure me there are enough staff but you are lucky if you can find two."

The provider used a dependency tool which indicated the number of staff required to support people based on their individual needs and dependency. The registered manager

told us they did not feel the staffing levels indicated by the tool provided sufficient staff to safely care for people. They told us had been using agency nurses and care workers and also used staff from other homes in the provider group to increase staffing levels and fill gaps in the permanent staff rota. The area manager told us they supported the use of agency staff to enhance staff numbers if the registered manager could give rationale as to why it was needed. Staff rotas we looked at confirmed this, but many shifts continued to be staffed according to the dependency tool, and there were occasional days when numbers fell below the minimum identified level. The provider informed us after our inspection they had recruited two nurses who were receiving an induction and due to start work at the home.

This was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff told us they understood the different forms of abuse and how to report concerns; one told us abuse meant, "People not being cared for. It can be anything from physical to verbal. Any personal care not received is a form of abuse. Any of their needs not taken care of is abuse."

Another care worker told us, "There are different forms, financial, physical and emotional. It could be a poor moving and handling technique. If you talk down to people, I see that as emotional abuse."

Staff said they would refer any concerns to the registered manager. Comments included: "I would report them to the manager. She would report it to her manager and she would have to do an investigation." "I would get the resident to safety and report it to the manager and CQC."

One member of staff was not clear what action the manager would take on receiving information of concern. However, they went on to say that if they felt the person responsible for the abuse had not been dealt with, they would report it to the 'health authority' and said, "The phone number is on our pin board and we have the contact numbers in the nurses station."

Information about the local authority safeguarding process was available for people and visitors in the entrance to the home.

A relative told us, "We came in three weeks ago and found [person who lives at the home] in bed, he was wet and had no buzzer [call bell], I complained." Another relative told us, "Her call bell is usually not in reach. Several times it was disconnected."

During our visit we saw one person's call bell on their bed but it was placed out of their reach. Following our inspection we received a concern from a relative who told us their relative had mentioned their call bell had been removed at night as they were "Using it too much." Another relative told us; "The call bell is usually not in reach, several times it was disconnected."

This meant people were not kept safe as they were unable to call for staff if they needed assistance. Although staff told us they understood their responsibility to keep people safe if people could not call for assistance when they needed it this was placing them at risk of potential harm.

The service used risk assessment tools to identify risks to people and their safety. Risk management plans were in place to minimise those risks and maintain people's health and wellbeing. However, we identified staff were not always following these. For example, one person, who was nursed in bed, was assessed as being at very high risk of their skin breaking down if their position was not changed every two to three hours. This was necessary to reduce the pressure on their skin. Records showed for three days there were gaps of around four hours between position changes and on 9 October 2015 there were no position changes recorded after 3.30pm until the following day. Another person had been assessed as being at very high risk of their skin breaking down. Their care plan stated they needed repositioning every two to three hours and what areas of their body were at risk of skin breakdown. They were sitting in a chair when we arrived at 9.15am and were still there at 5.00pm. We asked staff if this person was able to move independently and were told they could shift their weight when sitting, but could not stand. Staff confirmed they had not assisted them to stand during the day. Records on three separate days indicated they had sat in a chair for long periods and had not been assisted to stand in excess of six hours on each day.

This person's care plan also instructed staff to check the person's skin regularly to see if it was broken or red. Records indicated staff had checked the person's skin twice on the day of our visit. We asked staff how they checked the person's skin in accordance with their care plan if they had

Is the service safe?

not been assisted out of their chair to relieve the pressure. They replied they checked the skin that was visible such as the person's arms. This meant staff were not checking the right area of the body at risk of skin breakdown.

We asked the registered manager about this and they told us it would be their expectation the person would be supported to alleviate pressure on their pressure points by lifting the person out of the chair using a hoist and then placing them back down. Staff told us they had not done this.

Prior to our inspection a relative contacted us expressing concerns over the unsafe care of their relation. Due to a health condition they had to be positioned a certain way in bed to keep them safe from the risk of choking. They told us they had visited on occasions and found the person had been positioned inappropriately. On the day of our visit we also found the person was not positioned correctly.

We spoke to a visiting health care professional who had been asked to review a person with existing skin breakdown. They told us this person should have been repositioned regularly every two hours. Documentation showed the person had not been repositioned for 12 hours and their skin breakdown had deteriorated. Another healthcare professional told us that pressure relieving equipment within the home had been incorrectly used which placed the person at serious risk of harm. This meant that identified risks were not being managed by staff to ensure people's safety.

We checked the administration of medicines and saw some people were not consistently receiving the medicines they needed. We looked at ten of the medicine records and found on some occasions there was no explanation given of actions taken if medication was refused.

Some relatives told us that staff did not always ensure that people received their medicines as prescribed. A relative told us "Two or three times in the room I have seen a lid with some tablets in it. When I enquired they couldn't tell me why." Another told us, "I found [persons] medications were sometimes given two hours late, it's essential they receive it on time." They went on to say some of the staff did not know how to administer a particular medicine. This person's medicine needed to be given at the correct time and in the correct manner to manage their medical condition correctly.

One person's skin had significantly broken down in one area. This needed dressing by one of the nurses, but the person found it a very painful process. They had been referred to a tissue viability nurse (wound nurse) who advised they sought a prescription from the GP for pain relief. Although the GP had reviewed this person, records did not demonstrate this had been requested and that pain relief was being given routinely prior to the dressings being changed. We observed a medicines administration round and spoke to the nurse who was responsible for giving people their medicines. They told us only nursing staff who had been trained in the safe handling of medicines could give them. There was a safe procedure for storing medicines, however on two occasions we saw the medicine trolley left open and unattended whilst the nurse left to administer medicines to people. This is unsafe practice as medicines could have been removed and taken by someone else without the nurse's knowledge.

We found staff were not always following the guidelines for the safe management of medicines. We saw each person had a medicines administration record (MAR) which showed when medicine had been given and a medicine plan for when medicines were prescribed on an 'as required' basis, for example pain relief drugs. This meant they only received medicines when they needed them. On looking at one record we saw a prescribed medicine had not been given for eight days and the nursing staff on duty could not explain why. One person had been prescribed antibiotics in liquid form. A bottle containing 200ml of liquid had been issued to the home but according to the records 120ml had been given and it was then recorded as course completed. The records showed the person receiving this medicine had not completed the full prescribed course which would be important to treat their condition.

We also found two dates when other medicines administered had not been correctly signed for. These were controlled drugs which are often given for the relief of pain and must be carefully stored and monitored due to their strength. The provider's policy was that nurses must administer these medicines in pairs and both sign to say they have been given. From two records we could not see if they had been given by two members of staff as there was only one signature recorded. This means we could not be certain two nurses administered the medicine or if the person actually received it.

Inadequate

Is the service safe?

One person needed their blood pressure to be checked prior to being given their medicine. Records showed this was not consistently done. This may have placed the individual at risk of harm if the medicine was given without establishing if the dose needed to be changed, or not given.

We asked the registered manager about this, they told us they were not aware of these particular issues but they did conduct medication audits to make sure nurses were keeping records up to date and people correctly received their medicines. They had identified gaps in peoples MARS charts and raised this at staff meetings however we saw that despite these errors were still being made.

This was a breach of Regulation 12 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

In the reception area we saw risk assessments and management plans to keep people safe in the event of an emergency; however they had not been regularly reviewed and updated. Information for the emergency services was not up to date which could impact on their ability to evacuate the building safely. The fire evacuation plan was dated 2010 and the emergency phone numbers for staff had not been updated with the current staff or manager's details.

We looked at staff recruitment procedures. We saw by looking at staff files and talking with staff, that the provider had undertaken safe recruitment practice. A relatively new member of staff told us they had to wait until all appropriate recruitment checks had been completed before they were able to start work. They told us "I had a full DBS and they chased up my references. I had to wait until they were all in place". Staff files we looked at included references, full employment history checks, and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that keeps records of criminal convictions. Staff were not able to start work at the home until all checks were completed.

One person did have their bell and whilst we were present they pressed it and staff came. We observed that call bells during the day were responded to quickly.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in October 2014 we found there was a breach of regulation in relation to record keeping, including the recording of people's dietary and fluid intake.

At this inspection we found that sustained improvements had not been made.

We observed people being supported to eat and drink, and spoke with people and their relatives about food and drink. People who required no, or little, assistance with food and drink had their meals, however those with higher dependency were sometimes not getting the food and drink they required or received it much later than those who could eat independently. Lunchtime started at 12:30 and we saw some people did not receive their meals until 13:45.

We asked staff why this was and who was responsible for giving people their meals. One of the care staff told us "I have to plate food first for those who can manage it and then go and feed those who can't, We need more time to be with the residents."

One relative told us; "I don't think there are enough staff to help people eat. He waited until 1.30pm to eat because he needs to be fed. He is always the last to be fed." Another relative told us, "[person] will drink tea but I have seen examples where tea has been left to go cold, [person] can't hold the cup." Another said, "[person] gets their meals in bed and spills it down their front. My daughter came on Sunday, in her notes it said [person] had porridge for breakfast but it was there on the table at 12.00pm stone cold."

One relative told us their family member had a percutaneous endoscopic gastrostomy (PEG) tube. This is used when people are unable to swallow food or fluids, and need these to be delivered through a feeding tube inserted into the stomach. They told us on one occasion the person's 'feed' had not been given by the night nurse. The registered manager had informed us of this at the time and confirmed the "feed" had been omitted in error by the nurse on duty. We saw that another person with a PEG feed had a fluid chart that was incorrectly completed from the previous night. The nurse on duty told us that the night nurse (an agency nurse) had given the feed but not filled in the chart. We also saw that people had drinks but they were not always placed in reach.

Some people were identified as being at risk of dehydration and malnutrition and were being monitored by staff to make sure they received enough fluids and food. We saw that some people were being monitored by staff but not all of their charts were being correctly completed.

The registered manager acknowledged that staff were not always recording information correctly and had addressed this at staff meetings and carried out spot checks to ensure staff were correctly completing charts. However we saw from the records this was still an on-going issue.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

We observed that when staff assisted people with their meals and drinks they took time doing this. They supported people to sit correctly and fed them at a pace that was suitable for the individual.

We asked a staff member how they knew whether people were on a special diet to maintain their health and safety. They responded, "If you didn't know you would have to check their care plan. If you are ever in doubt you check their care plan."

Snacks and drinks were offered throughout the day to people and the cook had a board with individual residents' specific dietary requirements. There were pictures of menu food available for residents to assist them making decisions about what meals they wanted if they could not communicate their requests.

Some people we spoke with about the food told us, "The food is very nice. You get several choices, I eat in the dining room it's very enjoyable". A relative said; "The food is good [person] gets a choice of two meals at lunchtime, if [person] has refused his lunch and they ask him if he would like anything else. It looks appetizing and homemade."

People's weight was being monitored and where weight loss was identified, referrals were made to the dietician. If there were concerns about people's ability to eat and drink safely people were referred to the relevant professional such as the speech and language therapist. A visiting healthcare professional on the day of our visit confirmed they received appropriate referrals for people who had problems swallowing. They told us when they visited they had no concerns about the care people were receiving.

Requires improvement

Is the service effective?

We asked people whether they felt staff had been trained to undertake their job roles. A couple of people told us they felt they were, however one relative told us, "Some are fairly well trained but staff change here all the time. Some are slap dash."

Staff told us they received sufficient training in order to have the skills and knowledge to provide care and support. One staff member told us they were going to apply to study for further qualifications in health and social care and we saw posters informing staff how they could pursue further qualifications. Staff told us, "[Manager] has put me down for more training and I am going to do the NVQ." The registered manager confirmed they were encouraging staff to gain further qualifications and that 77 per cent of staff had completed a course called "React to Red." This is training offered by the local tissue viability team (nurses who reduce the risks of skin breakdown) and the aim to educate care staff about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. We found although staff had received training in specific areas such as preventing skin breakdown they were not consistently putting their knowledge into practice in order to keep people safe and meet their individual needs.

We spoke with a member of staff who had started work at the home earlier in the year. They said they had received an induction and explained, "I was shadowing at first (following an experienced staff) I did a full week of shadowing. I had all my training with her."

The registered manager told us all staff had training on the Common Induction programme which is training that people working in adult social care need to complete before they can safely work alone. This is now replaced by the Care Certificate and the registered manager told us they would be looking to access this for new staff.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA sets out the requirements that decisions are made in people's best interest when they are unable to do this for themselves. DoLS make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. One person in the home had an application submitted for assessment by the local authority.

Where people lacked capacity they were assessed in accordance with the MCA. We saw where decisions needed to be made the person's family, or healthcare professionals, had been involved in the process. We found a care plan for one person which stated they lacked capacity to make certain decisions, however no formal assessment was in place apart from one which related to the use of bed rails and this assessment had not been fully completed. This information needs to be completed correctly to show that the decision is being made in the persons best interests and the use of the bed rails is necessary for their safety and not to restrict their movement.

We asked people if staff asked for their consent before giving care. They told us, "Sometimes they ask if it's ok to do things other times they don't. Another said, "No-one has ever asked my consent, they've never done that". A relative told us; "They don't ask consent they just get on and do it."

We asked staff what they would do if someone refused personal care. They told us, "I would ask again and then I would have to record it in their progress sheet and care plan that they had refused a shower. We try to encourage them but we never force anyone." Staff we spoke with had a good understanding of when they would need to seek the help of relatives and healthcare workers when decisions needed to be made.

We saw people had access to healthcare services. The manager informed us a local GP visited the home once a week and we saw people were referred to other professionals in relation to their care. The manager told us that other services were on offer for people such as a chiropodist and optician. One relative however told us. "The doctor comes Monday every week. They are aware of his chest. We asked for him to go to the dentist. We waited eight weeks and gave up waiting. We arranged it ourselves in the end. The chiropodist is ok". Another said; "I had to go outside because of the state of [persons] feet, their nails hadn't been cut. We pay for a chiropodist; the manager says they come every three months." The registered manager said they had investigated this and had not found any evidence this person feet were in a poor state. Others told us, "The physiotherapist has come in, and a chiropodist has been". "I do [persons hair and nails]. The optician keeps a check on him."

We saw some people had agreed that in the event of them having a cardiac arrest the emergency services should not attempt cardiac resuscitation (DNAR). The registered manager informed us that some people were awaiting updates to their DNAR paperwork as they were not

Requires improvement

Is the service effective?

currently valid. This meant that while the updates were taking place, people at the service were at risk of being resuscitated against their wishes. The regional manager informed us they were following this issue up with the local GP and had written to them asking for the paperwork to be updated as soon as possible.

Requires improvement

Is the service caring?

Our findings

Individual staff members were kind to people when communicating with them or providing care. For example, we saw one assisting a person to eat and gently encouraged them to complete their meal. We heard staff speaking kindly to people and touch them on the hand when talking to them.

However, one person told us that staff didn't have time to sit and talk with them. They said "They never sit with me, you are the first one".

Prior to our visit we had received some concerns from relatives that people were not consistently having their personal care needs met and their privacy and dignity was not always respected.

On the day of our visit we did not identify anyone who looked unclean or unkempt but records did not always evidence that personal care was being provided. For example, according to one person's records they had not received a bath, shower or bed bath on six dates in October. This meant we could not be sure if the person had actually received personal care or if this was because staff were not completing records accurately.

One relative told us how distressed they were when they went in see their relative. They noted he looked unkempt and hadn't been shaved. They told us, "The record chart was retrospectively filled in. It didn't show [person] had care given but when I checked later on it had been completed. I complained to the manager about his care and they told me they would make sure they got extra staff in."

Relatives told us, "We have come here and [person] has been in disarray with her breasts showing and her clothes in a mess. We have taken dinner food out of her bed." Others told us; "When we come here she's always in bed. We have asked can she get up. We have waited two hours for them to get her up and nothing happened. We changed her socks because the ones she was wearing didn't match her clothes. I have complained that she smells."

Another told us; "[Person] hadn't had regular washes, he smelt. One day we came in, they told us that he had pulled his catheter out and his bed was soaking. We came again and found his bed soaking, this was at 11.15am." They went on to tell us when the person first came to live at the home they had not been receiving showers over a 9 week period. When they complained to the staff they were told that a risk assessment had not been carried out and this was why showers had not been offered.

During our inspection we overheard a care worker speaking to a person when they brought them a drink at 11.45am. "You should have had a wash at 10.00am. I will find out about it." This person was in his bed with his shoes on. The care staff made no attempt to ask him if he would like his shoes off. We asked the person if he preferred to leave his shoes on. He said "Not really."

We asked other relatives whether they thought their family member's personal care needs were met and they told us; "Oh yes, you can't fault that." Another described care staff as "Brilliant, absolutely brilliant". And another said, "I have no concerns about his care. Very happy with how he's looked after." "I think they are very caring".

On the day of our inspection we saw people were clean and smart and their bed linen was clean.

In one of the lounges, we saw a person had been placed in a chair so they could only look out of the window. This person was there for several hours during the day with little interaction from staff. When we went to speak with them, they held our hand and smiled and clearly enjoyed the contact.

One relative we spoke with, unconnected with this person, told us they frequently saw this person in the same position when they visited their own relative. They told us, "I never saw anyone speak to them and people were often left in front of televisions which would be blaring all day". We observed the TV was on and very loud. One member of the care staff told us, "The residents probably don't like it on." During lunch we heard a radio on in the dining room which was very loud. Eventually a care worker turned it down.

We asked people if they thought staff were caring and they told us, "Most of them are caring and respectful. No-one has mistreated me. They leave me alone mostly." Another said; "The staff are decent, respectful." Some people and relatives told us staff were caring and attentive to their needs and we saw doors were shut when staff were providing personal care.

We asked people whether they had they been involved in planning their care. People told us, "I don't know what a care plan is", another said; "Never heard of a care plan".

Requires improvement

Is the service caring?

This indicated that some people may not have been involved in making decisions about their care and how they receive it. Some relatives acting on behalf of people knew what the care plan contained and told us they did have review meetings to discuss the care their relative was receiving.

Requires improvement

Is the service responsive?

Our findings

We asked people if they were supported to pursue their hobbies and interests. We received mixed responses. One person said there were some activities and one person and two relatives said there were not. We asked people about activities in the home and they told us; "Sometimes there's a singer I listen to. We do exercises, for the aches I've got we do enough, I never go out. They have never asked me to my knowledge." We asked one person if staff knew what hobbies they liked, they told us; "I don't think so, I only watch football on TV, nothing else, I don't go out, not been asked." Another told us; I can do what I want more or less, I haven't been in the garden. I've never been out anywhere, it would be nice"

The registered manager told us there were two part time activities coordinators at the home and they worked weekdays but not at the weekends. On the day of our inspection the activities co-ordinator was often seen carrying out other tasks such as answering the door and providing drinks. This meant the staff member could not devote their time to support people with their hobbies and interests.

Activities for the day of our visit were 'sensory hands' and 'nail care'. We did not observe these happening during the inspection and did not see any activities during the day, we rarely saw staff sitting with residents and interacting with them.

A relative said, "She [person living at the home] likes peace and quiet, they just stick her in front of the TV, she hates noise. They told us that most activities are in the morning. Never see staff stimulating residents." Others told us, "They asked me about his hobbies and tried to do dominoes with him. He doesn't want to know. They've not asked him to go out in the garden." "They are aware of his interest, he likes gardening but he can't do it here. Never seen any activities in the afternoon."

We asked staff if there were enough activities for people to take part in. Responses included: "There are two activities people. Mostly they read to people and put music on." One staff member when asked was there enough for person to do replied, "Yes and no. I think they should have more, I don't think there is enough for them."

The provider's 'resident survey' in December 2014 had already highlighted that people did not feel there were enough activities. 43 per cent said social activities were good or very good but only 20 per cent said social outings were good. This showed, and people told us, that there were not enough activities to meet people's individual needs. The registered manager told us they wanted to improve the activities offered. We saw minutes of an activities meeting on 29 July 2015. This discussed how to personalise activities for people and for staff to speak to each person to make sure they understood their likes, dislikes, hobbies and favourite things to do. The manager told us they were in the process of creating a personalised activity planner for each person which would be placed in their own care plan. As we saw the activities coordinator already involved in duties outside of their role we asked the registered manager how they would ensure that individualised activities were achieved.

They told us whilst the activities coordinator was carrying out other tasks they were still engaging with people by talking to them and holding their hands.

One person's care plan said they liked to listen to classical music in their room and we saw there was classical music playing.

A vicar attended the service once a month or sooner if requested by a person; the manager told us that a person who was of a particular faith had been offered access to a support group but they had declined this.

One staff member told us they knew a little bit about people's backgrounds and said, "I do like to find out as much as I can to talk about with them and reminisce." We asked why that was important and they responded, "To know what they have been through and where they are coming from. It is nice to have the knowledge so when you are talking to them you can spark a memory".

We found care plans contained relevant information about people and were centred on the person and their individual needs. The manager told us they regularly reviewed and audited the care plans, however staff told us they did not always have time to sit down and read them so they could keep up to date with any changes. This meant staff may not be fully aware of any changes in people's needs and care. Staff we spoke to however could tell us about peoples care needs.

A member of staff from another of the provider's homes who was working at Milverton Gate told us, "I have skimmed through some but I haven't had time to sit down

Is the service responsive?

and read them as I would like to do. For residents who can communicate it is easier but for those who can't, it is relying on staff. I refer to the staff on duty and if they don't know, I refer to the care plan".

Another staff member said; "All the information is in the care plans and you try to find time to read about new residents. We can't always find time but we find information from nurses or staff

and can respond appropriately: We have the handovers and the nurses tell us about each resident. If we have problems that is who we go to first, the nurses." "If there are any changes when we have our handover, they will be brought up."

The registered manager told us there had been an open day in July and there would be a harvest festival celebration coming up. One person had their 100th birthday and a singer from the 'X factor' had attended. Another person was going to be celebrating their 100th birthday soon and staff told us they were hoping for the local mayor to attend.

We looked at how the provider managed complaints. We asked people if they knew how to make a complaint about the service. People told us; "I would say something depending on what it was but I've never complained". Another said; "I would complain if needed. I never have". Some relatives said they had made complaints and sometimes had an unsatisfactory response. One told us that they had not received adequate information about their relative and there was poor communication from the manager. They told us they had arrived at the home to see their relative and were told they were being seen by a doctor; "We came one day and the door was shut, [manager] said she hadn't been well and the doctor was coming. What she didn't say was that two paramedics were in her room with her and an ambulance was outside. We tried to talk to the manager but she had disappeared."

Another relative told us; "Yes, we do complain to the manager. Not seen any official complaints procedure. "We made a complaint to the area manager in reception four weeks ago. She said she would come back to us, she didn't. We rang again and she still didn't come back to us." The registered manager informed us that this complaint was now being investigated by another senior member of the team.

The registered manager told us there was a 'tablet computer' in the reception area which was available for anyone visiting the home to use. This could be used to request an appointment to speak to the manager and also to raise concerns and complaints. The registered manager told us they reviewed this regularly and addressed any issues raised. They told us one family had requested to speak with them via the 'tablet' and they had made arrangements to have a meeting with them. During our inspection we saw the provider's complaints procedure was on display on the notice board in the entrance of the home.

We looked at the complaints file and saw there had been three complaints which records showed had been investigated and responded to in accordance with the provider's complaints policy and procedure. Learning from complaints had been shared with staff in staffing meetings and individual supervision sessions. One complaint from a relative had not been resolved with the registered manager and had been escalated to the regional manager to investigate. This was still being progressed.

Inadequate

Is the service well-led?

Our findings

The provider has a history of non-compliance with the regulations of the Health and Social Care Act 2008 at this service.

In May 2013 under our previous inspection methodology we found the provider was non-compliant in the regulation associated with staffing; a follow up inspection in September 2013 found them to be compliant again. At our inspection in October 2014 we found the provider in breach of regulations for not keeping accurate and up to date care records. There were also insufficient numbers of suitably qualified, skilled and experienced staff. The planning and delivery of care did not ensure the welfare and safety of people.

At this inspection we found that sustained improvements had not been made. The provider continued to be in breach of the regulations associated with the safe care and treatment of people and we found there were still insufficient numbers of qualified, skilled and experienced staff. We found the home was not well led and found the provider failed to consistently provide, and ensure, good governance.

There was a lack of consistent leadership at the home. Since our last inspection the previous registered manager had left their employment at the home. An interim manager came into post from one of the provider's other homes in April 2015. They were registered with us shortly before this inspection. They then notified us they would be leaving the home in December 2015. The provider had recruited a new manager to start in December 2015. The home did not have a deputy manager as the previous had left in August 2015; the provider informed us they were in the process of recruiting for a new one.

Following our inspection the registered manager went on leave of absence and the provider arranged for an interim manager to oversee the home until the new manager came into post. On the day of our inspection a regional area manager visited the home; however they were not the area manager for the home, and were covering for the usual manager who was also on leave of absence.

During our inspection we asked the registered manager if they felt well supported by the provider and they told us that they did not feel consistently supported in their role. They told us they had tried to make improvements since they had taken over the management of the home but felt under a great deal of pressure at times. There had not been any administrative support until July 2015 and this additional responsibility had fallen to the registered manager and meant they were taken away from performing other managerial duties.

Following the inspection the provider acknowledged the registered manager had not received adequate support in their role and the home had not been well led. The regional area manager told us they were working with the staff, and the interim manager, to improve the support given.

We found that the provider did not consistently monitor the quality and safety of the service. The registered manager and provider were both responsible for carrying out a system of checks on the service provided. We found some audits were being carried out but when areas of concern were identified they were not being dealt with effectively. The provider acknowledged that the monthly 'area manager audits' had not been consistently carried out.

The registered manager was responsible for carrying out spot checks and "walkabouts" in the home to look at quality of care people received safety and cleanliness. They also took this opportunity to speak to people living in the home. We saw issues had been highlighted, such as gaps in people's medication charts and fluid recording charts. The issues regarding peoples call bells not always being in reach had not been identified.

We asked the registered manager what they had done to improve recording by staff, and they told us this had been addressed at staff meetings. We asked whose responsibility it was to make sure charts were being completed and the registered manager told us it was the nurse on duty and they would double check to make sure this was being carried out. They told us on occasions they would call the night staff to remind them of their responsibilities. We asked why that was necessary and, if it had been addressed at team meetings, staff were still on occasions not doing this. The registered manager told us things had improved and charts were being completed 90 per cent of the time but acknowledged this was not acceptable and they would be speaking with staff individually and at staff meetings.

The registered manager carried out regular weekly audits of care plans. We asked who was responsible for updating the care plans and they told us this was a nurse's

responsibility. They told us agency nurses were not allowed to do this and this had meant some of the responsibility had fallen to the registered manager. These audits had not identified the shortfalls we identified in peoples personal records.

People had opportunities to share their views about the service they received. Service satisfaction surveys were sent out annually. We looked at the results of the last survey which had been produced in December 2014. We saw mixed responses regarding the quality of care in the home. 67 per cent said the home was good or very good, 43 per cent said social activities were good or very good but only 20 per cent said social outings were good. Half of respondents said food, the response of staff and bathing was good and 43 per cent said they felt involved in decisions regarding their care. 80 per cent said the planning of care, staff knocking before entering their rooms was good and that they felt at ease speaking to staff. Some people and their relatives were still highlighting concerns around personal care and the response of staff 10 months after the questionnaire. This showed that the provider had not taken enough positive action to improve the service and the level of care given to people. A new survey was due to be sent out shortly after our inspection.

This was a breach of Regulation 17 (2) (a) (b) (c) HSCA 2008 (Regulated Activities) Regulations 2014.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The registered manager told us information was recorded onto a 'tablet computer' and this could be inputted by any member of staff. The registered manager would then analyse the information and put action plans in place to make improvements such as updating peoples risk assessments or referring them to healthcare professionals for support. We asked for this information from the registered manager but it was not provided to us.

The regional area manager told us they also analysed this information to ensure problems were being dealt with correctly by the registered manager. If trends were found across the provider's homes this information would be shared at regional meetings.

We asked people and their relatives whether they felt the home was well led. People told us; "The atmosphere is good. I know where the manager is, I can speak to her when I like, and she's always around. "Another said; "Atmosphere's alright, the manager is quite nice, see her occasionally." One relative who had made a complaint about their relative's care said there had been some recent improvement following this. They told us; "The staff do the best they can. Some are brilliant but the leadership is poor, it has improved now; two weeks ago I would have given it two out of ten. Now six out of ten."

Staff told us they felt there was an open and transparent culture in the home. Staff we spoke with were positive about the registered manager, they told us; "She is lovely, great, she is straight and no nonsense. She means what she says but she is not unapproachable. She gets things done when they need to be." Another told us, " The manager is very open minded if she has time she will talk, sometimes her door is shut if she is busy but when its open we can speak with her."

The registered manager told us they believed they led by example and said; "Staff recognise I am open and honest, I will lead by example and respond to call bells and help with personal care." Staff told us they would feel confident in raising concerns with the management team and knew how to whistle blow if they were felt their concerns were not being adequately managed.

We saw that regular staff meetings were held and the last had been in September 2015. The meetings were used as an opportunity to talk about how to improve practice in the home. The registered manager told us that staff were also regularly updated regarding their responsibilities in improvements that were required in the home identified from the last inspection. Staff we spoke to told us they understood their roles and responsibilities.

In relation to staff meetings one staff member told us, "We have just had one [meeting] and we have the next one in December." We asked if they felt confident to contribute to meetings and they responded, "It is a bit back and forth. Everyone gets to say if they feel something isn't working. I believe the staff all feel comfortable saying something should be done. We get to say our piece as well."

We asked the registered manager how they encouraged staff to put forward their opinions and promoted an open and transparent culture. They told us they led by example and said "Staff recognise I am open and honest and if I need to I will speak privately to them or they can approach me."

Inadequate

Is the service well-led?

There was a 24 hour on call system to support staff if they needed to speak to a manager. The provider had sent notifications to us about important events and incidents that occurred at the home. The manager also shared information with local authorities and other regulators.

We saw that group meetings were held with people and their relatives. During these people were asked for feedback about the quality of service provided and suggestions were put forward. We saw the minutes of the last meeting held on 17 September 2015. During the meeting suggestions were made for menu changes and ideas for Christmas. People stated they would like more variety of drinks and a 'pamper day' One suggestion from the July meeting had been for the dining room to be painted yellow and we saw that this had been done. Not all of the relatives we spoke with were aware that these meetings took place.

The CQC ratings from our last inspection were on display in the home and a copy of the inspection report was available. This meant that people, relatives and visitors could see what we said about the provider and the improvements they needed to make.

Commissioners also have concerns consistent with our findings and have recently met with the provider to discuss the concerns.