Albany Farm Care (Havant) Limited

Milton House

Inspection report

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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/or autism.

People's experience of using this service and what we found
The provider had not established an effective system to ensure people were protected from the risk of abuse. Risks to people's health and wellbeing had not been monitored or mitigated effectively. People were at risk of harm because staff did not always have the information, they needed to support people safely. A number of safety concerns in relation to the environment were identified. The service was not always clean. Medicines were not managed safely, and medicine administration records were not always complete. The provider had not ensured there were sufficient numbers of competent and skilled staff to support people safely. Fire risk was not managed safely. At our last inspection we found safeguarding incidents had not always been reported as required to the local authority. At this inspection we identified a continued lack of reporting of safeguarding incidents.

At the last inspection we found care plans and risk assessments lacked sufficient detail to ensure people were supported safely. At this inspection we found improvements had not been made. We observed care plans and risk assessments continued to lack sufficient detail to support people safely.

People were not protected from the risks of COVID 19 and other infectious disease and we could not be assured the provider was making sure infection outbreaks could be effectively prevented or managed.

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.

Based on our review of key questions safe and well-led, the provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care right culture. The service was not maximising people's choices, control or independence. People were not always supported to make meaningful choices. There was a lack of person-centred care and people's human rights were not always upheld. A lack of timely action by leaders to ensure the service was well staffed and safeguarding incidents were responded to meant people did not lead inclusive or empowered lives.
People were not given regular opportunities to discuss their individual care needs or wider issues in the home. People had care plans in place. However, these were not always written in a way that was person-

centred and easy to understand. We observed people were not always supported in an open, inclusive and empowering way.

Systems in place to promote staff learning and development were ineffective. Improvements were not clearly identified.

The service was not well led. At our last inspection the quality assurance systems to assess and monitor the service were not always in place, and where they were, they were not effective. At this inspection we found the provider did not have enough oversight of the service to ensure it was being managed safely and quality maintained. Quality assurance processes had not identified all of the concerns in the service and where they had, sufficient improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. Indicators of a closed culture were identified, and staff morale was low. This meant people did not always receive high-quality care

The provider had failed to notify CQC of significant events that happened in the service as required by law.

The provider had not displayed their rating for Milton House within the service.

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 Inadequate (published 28 September 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been sufficient and the provider was in breach of nine regulations, eight of which were continued breaches.

This service has been in Special Measures since 16 August 2021.

Why we inspected
The inspection was prompted in part due to concerns received about information shared being incomplete or inaccurate, withholding of information, people not being supported appropriately to prevent them from becoming distressed, lack of communication between the nominated individual and staff, incidents not being taken seriously and responses to safeguarding enquiries not being met. 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 remains 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.

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 staffing, person-centred care, safe care and treatment, management of risk, safe management of infection prevention and control, safeguarding people from abuse, safe management of medicines, premises and equipment, duty of candour, assessing and monitoring risk, good governance, failure to display ratings and failure to report to CQC.

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

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains 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 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.

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. There was a manager in post who was planning to become the registered manager. We refer to them as the manager throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We 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.

During the inspection
We carried out observations of people's experiences throughout the inspection. We spoke to two people who used the service about their experience of the care provided. We spoke with eight members of staff including the nominated individual, the manager and care workers, including agency care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to two family members about their experience of the care provided. We reviewed a range of records. This included positive behavioural support plans and medicines records for two people. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service.

After the inspection
We spoke to two relatives about their experience of the care provided and received feedback from one member of staff. We reviewed a range or records. This included three people's care records and four people's medicine records. We reviewed a variety of records relating to the management of the service, including risk assessments, quality assurance records, training data and policies and procedures. We continued to seek clarification from the provider to validate evidence found. We received feedback from two professionals who were in regular contact with the service and from one staff member.

Following our first three site visits and review of documentation, we were not assured people were receiving safe care and treatment. We made the decision to carry out a further site visit on 7 January 2022. We spoke with three care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Observations from this visit have been included within this report.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 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 regulations.

- The provider did not have effective systems and processes to safeguard people from the risk of abuse.
- At our last inspection we found safeguarding incidents had not always been reported as required to the local authority. At this inspection we identified a continued lack of reporting of safeguarding incidents. For example, an incident form told us one person had asked for a sword to kill another person with. The staff member recorded the person seemed to be serious about this. This incident does not appear to have been explored any further and was not referred to the local authority safeguarding team. The manager told us they would look into this. We asked the nominated individual to submit a retrospective notification for this incident. We have not received this notification.
- Safeguarding incidents were not always properly managed, recorded and investigated. For example, there were two incidents where staff had reported medicines errors, one involving an overdose of prescribed medicines on 18 November 2021, and one involving an underdose of prescribed medicines on 10 September 2021. We saw no evidence these incidents had been reviewed, investigated or action taken to mitigate risk of further errors. This placed people at increased risk of harm.
- People were not protected from the risk of financial abuse. We found discrepancies within people's financial records which had not been identified by the provider. We spoke to the manager about this who told us they would investigate the discrepancies and share their findings. We raised our concerns with the local authority safeguarding team.

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

- Staff understood their safeguarding responsibilities. Some staff had whistle blown to CQC and their information had in part prompted the inspection.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to manage the risks relating to the health, safety and welfare of people. 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 regulations.

● This inspection was in part triggered by concerns about how people with complex needs, and who behaved in a way that placed others at risk of harm, were supported. We found risks to people were not managed safely. The provider had not fully recognised the risks faced by people living in the service.
● Incidents where people's behaviours may challenge others were not effectively recorded. For example, for one person there were multiple records stating the person had been supported to their room during heightened states of anxiety. There was no detail stating how this person was supported to their room, especially during times where they were physically aggressive towards others. This intervention did not appear to be effective as records detailed actions taken did not result in a de-escalation of the incident. The lack of detail meant it was difficult to identify patterns and triggers to inform reviews and updates of care plans and to mitigate risk of further incidents.
● At the last inspection we found care plans and risk assessments lacked enough detail to ensure people were supported safely.
● At this inspection we found improvements had not been made and the concerns found at the last inspection remained.
● For example, one person had type two diabetes, the 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.
● The same person's documents identified they had an underactive thyroid. However, there was no risk assessment relating to this condition. This meant staff would not know the risks associated with this condition and may not know correct procedure to follow to get the right support for this person.
● In addition, during this inspection documents demonstrated the person required support to test their blood glucose levels weekly. There was no guidance for staff to identify what levels were acceptable and when staff needed to seek medical attention on the person's behalf. This meant people were placed at increased risk. There was a risk staff would not spot the warning signs or recognise when to call for medical attention which put people at increased risk of harm.
● Another person's care plan stated, 'I have weak ankles due to my weight'. However, there was no detail about how this affected them, signs for staff to look out for or details of when to seek medical attention.
● Relatives and the local authority told us they were concerned about the lack of action by the provider to respond to people's health needs. We also saw evidence to support these concerns. For example, concerns had been identified in relation to rapid weight gain for people. The provider had received support from external professionals to support people to manage these concerns. However, the provider had failed to effectively implement some of the recommendations. People had not been consistently supported to be weighed weekly, people's dietary recommendations were not consistently supported, and care plans did not contain the information required for staff to be able to support people effectively. For example, one person's care plan stated, "Any radical weight increase is to be reported to health officials." There was no other guidance available to staff as to what would be considered a 'radical weight increase'.
● People were not supported to follow the dietary recommendations. We observed significant amounts of high calorie processed foods in the freezer. In addition, food records demonstrated people were not being offered healthier food choices consistently.

The failure to assess and do all that is reasonably practicable to mitigate risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were several safety concerns in relation to the environment.

● Fire safety was not effectively managed. Multiple documents relating to fire safety were not consistently completed. For example, emergency lighting checks, weekly fire alarm tests, fire door checks, daily tumble dryer lint checks, weekly firefighting equipment test and daily fire escape route checks. This meant the provider could not be assured the premises remained safe for people.
● Areas of the home were not clean. Including, the flat, kitchen, work surfaces; which were very dirty and had spillages that had dried on. The fridge contained some out-of-date food and we observed unsafe storage of food.
● The provider had not ensured regular cleaning had taken place which was evidenced by our observations. We asked the manager for evidence of cleaning schedules however; these were not provided. One person's flat was very dirty, having stains on the walls and curtains. One person's bed was unclean with had stains on the mattress, duvet cover, pillowcase and headboard. The curtains were stained and detached from the curtain pole at one end. The dining table had food debris on the floor. The person had been asleep in bed in their clothes with no sheet on their bed. Their bathroom was dirty. We observed the floor and wall outside the bathroom was damp with mould developing. We spoke to the nominated individual regarding the cleanliness of the flat, they told us it was not acceptable, and they would arrange for it to be cleaned. This had not been identified by the provider.
● A relative told us some areas are dangerous. They said, "Parts of the trampoline had poles sticking out, this is not safe, we had to point it out to staff." Another relative told us, "They are not cleaning his room effectively, just doing the middle, not round the edges."

The failure to ensure the premises was clean, properly maintained and secure was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us they had taken action to improve the cleanliness within the service. They shared the new cleaning schedule they had implemented. Documents demonstrated this was not being consistently completed. However, it is new and may need time to become embedded within their practice. The provider told us they had carried out some deep cleaning and had redecorated one of the bathrooms. We observed a bathroom had been redecorated and areas of the home had been cleaned following our feedback.

Staffing and recruitment
At our last inspection the provider had failed to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 (Staffing) 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 regulations.

● The provider had not ensured there were sufficient numbers of suitably competent and skilled staff to support people safely.
● Staff and relatives told us there were not enough staff. Comments included, "They never have enough staff", "It's hard because there are a lot of agency who haven't worked with people before" and, "The staff turnover is horrendous."
● During the inspection we observed people's support needs and commissioned hours were not always being met. The manager did not have a good understanding of people's commissioned hours which impacted on their ability to ensure the rota was covered to meet people's needs and to keep people safe. The lack of management oversight meant the shortfalls in rota had not been identified by the provider.
● There was a significant reliance on the use of agency staff. Agency staff were not trained in the

administration of medicines. We observed the negative impact this had for one person during the inspection.
● Only one member of night staff was trained in the administration of medicines. There were nights when there was no medicines competent staff on duty. This meant when people required PRN medicines on-call needed to be contacted to come out and administer medicines. People did not have immediate access to required PRN medicines.
● We reviewed the training matrix and found not all training had been delivered for staff to be able to fulfil their role effectively. This included, basic life support, diabetes, fire safety, safeguarding and food safety level two. One staff member, when asked if they attended fire drills, told us, "Never in the few years since I have been here."
● We were provided with a document which confirmed staff had received medicines competencies. However, they did not contain any detail of what was assessed during the competency.
● Staff did not have access to regular supervision and team meetings. One staff member told us, "I don't know when I had my last supervision to be fair longer than a year ago."
● Records relating to induction were not consistently completed. Although these had been identified by the provider through their quality assurance processes, they had not been acted on. We requested copies of the provider's audits of staff files. However, these were not provided.

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

Following the inspection, the provider told us they had reviewed their staffing rotas and made changes to ensure people's support needs and commissioned hours were met. They sent us the updated rotas to evidence this.

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 regulations.

● We could not be assured medicines were managed safely.
● Some people had been prescribed medicines to be used 'as required' (PRN). These medicines need PRN protocols to explain their use and how much to give, or when to use the medicine. PRN protocols were in place however; they did not always contain enough information. For example, one person was prescribed PRN Ibuprofen. The PRN protocol stated, '[Person's name] can have a maximum of TWO TABLETS EVERY FOUR HOURS.' The PRN protocol did not specify the maximum dose which could be given in any 24-hour period. This meant there was a risk this person could be administered too much of this medicine putting them at risk of harm.
● Another person was not administered their prescribed medicine at 8 am on 10 August 2021, this was then administered on 11 August 2021 in addition to the same medicine already prescribed for that day resulting in an overdose of this medicine. There was no evidence this had been identified and no information to demonstrate any action had been taken to address this.
● We could not be assured medicines were always available to people. For example, when we viewed medicine administration records (MAR), we saw one person was prescribed medicated toothpaste. There

had been none in stock for a period of at least six months. We spoke to a staff member about this. They told us, "We can't get the GP to give us a prescription and the pharmacy won't give it without a prescription." We asked if a dentist would be the person to write the prescription, the staff member told us it was difficult because everyone blamed everyone else. There was no information available which demonstrated any action had been taken to address this. We spoke to the nominated individual about this who told us they would investigate.

● We found multiple gaps on MAR charts for all people, this included a wide variety of medicines some of which included, Levothyroxine to treat underactive thyroid, Metformin used to treat Type 2 diabetes, omeprazole to treat acid reflux and antidepressant medicines. This meant these medicines had not been given or had not been signed for. There was no evidence these gaps in MAR charts had been identified and acted on.

● Where people had refused their medicines, staff used a code to indicate the medicine had been refused. The medicines care plan for one person stated, 'The MAR chart should be completed using the correct code for refusal along with notes written on the back.' The providers medicines policy stated, 'A record must be made if the medicine is refused or not administered including the reason why.' We checked the reverse of the MAR charts for two people where staff had recorded, they had refused prescribed creams, the details of the refusal had not been recorded. One person had refused their prescribed cream for eight consecutive mornings. This meant this was not being monitored and the person was at risk of their condition worsening.

● Medicines should be stored at the correct temperature to ensure they are safe and effective.
We found gaps in temperature records. This meant we could not be assured that medicines were always stored in line with the manufacturer's instructions and therefore safe to use.

● Topical creams and lotions were not safely managed. For example, all four people were prescribed medicated creams, lotions or shampoo. Records did not confirm that that all these creams, lotions and shampoos had been applied consistently in line with prescriptions. This meant people's skin conditions, and skin integrity, may deteriorate because they were not having creams applied as prescribed.

● We observed a staff member administer medicines. They informed us they could not wash their hands because they had a tattoo the previous day on the back of their hand and were not able to get it wet. This wound was uncovered and although the staff member wore gloves to administer the medicines the wound was exposed for the remainder of their time on shift. We spoke to the nominated individual about this who told us he would speak to the staff member. We requested staff related risk assessments from the nominated individual. However, these were not provided.

We found no evidence people had been harmed however, systems and processes were either not in place or not robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a repeat breach of Regulation 12 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 regulations.

● At the last inspection we found personal protective equipment (PPE) and lateral flow devices (LFD) had not been disposed of appropriately. At this inspection we were not assured that the provider was using PPE effectively and safely. The first day of the inspection was unannounced. On arrival we viewed the outside

donning and doffing area. We observed used LFD left on the same work surface we had observed during the last inspection. This meant improvement had not been made in this area and people were still at risk.
● At our last inspection we observed an open clinical waste bag on the floor containing used PPE. At this inspection a bin was now in place. However, the clinical waste bin was full, and the lid had been left open. The bin was surrounded by used LFD packaging. We observed a discarded used personal protection face mask on the drive; an area people had access to. There was a continued risk of contamination from these items. This meant people were not always protected from the risks of COVID-19 and other infectious diseases. We spoke to the nominated individual about this who was surprised and said every time he had checked there had never been a problem.
● The provider's infection prevention and control policy and procedure was up to date. However, we observed the guidance within the policy and procedure was not always followed. People were at risk from catching infections because procedures to prevent visitors from spreading COVID-19 were not effective. Visitors entering the service were not always asked COVID-19 screening questions, did not always have their temperature checked and did not always have their COVID-19 vaccination status confirmed prior to entry.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We observed the systems and processes in place to manage and mitigate the risks were ineffective. For example, on the third day of inspection we were told a staff member had tested positive for COVID-19 and a person was showing symptoms of COVID-19. While we were outside, we observed an agency member of staff come from inside the service to the donning and doffing area and proceed to carry out an LFD test. This meant the staff member had entered the service without having undertaken an LFD test. This put people and staff at risk as their COVID-19 status was not known prior to entering the service.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The premises were not hygienic. For example, bathrooms were unclean. Quality assurance audits relating to infection control were not robust. Where concerns had been identified in these audits' actions had not been taken. For example, on the 'daily walkaround' audit, on 11 and 12 December 2021, for two consecutive days the bin area was recorded as being 'very untidy' however, no action was recorded as having been taken in response.

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 accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Following the inspection, the provider told us they had taken action to improve the cleanliness within the service. They shared the new daily audits they had implemented to ensure their visitor's policy and procedure was followed and PPE was safely and appropriately disposed of.

Learning lessons when things go wrong
● The provider has a history of not achieving the required standards. This was the third consecutive inspection where a rating of good has not been achieved in safe and well-led.
● The provider had not made improvements following our last inspection, there continued to be a lack of analysis of documents to improve the recording made by staff or to identify any learning needed. We found records continued to have missing information. This meant people were still at risk of not being supported in line with their care plans and risk assessments and as a result, having increased anxiety and behaviours that challenged themselves or others.
● When things went wrong there was no evidence action had been taken or lessons learnt. For example, the

accidents and incident forms reviewed during the inspection did not evidence what investigation and action had been taken.

● Systems in place to promote staff learning and development were ineffective. Improvements were not clearly identified. Staff recording of incidents remained consistently poor. Although the nominated individual recognised significant improvements within the service were needed, plans that had been put in place following the last inspection had not brought about any significant improvements.

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 inadequate. At this inspection this key question has remained the same. 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 regulations.

● At our last inspection the quality assurance systems to assess and monitor the service were not always in place, and where they were, they were not effective. At this inspection we found improvements had not been made.
● The provider's oversight and governance of the service was ineffective in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe section of this report. One relative told us via e-mail, "They do not have effective governance and systems to check safety, quality of care in order to avoid neglect or abuse to its' Service Users." Another relative told us, "It hasn't been good of late, I have been through this process before, it was all down to lack of management, poor quality of management, I don't think COVID helped."
● Systems and processes to monitor the service were not robust. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Concerns were found with regards to infection control, medicines, safeguarding, staffing levels, risks, accidents and incidents, the premises, person-centred care, failure to report and quality assurance. One staff member told us, "It's not organised, it is frustrating it's not organised. No one is supervising / checking things are done."
● The provider failed to follow their own governance policy to ensure quality and safety. Some audits were carried out, but these were not done in line with their policy because they were not completed consistently or effectively. When medicines audits had been completed; they did not drive improvement. For example, gaps on MARs had not been identified and no action was taken, multiple gaps were identified during our inspection.
● The provider failed to ensure records were accurate and up to date. For example, we saw care planning documentation contained out of date information which was meant staff did not have easily accessible current information about people. In addition, records relating to the management of the home were incomplete. These included cleaning schedules, fire monitoring records and medicine storage temperature

records.
● Documentation was not always available throughout the inspection. The nominated individual told us he couldn't access some things as the manager wasn't in. On a different day the manager told us that they could not access some documents due to the nominated individual not being in. We requested this information on several occasions. Although we received some documentation, we did not receive everything we had requested. We could not be assured these documents were available. For example, evidence of people's access to healthcare professionals, including but not limited to GP, dental and opticians records, night observation checks and some financial records.
● The local authority and safeguarding team told us the provider does not always provide documentation they have requested. A relative told us, "They are very slow getting back to me, I have asked for weight charts and eating plans, several times, I still have not received them" and, "Activity plan, I have asked for it from his keyworker, he is not very proactive, I should have had that activity plan by now."
● Another relative told us they had asked for records relating to their family member; however, they were provided with documentation relating to other people. This meant that confidential records were not always managed securely. The relative was concerned the provider was unaware of the importance to comply with regulations and protect those in their care.

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

At the last inspection the provider failed to notify the Care Quality Commission of significant events. This was a breach of the regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● 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. At the last inspection the provider had failed to notify CQC of significant events and the nominated individual told us they would ensure notifications would be sent in as required.
● At this inspection we found the provider had continued to not notify CQC of significant events that happened in the service as required by law. This included, over medication, allegations of sexual abuse and a threat to life made about a person living at Milton House. We spoke to the nominated individual about this who told us the manager had been away from the service. The lack of reporting had not been picked up by the provider. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents.

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

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

At the last inspection the provider failed to provide people with person centred care. This was a breach of regulation 9 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

regulations.

● The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not person-centred and the poor leadership by the provider did not ensure people led empowered lives. One relative told us, "They don't see them [people] as human beings, the [people] are being dehumanised and are unsafe."
● People continued to 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 on in more detail in the safe domain of the report.
● While the building blended in with the local community; the lack of effective quality audits had meant the support provided was at risk of becoming a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support.
● There was a lack of leadership within the service. At the last inspection this had been a concern and the nominated individual told us they would be based at the service and taking over the management responsibility until a new manager was established. At this inspection, a manager had been in post since July 2021. The nominated individual told us they were spending one and a half days a week at the service. However, improvements had not been made.
● There continued to be 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 opportunities to discuss their individual care needs or wider issues in the home.
● One relative told us there was a lack of activities for their family member. Another relative told us they were concerned one to one support was not always effective. We observed people were not always supported to make meaningful choices or offered opportunities for engagement. For example, we observed one person waiting to go out for a drive. We observed them becoming increasingly agitated whilst waiting for an opportunity to go out. However, they were not offered any other activities, and had very little engagement from staff, whilst they waited for almost two hours to go out.
● People were not always supported in an open, inclusive and empowering way. On the first day of inspection, we observed one person come out of their bedroom, they approached a member of staff making a humming sound and leaned their head towards the staff member, the staff member pointed to the person's bedroom and said, "What are you doing that for, go to your room." On the fourth day of inspection we observed a staff member saying to a person, "If you say food one more time, you'll go to your room." This meant people were not being treated as adults and were not responded to in line with their care plans.
● People had care plans in place. However, these were not always written in a way that was person-centred and easy to understand. Some of the care plans were not clear and were not always accessible for staff to understand how people wanted to be supported. For example, for one person, in the section called 'what actions are you going to take', the care plan stated, "Staff to try to support me to their best of abilities to meet my required expectations." Another example, in one person's positive behavioural support (PBS) plan, the support plan stated, "Hypothesised function – escape. Negative reinforcement via removal of aversive stimulus in the form of perceived criticism." This was not clear and easily understandable for staff. The nominated individual told us they were aware of the concerns with the PBS plans and were taking action to make them more accessible.

The failure to provide people with person-centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection the provider failed to act in an open and transparent way. This was a breach of regulation 20 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 regulations.

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. At the last inspection we found this had not always been followed and concerns were not always reported to the local authority. At this inspection these concerns remained. We've reported on this in more detail in the safe domain of this report.
● A relative told us in an e-mail, "They are not open and transparent with parents and I believe are not always open and transparent with other outside authorities. They often fail to communicate when something goes wrong. Incidents often go unreported."

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

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

At the last inspection the provider had failed to seek and act on feedback from relevant person and other persons on the services provided. 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 regulations.

● At the last inspection we found people, staff and relatives were not always engaged and involved, and feedback was not always followed up on. At this inspection we found the same concerns remained. Relatives continued to tell us communication was not always effective, and they were not always kept fully informed.
● There was a lack of systems in place to evidence people were supported to express and review 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.
● We did not see evidence for one person their culture needs had been considered. There was no description of their cultural needs within their care plan. When asked if this person had any cultural needs, a staff member told us, "Not that I know of, not that I have read in their care plans or anything."
● Staff told us they did not always feel valued or listened to. One staff member told us, "When you are saying things to people above and not being listened to, I don't know what I'm doing wrong. I raise things and not listened to."
● Systems and processes were not in place to ensure staff had access to appropriate support, supervision and appraisal.
● The provider had failed to recognise or investigate incidents to prevent reoccurrences and failed to communicate to professionals and families when incidents had occurred.
● Professionals told us the provider did not always work in partnership with them. For example, the provider did not always respond to their e-mails and failed to provide documentation when it was requested.
● The provider had not sought feedback from people and their relatives. We spoke to the nominated individual about this and they told us they were planning to do this.

● Staff questionnaires had been sent out to staff. However, there was no evidence these had been reviewed and acted upon or fed back to staff.

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

At the last inspection the provider failed display ratings on the providers website. This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 20A.

● The provider has a legal requirement to clearly display their most recent CQC rating. On the first day of inspection we observed the provider was not clearly displaying their rating at the service. We spoke to the nominated individual about this who told us it must have fallen down. On the second day of inspection the ratings were still not on display. However, we observed the ratings were on display on our site visit on 7 January 2022.
● At the last inspection the provider had failed to display the ratings on their website. At this inspection we saw the ratings were displayed on their website.