

Four Seasons (Bamford) Limited

# Milverton Gate Care Home

## Inspection report

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Date of inspection visit:  
21 November 2017

Date of publication:  
19 March 2018

## 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 

# Summary of findings

## Overall summary

This inspection took place on 21 November 2017 and was unannounced. Milverton Gate 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. Milverton Gate Care Home provides both personal and nursing care across a two storey building and accommodates a maximum of 39 older people. On the day of our inspection 26 people lived at the home, several people lived with dementia and other people had high level nursing needs.

When we inspected the home in October 2015 we found there were four breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. These breaches were in relation to: the safe care and treatment people received, ineffective medicine management, people's nutritional needs not being met, and insufficient quality monitoring of the service. There were also not enough suitably qualified, experienced staff to meet people's care and treatment needs.

At the following inspection on 1 March 2016, sufficient improvement had been taken in response to the breaches in regulations but there were still areas which needed further improvement.

At the last inspection on 4 April 2017 we found previous improvements had not been sustained. The provider was again in breach of the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take the necessary action to improve. This included improvements to staffing arrangements, the notification of specific incidents (such as incidents that impacted on people's safety) and improvements to the management of the home.

Although the provider had an action plan in place to address these areas, when we carried out this inspection on 21 November 2017, we found action taken had not been effective in making and sustaining the required improvements. The breaches in the regulations from the previous inspection in April 2017 continued. In addition there was a breach of the Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is "inadequate" and the service is therefore 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.

There has been no registered manager at the home for since February 2017. 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.

Milverton Gate care home has had different interim managers supporting the home in the last 12 months. There had been changes in the provider's regional managers supporting the home. This had resulted in inconsistent managerial oversight of the home which staff told us they found challenging. When we carried out this inspection, a new manager was in post and had been working at the home for one week. People and staff were still getting to know the new manager and new regional manager but initial feedback from people was positive.

People and their relatives told us staff were not always available when people needed them and we found this to be the case. Throughout the day we saw some people received delayed care because staffing arrangements were not sufficient and effective. At mealtimes, there were not enough staff available to support people with their meals in a timely manner.

The provider had not ensured people received consistent safe care and treatment. We found serious risks associated with people's care had not always been identified by the provider and staff. This placed people at risk of ill health. Records available did not always show how risks, such as those related to skin damage, were to be managed or stated how they had been managed.

Quality monitoring systems to assess, monitor and mitigate risks were either not in place or were not effective. Some serious incidents and accidents had not been investigated thoroughly, or reported to us and the local authority as required, to make sure health and safety risks to people were managed. There were some risks associated with the environment such as exposed hot pipes and a hot food trolley which had not been identified during audit checks of the home. This meant the risk of burns to people had not been assessed so they could be prevented.

Some people and their relatives were not aware of meetings they could attend to discuss the home. They were also not aware of questionnaires they could complete to offer their opinions of the home. There was a complaints procedure on display stating how people could raise a concern. There had not been any recent complaints received at the home.

Staff completed training to update their skills and knowledge but new staff had not consistently completed the induction training planned. Supervision meetings had not taken place since the last inspection to support staff in their role.

Staff lacked an understanding of the Mental Capacity Act despite having completed training on this. People were not always asked for their consent before care was provided. The requirements of the Deprivation of Liberty Safeguards (DoLS) were not met as people had not been referred to the appropriate authority for an

assessment when they thought the person's freedom was restricted. There was no effective process to determine people's capacity where decisions needed to be made in people's best interest.

Medicines were not always managed effectively to ensure people received them as prescribed. The new manager had recently implemented regular checks of medicines to make sure this was safe.

Arrangements were in place to ensure people could access healthcare professionals. Staff made contact with the GP when necessary to ensure referrals for dieticians, the speech and language team, and other healthcare professionals could be made.

People looked well presented with clean clothes to maintain their dignity. Staff knew about practices they should follow to respect people's privacy and dignity. Most staff interactions were kind and caring but we saw they had limited time to engage with people and did not always have time to sit and talk with them. Some social activities were provided at the home but these were not always in accordance with people's interests and hobbies.

The provider had taken immediate steps to ensure a new manager was recruited when the previous manager left. The provider had increased the number of quality checks at the home. We found some actions in response to improvements needed were still to be implemented. The provider's management team were at the home on the day of our visit. They were open and honest regarding areas needing improvement and felt the actions they had planned would address these.

Shortly after this inspection visit, the provider sent us an action plan outlining the actions they were taking to address some of the issues we highlighted and they stated they would keep us updated about improvements made. The provider told us they had carried out a further review of staffing arrangements to ensure these were sufficient and stated they would not be accepting further people into the home until they had improved.

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.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate** ●

The service was not safe.

People, staff and relatives told us there were not always enough staff available when people needed them. People did not always receive safe care and treatment that met their individual needs and ensured their safety and welfare. Medicines were not managed safely or consistently. Staff understood their responsibilities to report any potential abuse. A safe recruitment system was in place. We identified some concerns in relation to the safety of people's living environment.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Permanent staff had received some training to deliver effective care, however staff did not feel this was always sufficient to support their learning. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but these were not being followed. Risks associated with people's nutrition were not always managed effectively. People had access to a range of healthcare professionals to support their needs.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

People did not consistently receive personal care that met their individual needs. People were positive about the staff and we saw staff were caring in their approach but care was mostly task focused.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

Staff knew about the needs of people who lived at the home and did their best to meet them. However, staff had limited time to respond well to people's individual needs and ensure they received care and support in the way they preferred. There were

limited daily activities to support people's interests and hobbies. People knew how to raise a complaint if they needed to.

**Is the service well-led?**

The service was not well led.

There was a history of non-compliance with regulations at this service and there had been numerous management changes at the home resulting in an inconsistent managerial oversight. There were quality monitoring systems in place but these had not been effective in driving improvement in the home and outcomes for some people remained poor. Some statutory notifications about notifiable incidents had not been submitted.

**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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve across all key questions, Safe, Effective, Caring, Responsive and Well Led. This inspection took place on 21 November 2017 and was unannounced. We found actions proposed and taken had not been effective in making the necessary improvement.

The inspection was undertaken by two inspectors, a specialist nursing advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection visit we 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.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We found some aspects of the service had changed since it had been submitted in March 2017 so did not consistently reflect our findings.

During our visit we spoke with four people who lived at the home, three relatives and one family friend, plus nine members of staff. This included day and night nurses/care staff. We spoke with a visiting healthcare professional, the new manager, the regional manager, a member of the resident experience team (RET) manager, and a manager from another of the provider's homes.

We spoke with commissioners of the service who regularly monitored the home. They had identified some of the issues we found during our inspection visit. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We observed care and support provided in communal areas on both floors and we saw how people were supported to eat and drink. We looked at a range of records about people's care including four care files, daily records for personal care, food and drink charts and medicine administration records (MARS).

We also looked at three staff files, staff training records, staff duty rotas and quality monitoring information. This included health and safety records, audit checks and staff meeting notes.



# Is the service safe?

## Our findings

In April 2017 the key question of 'safe' was rated as 'requires improvement'. We had identified there were insufficient numbers of staff to support people's needs, people did not receive consistent safe care and the correct procedures had not been followed in response to safeguarding incidents. Although the provider had told us in an action plan how they would improve, we found actions had not consistently been completed and improvements had not always been sustained. This has resulted in an 'inadequate' rating for the safe key question.

Arrangements were not in place to ensure people remained safe. For example, when we arrived, we walked around the home and saw people did not have call bells that were accessible to them. Call bell leads were either behind people's beds or resting on the floor out of their reach. This meant people could not alert staff when they needed them. Staff told us these people would have been able to use their call bells had they been in reach. During the morning one person, who had a visual impairment, called out for help as they could not locate their call bell and we had to intervene to locate a staff member to assist them.

The provider had not taken sufficient steps to ensure people lived in a safe and clean environment. There was an unpleasant odour in a number of areas within the home and carpets in the lounge were stained. The provider's management team told us there were plans in place to refurbish the lounge, including replacement of the carpet to address these issues. It was of serious concern that we saw there were exposed hot water pipes in communal toilets being used by people who lived at the home that had not been covered. These presented a risk of burn injuries to people should they fall against them. We raised this with the manager who made arrangements following our visit for these to be covered.

We checked staff's understanding of safeguarding people. Staff told us they were not aware of the provider's whistleblowing policy but understood their responsibilities to safeguard people from the risk of harm or abuse. They knew to report any concerns they identified to their manager. However, during our inspection we found safeguarding concerns had not been effectively managed to keep people safe. For example, we found accidents and incidents were not always investigated and reported to us as required. In one case there had been a serious allegation made against a staff member at the home (prior to the new manager starting). This had not been reported to the relevant authorities and initial checks by the previous manager had not been concluded to ensure people were safe. The manager said they would make a safeguarding referral to the local authority and would take action to address this new concern as well as others we had identified. We have subsequently been told of action taken to manage the risks we had identified and have received the appropriate notifications.

The provider had some processes to identify risks to people and maintain their safety, however, we found these were not consistently effective. For example, a care staff member told us that a person had a wound on their foot. We spoke with a nurse who worked at the home and they told us they were not aware of this wound. On checking, the nurse identified a pressure wound they considered to be a grade 4. This level of wound occurs when skin is severely damaged. As the nurse was not aware of this, there was no treatment plan, no wound care plan and no photographs for monitoring purposes. When we checked this person's file,

we saw a "body map" showing a wound on the person's foot dated 10 November 2017 (11 days prior to our visit). However, this had not resulted in any action being taken to ensure the wound was managed. Positional change charts for this person contained conflicting information, for example, on one record dated 12 November 2017 it stated "no risk issues observed" but on the same record also stated "sore heel". Further entries after this date described the person's skin as being "intact" when it was unlikely this was the case. We therefore could not be confident that records maintained were accurate and could be relied upon to confirm people's health and safety. Action was taken following the identification of this wound at the inspection visit, to seek health professional support and advice to ensure the wound was managed. We found risks associated with people's nutrition were not effectively managed. One person had been admitted to hospital on two occasions following incidents where they had not received their food and drinks in accordance with advice given by the speech and language therapist. On one occasion a visitor had given the person water without their prescribed thickener, the visitor had stated to the manager they did not know about the need for the person's drinks to be thickened. As the person had consumed drinks without their thickening agent added, this had placed them at risk of choking and ill health. Arrangements to manage the risk of the person choking had not been effective. Following our visit we were made aware of a third incident of a similar nature involving this person where they were placed at risk of choking.

On the day of our visit, a relative told us they sometimes assisted their family member to eat and they were on a 'fork mashable diet'. We established they were not fully clear on what range of foods their relative could eat because this had not been clearly communicated to them. When we checked this person's food and fluid charts, they did not indicate the meals provided had been prepared as required, although the cook told us this was being done.

We looked to see if people received their medicines as prescribed. We found most medicines were administered, stored and disposed of correctly and most people told us they received their medicines on time. However, there were some handwritten changes made to prescribing instructions by staff such as adding the word "PRN" (as required) which was not how it had been prescribed. Staff are not authorised to make changes to prescribing instructions and it was not evident the changes made had been on the instruction of a GP. One person had been prescribed a cream to be applied "two to three times a day". The "to three" had been crossed out by hand, it was not evident this was in response to any instruction by the GP. The application record used by care staff to record when cream was applied showed this was not applied to the prescribed frequency.

This was a breach of Regulation 12(1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and relatives gave differing views of their experiences of staffing arrangements at the home and whether staff were available at the times people needed them. One person told us, "They are very considerate and always available." Another told us, "When I use my call bell they come very quickly." However, a relative told us, "There's only two carers up and down (stairs). They are always busy with somebody, they are never free. There is never enough staff when I come." They went on to tell us they would be helping their relation with some of their personal care because staff had not been able to complete it fully that morning. Another relative told us, "Before the last inspection carers never spoke to anyone. Now they do but there's still not enough staff, where are they? It's always the same when I come. I've been here 40 minutes and no-one has come in to the lounge to talk to residents. They need to stimulate them."

Prior to this inspection visit, we had carried out inspections in October 2015, March 2016 and April 2017 at Milverton Gate Care Home. At our October 2015 inspection, we found there were not enough suitably

qualified, skilled and experienced staff to meet people's needs and the provider was using high numbers of agency staff. In April 2016 the use of agency staff had reduced and more nurses and care staff recruited but agency staff usage had increased again when we visited in April 2017. This was because several permanent staff members had left their employment at the home. During this inspection on 21 November 2017, most of the staff working in the home were permanent staff. There were some agency staff working at the home but there was a focus on regular staff covering shifts where possible. This was to provide consistency of care as they were more familiar with people's needs and how to support them.

The manager told us there were three care staff on duty at night with the nurse but staff told us this was not enough. Staff told us they could not provide safe care at night because when the nurse undertook their specific duties it left three of them covering two floors. Many of the people who lived at the home required two staff to attend to them each time they needed support. This left just one member of staff available. They told us that one member of staff on their own could not support people with high dependency needs without compromising the person's and their safety. For example, moving people usually required two staff. One staff member told us, "They teach us to do it one way (two staff) but don't provide the staff needed."

We found during this inspection that staffing arrangements continued to be ineffective as people's needs were not being met consistently. For example, we saw people did not always receive person centred care. On the day of our visit most people were left in bed almost until lunchtime because staff were busy completing other duties including personal care to support people's needs. People told us they wanted to be up but had to wait. We only saw three people up during the morning. A staff member told us, "It's not really their choice (time to get up). If residents are wet or at risk of pressure sores, we get them up. We start getting residents up at about 5.30am. We have to start then because we've got to get people up. We wash and dress them in their day clothes and leave them in bed." They went on to say they did not dress people's "bottom half" because it was easier for the day staff to attend to people's personal care. The staff member told us, "I know it's not right but what can we do? I have raised it so many times." Staffing arrangements were discussed with the manager with a view to these issues being addressed.

A relative told us there were problems with staff being available in the afternoon and evening to support their relative's wishes to return to bed. They told us, "[Person's] care is lovely, I can't fault it, only they need more staff at bedtime. [Person] wants to go to bed after lunch, they keep saying 'in a minute, in a minute'. It's always 'in a minute.'"

We saw on one floor at 6.50pm all people in the home were in bed. When we asked staff why this was we were told, "They are only allowed to be out of bed for four hours. That's how it works here." The staff member told us they had been instructed to do this by management staff as opposed to this being in response to the needs of people.

We saw examples of staff not having sufficient time to deliver care planned. Staff told us that people at high risk of malnutrition were provided with a 'pudding' at 11am to help increase their calorific food intake. They told us six people on the first floor were to receive these. We saw none of these people received their puddings because staff told us they had run out of time completing other care duties to be able to do this. This increased the risk of people's nutritional needs not being met as they had not received the amount of calories they needed to maintain their health and wellbeing.

At lunchtime in the dining room located on the ground floor, we saw people were sat with meals and drinks in front of them and no staff were available to support them. For example, one person had to wait approximately 20 minutes to be supported to eat, by which time it was likely their food was cold. This was not reheated before it was given. On the first floor a person spent 25 minutes attempting to load food onto a

spoon. The person was finding it difficult but no staff were available to assist them. The person eventually put the spoon down. After 25 minutes when a staff member came to assist, it was likely this meal was also cold.

During the afternoon at about 6pm there were no staff available in the lounge and dining area. From a distance, we saw one person tried to walk in between a chair and the food trolley used to serve hot food. We saw the person put their hands on the trolley for support before we noticed that the trolley was plugged in. The trolley was extremely hot to touch. The lack of staff presence placed the person at risk of burns. We alerted a staff member to this and they supported the person into the lounge.

During the evening of our inspection we noted that an alarm connected to a piece of equipment was sounding in a person's bedroom for a long period of time. No staff were around to attend to this alarm to check all was well and this was subjecting the person and others nearby to the noise.

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

Following our inspection visit the provider took action to reassess people's needs using the provider's staffing dependency tool to make sure this had been used correctly to determine the staff numbers at the home. They sent us an action plan which stated that staffing levels had been reviewed and there had been an increase in the nurses available and management staff support at the home.

Despite the safety and staffing concerns we identified, people spoken with who were able to communicate verbally told us they felt safe living at Milverton Gate Care Home. One person told us, "Quite safe, never felt frightened. The staff make me feel safe. They come and check on you to make sure you are alright." Another told us, "Yes I do (feel safe), the staff are as good as gold and they help me feel safe here".

The provider had personal evacuation plans to show how people should be supported to evacuate the building in the event of an emergency. Plans were reflective of people's assessed needs and were up to date.

People were protected by the provider's recruitment practices which minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. We reviewed three staff files and saw prior to staff working at the service, the provider carried out a range of checks to confirm their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for DBS checks and references to come through before they started working in the home.

The provider had systems to promote good hygiene and help prevent the spread of infections. Despite the carpets being stained and there being an unpleasant odour in areas of the home, staff knew to follow good infection control practice. This included wearing gloves and aprons when completing their duties and carrying clinical waste in sealed bags. We saw light pulls had a plastic coating for ease of cleaning and there were hand wash signs displayed in toilets, bathrooms and the staff room. Staff told us, "You must always wash your hands. If not you could risk passing on germs" and "I change my gloves once I have done personal care with a resident and get a new set." This demonstrated staff had understood their learning around infection control and what was expected of them.

During our review of medicines we saw one person was on regular pain relief medicine due to pain they experienced pain from a health condition. When we checked their records we saw, there was a pain

assessment tool used to assess the right level of pain relief was provided to manage this. The new manager told us when they had started working at the home they had undertaken their own detailed audit of medicines. They had identified areas needing improvement and had been working with staff to make these improvements. They told us following our inspection visit that both daily and weekly checks were being undertaken of medicine's to ensure any concerns were promptly identified and addressed.

## Is the service effective?

### Our findings

In April 2017 the key question of 'effective' was rated as 'requires improvement'. We found during this visit, there remained areas which required improvement.

People told us they were offered a choice of meals and liked the food provided. However, there were mixed comments about this always being sufficient and suitable for their needs. One person told us they had a choice of three or four meals which they thought was good. They told us they received support to eat when they needed it, and the support was never rushed. They did however say they only received drinks at meal times. Other people told us, "The food is nice, you don't get enough of it, its kid's meals...they never offer more, I don't ask" and "You can have a drink every couple of hours. A trolley comes round. No snacks are offered. It comes two or three times a day."

On the day of our visit the meals provided looked appetising. Drinks were provided to people but they were not always accessible to people within their rooms as they had been placed out of their reach. Staff were rushed during the mealtime and they were hindered by the fact the lift was not working. This meant staff needed to walk up and down the stairs to deliver food to people. We did not see additional staff were made available over the lunchtime period to assist. When staff were in a position to support people, meals provided were likely to have been cold. When people refused meals they were offered a sandwich but there was not always encouragement or support for people to have something different that they might like.

Where people had been identified at risk of malnutrition or required special diets to maintain their health and wellbeing, we saw appropriate referrals to health professionals had been made. This was so an assessment of their needs could be undertaken. The cook told us they had information about people's dietary needs so they could ensure food was prepared appropriately.

Staff told us of people who had lost weight. We asked the manager for documentation to show people's weight was regularly monitored to make sure they received sufficient food to maintain their health. The manager told us this information had not been recorded on their system and was not available. We therefore could not check staff had effectively responded to any weight loss. We were told about three people where it had been advised by the dietician, they had high calorie milkshakes each day. Records available did not confirm that they received these consistently as prescribed. For example one person was to have them twice a day but records did not confirm this. Some staff said they were provided. Fluid records of those people at risk of dehydration had not been regularly checked to make sure people had consumed enough in line with the daily recommended amount.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People gave mixed responses when we asked them if staff asked their consent before providing care. One person told us, "They always ask me first before doing anything." Another stated, "They come and ask me first before doing things." However, one person told us, "They come in, don't ask, they do what's needed....I don't ask to get up, they get me up in the hoist."

Staff told us they had completed MCA and DoLS training and understood the importance of obtaining people's consent. One staff member told us, "If they (people) refuse then you leave and try again later. If they still refuse we would tell the nurse, but we know it's their decision." Another told us "You ask before you do anything. It's important." However, in practice we saw this did not always happen. We saw two people sat in specialist chairs in the lounge were approached by staff from behind and wheeled backwards to the dining room. The staff member did not engage with the people to ask if they wanted to move to eat their meal in the dining room.

Some people said they did not feel restricted in relation to what they wanted to do, for example, one person told us, "I don't feel restricted, I can go out anytime I want. I went out the other day in my wheelchair with staff." However, staff told us about one person who had been subjected to restrictions in relation to their care. The person received their nutrition through a percutaneous endoscopic gastrostomy (PEG) tube and had told staff they did not wish to receive their nutrition this way. A PEG tube provides nutrition for people who are having trouble swallowing. Advice provided by a dietician had not been followed and the person had continued to receive all nutrition through the tube against their wishes. As a result, they had lost weight. Since the new manager had been in post, this had been addressed. Staff told us the person now was assisted with a pureed diet. A visiting dietician told us the person was making positive progress and they noted the person sitting out of bed in a chair which was a sign of improved wellbeing.

An assessment of those people who may need a DoLS referral had not been undertaken. There were people in the home who lacked mental capacity and were subject to continuous supervision and control who were not safe to leave the home independently. This meant there may be people subject to restrictions that had not been authorised. The manager told us this was something they planned to address.

People and their relatives told us they felt staff were sufficiently trained to provide care and support to people. One person told us, "As far as I'm concerned, they are all experienced and know what they are doing". Another told us, "I'm very happy with them all (staff), very skilful."

Staff told us they had an induction when they first started working at Milverton Gate Care Home which included completing training the provider considered essential. Staff said they worked alongside a more experienced staff member before they worked unsupervised. One staff member told us, "My induction was good. It was good to spend time getting to know the residents and learning what I need to do for them." However, there were other staff that told us their induction was not effective because it did not provide them with the information they needed to undertake their role safely. One staff member who had worked at the home for a number of months described their induction as "Okay but not as it's supposed to be". They told us, "No-one showed me where the emergency exits were or how to press the emergency alarm (call bell in people's room)." They added they knew how to do this now.

Staff spoken with told us they had not completed the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. This training should be



completed within the first twelve weeks of a staff member starting work. One member of staff told us, "I am supposed to be doing it but I have not started yet." Another said, "I submitted some work but I haven't had any feedback yet. Nothing at all, so I can't carry on." A home manager from one of the provider's other homes, who was present at the inspection, told us all new staff were expected to complete the Care Certificate. They said, "Each staff member should be allocated a care coach so they can progress through the certificate." The provider's training record confirmed new staff had been assigned the Care Certificate training but this had not been progressed or completed. For example, this training had not been completed by 12 staff between February 2016 and November 2017.

Staff told us they did not always find the training they were provided with supported their learning. One staff member told us, "The problem is the training is not face to face, it's just on-line (computer based). Sometimes it's not easy to understand on-line. If it was face to face you could ask questions." Another staff member told us, "Some of the training is good." One staff member told us they found it difficult to find the time to complete the required training and another told us they had not done any training since their induction training which had been several months ago.

The manager was open and transparent regarding staff training and acknowledged that some staff had not completed all of the training expected of them. They stated these staff had been sent letters advising them that outstanding training must be completed.

Staff did not feel supported in their roles. All the staff spoken with told us they had not had supervision meetings with their manager or an annual appraisal of their work. Staff records confirmed formal staff supervisions, appraisals and observations of practice had not taken place since the last inspection. This meant staff were not given opportunities to talk about their role, raise any concerns they had, or discuss their training and developmental needs to help guide them with their work. Staff comments included, "No, not had one of those (supervision)," "Supervisions don't happen" and, "I don't think I have ever had one (supervision). No one has observed me." The manager was aware this needed to be addressed and stated plans would be put in place to address this.

People had their own personal effects in their rooms to make them more homely and had access to equipment such as specialist beds and chairs to support their needs. There were hoists available to assist those people who needed support to move and there were suitable signs around the home to assist people to find their way around, including locating their rooms. A lift was available to support people to access the first floor and people were able to access the garden if staff or family were available to support them. One person told us they had been into the garden and it was "very nice". A relative told us their family member had not been taken into the garden.

People had access to healthcare services and arrangements were made for people to see healthcare professionals when required. This included a GP, Tissue Viability Service (wound care), speech and language therapists, dieticians, chiropodists and opticians. One person told us, "I see my own doctor, they arrange it. He just came to visit me." Another told us, "The doctor comes regularly, if you need him you just have to ask.... I have new glasses, I have no teeth, I tried dentures but I don't want them."



## Is the service caring?

### Our findings

In April 2017 the key question of 'Caring' was rated as 'requires improvement'. We found during this visit, there remained areas which required improvement.

People were complimentary of individual staff members. One person told us, "They are friendly and very helpful." Another told us, "They are beautiful, great staff." Some people and relatives we spoke with during our visit were positive about the care provided. One relative told us, "The staff are very good, they chat with [Person] when they have time. [Staff member] bought them fish and chips from outside... If anything worries [Person], they will get to the bottom of it. They do a really good job." However, a second relative told us, "[Person's] care is based on their basic needs, I think they don't appear to have the time for anything else."

During the morning staff had a handover meeting in the 'resident' lounge. A person sat in the lounge was asked to go to their room so staff could maintain confidentiality when handing over information about people to the next shift of staff. Whilst this demonstrated staff understood the need to maintain confidentiality, the arrangement did not take account that this was the person's home and there should have been arrangements for staff to use a more private staff area.

People spoke to us about some of the daily personal care tasks they could do for themselves to help maintain their independence and wellbeing. Staff told us how they aimed to support people's independence. For example, one staff member told us, "Even if it's just washing their own face we encourage it. Another told us, "Most of them can do something for themselves. We do try and encourage, but we don't always have the time." However, during our visit we saw that people were not always encouraged to be independent. Staff were focused on the completion of tasks and did not have opportunities to engage with people or to spend time with people. Staff were rushed and moved from completing one task to the next. For example, staff were still assisting people with their morning personal care at 12.15pm. Staff then started to support people to prepare for lunch.

People told us they felt their privacy and dignity needs were met and had no concerns around this when we spoke with them. One person told us, "They keep me clean, respectful, I'd say." A relative told us staff were, "very respectful" and spoke to their family member in a "very kind way". Another told us, "They are very good when washing [Person], I always leave the room". Staff understood to protect people's their privacy and dignity when supporting them. One staff member told us, "We make sure we close the curtains and bedroom doors when we help people have a wash." Another told us, "If someone needs assistance with personal care we cover them with a towel." However, staff told us they did not always have access to equipment they needed to support people such as nail clippers and wipes to maintain people's dignity.

Whilst sitting in a room near to the laundry we heard an exceptionally loud knocking noise of the washing machine spinning. There were a number of people's rooms located by the laundry meaning people were subject to this ongoing noise. We advised the manager of this during our inspection as it was clear people may have a disrupted sleep, particularly as staff told us laundry duties were completed at night. The manager told us they would address this.

Staff told us they were committed to ensuring people's needs were met and they were looked after well but said the provider's staffing arrangements meant they didn't have time to "chat" with people. One staff member told us they were only able to speak with people when they were supporting them with meals. Another told us, "We do our very best. We do care but we don't have time."

## Is the service responsive?

### Our findings

In April 2017 the key question of 'Responsive' was rated as 'requires improvement'. We found during this visit, there remained areas which required improvement.

People continued to receive limited support with their social care needs. One person told us, "No choices during the day really, I just stay here (in their room)." A relative told us, "I haven't seen any activities here. [Person] hasn't been out in the garden at all." Another relative told us, "[Person] doesn't have any hobbies here. They could stimulate them and do things with them."

The manager told us when people came to the home they completed a "My Choices" form with support from the activities organiser and any family members as appropriate. This was to obtain information about the person's interests, family, occupations and family history so that this information could be used to support their social care needs. We were told that they aimed to plan activities based on people's interests and tried to focus them on what they would like to do. However, when we looked at care files, this information was not available or was not sufficiently detailed.

People told us some activities were provided at the home. One said, "There are some activities, I hear of them. There's a man who comes several times, he sings, I enjoy it. There's been nothing else." Another told us, "I'm a football fan, I just watch TV. The routine here seems adequate, I'm happy with it." A person who was partially sighted told us talking books were made available to them every two weeks. They also told us staff made them aware if there was a singing activity in the lounge and supported them to attend.

There were two activity co-ordinators at Milverton Gates Care Home, but when we visited, the level of activities provided did not support people's social care needs. There were some people who spent long periods of time in bed with little or no interaction with people or staff other than when staff supported them with care. As people's interests and hobbies had not been being fully assessed and recognised, people did not routinely experience activities of their choice that they enjoyed and found stimulating.

Staff confirmed to us they did not have time to engage with people apart from when providing personal care. They added that they did not feel the activity workers created many opportunities for people and told us that people mostly sat watching the television or listened to music. One staff member told us, "I've never seen them (people) go out unless it's with their family." A second staff member told us, "Not a lot of things to do. We don't get time at all." We stayed in one of the communal lounges for one hour. During this time, two people who were unable to move independently were sat directly in front of the television. The television was tuned to a radio station so the screen was static displaying the radio logo. There was no staff presence or engagement with these people, the exception being, when the nurse passed through the lounge who stopped to say 'hello' to both people. We approached a staff member to ask why people were sat in front of a static television screen. The staff member replied, "I don't know. I will sort it." They then went into the lounge, turned the television on and left. There was no engagement with the two people in the lounge to determine if it was their wish to remain in the lounge, have the television on or to ask which channel or programme they would prefer to watch.

Some people spoke positively of the support they received in meeting their needs. One person told us, "I can wash and dress myself, I have a bath when I want, usually twice a week. They leave the door (of the bathroom) open to make sure I'm alright. Sometimes they leave me other times they stay by the door." Another told us, "I had a stroke, I can't get out, they get me up with a hoist, always two people do. They have never hurt me. I had a chest infection, they were worried about my breathing and called the paramedics."

We looked at people's care plans and most of these contained detailed information about how staff needed to support people's needs. For example, one person had a communication care plan that informed staff the person had impaired communication following a stroke. Staff were instructed to be patient and to give the person time to speak and use short sentences which assist in requiring yes or no answers. However, staff told us they did not have time to look at care plans to establish people's needs and check how people should be supported. One staff member told us, "Care plans are for nurses. We don't write in them." Another told us, "We don't have to read the care plans." Care staff told us they were dependent on information the nurses told them including information shared at handover meetings at the beginning of each shift to manage people's care. The manager told us they had identified staff did not read or record in care plans and this was going to be addressed.

People were not familiar with care plans but told us they were asked by staff about their care. People told us, "I don't know what a care plan is. Now and then they come and sit with me and have a chat about what's needed" and "A care person and my [relative] sat here and talked about what I needed. Not seen any records or a care plan." A third person told us, "They've never discussed my care with me, that's never happened." Relatives spoke of having some involvement in decisions about their family members. One relative told us, "My brother was called into a meeting a few weeks ago to talk about [Person's] care, it was alright."

We asked the manager how people's sexuality was recognised and supported. They were not aware of people's specific needs in regards to this but stated this would be addressed through the review of care plan documentation. We were told the home's brochure did not reflect the diverse culture of people the service could support. The manager stated this was something that needed to be addressed with the provider.

Following our inspection visit, the provider told us as a result of reviewing management support they expected people's experiences of their care and support would improve. They told us a lot of work had gone into the review of care plans and the 'Resident of the day' initiative. This was where one day each month one person and/or their representative would be spoken with, to see if they were receiving care in the way they wanted. Housekeeping, maintenance, kitchen, nursing and care staff were all involved in this process to ensure people's full needs were being correctly assessed and met. We were told care records would be changed to reflect any required or requested changes.

The provider had a complaints procedure on display that people could access if they wished to raise a concern. People spoken with told us they had never had a need to make a complaint and knew they could approach the manager or staff member if they needed. One person told us, "I've never made a complaint. I would ask for a form to fill in or see the manager." Another said "Never complained. I would see the nurse in charge." One person whose family member had made a complaint said it had not been responded to. They told us, "My [relative] deals with complaints. We only complained about missing clothes, nothing happened as a result." There was a file to record complaints when received. We saw there had been no recent complaints recorded in the file.

Arrangements were in place to support people when their health deteriorated and when they may be approaching the end of their life. Each person in the home had an end of life care plan on their file to be

completed with people if and when they felt comfortable to provide this information.

On the day of our inspection visit, there was a person with a serious health condition cared for in bed. Their care records confirmed staff had been in regular contact with outside agencies for advice especially the tissue viability team who provided advice to staff when people developed wounds or skin damage. The person had a sore caused by their health condition and there was a care plan in place to manage this. The person received regular pain relief and an assessment of their pain had been undertaken to ensure their pain relief was sufficient for them. We saw the person looked comfortable clean and well-groomed and was asleep. The person's charts, which included reposition charts and eating and drinking records were up to date. This showed that staff had responded to this person's needs to make sure they were kept comfortable and pain free as their health deteriorated.

## 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. At our inspection visit in October 2015 we found the home was not well led and the provider was in breach of the regulations; as a result the home was placed into special measures. At our inspection in April 2016 we found the home continued to require improvement but significant improvements had been made. At our inspection in April 2017 we found not all of the improvements made had been sustained and the provider was again in breach of the regulations. The manager that had been in post at the time of the inspection in April 2017 inspection had left their post at the home.

At this inspection, we found insufficient action had been taken to improve and the home was not well led resulting in an 'inadequate' rating. A new manager was in post and they had been there for one week. They were not registered with us. There had been no registered manager at the home since February 2017. The provider had failed to consistently provide, and ensure good governance. Outcomes for people who lived at the home remained poor in a number of areas.

The new manager was being supported by the provider's management team. They understood their responsibilities and requirement to submit the relevant statutory notifications to us in relation to information such as safeguarding and other incidents and events so that we were able to monitor the service people received. However, they or the provider had not identified that the serious incidents recorded on the provider's 'Datix' computer system prior to them coming into post had not been reported to us as required. The Datix system was used by the provider's management staff to record accidents and incidents that occurred in the home. Incidents not reported to us included a person making an allegation of physical harm. This had also not been referred to the local authority safeguarding team as required for them to determine the required actions including investigation. There had been an incident whereby a person had been taken to hospital as a result of their specialist dietary needs not being followed causing them to choke and placing them at risk of infection, and an incident whereby a person developed a wound to their foot that had not been identified during care delivery and hence not reported to us. Incident reporting was also an issue of concern identified at our previous inspection. This meant the provider's systems had not been effective in ensuring risks and notifiable incidents were identified, reported, and appropriately acted upon.

The lack of reporting notifiable incidents was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18 Notification of Other Incidents

We found the home was not consistently well-led. Since our last inspection, there had continued to be inconsistent leadership at the home. The manager that was in post at our last inspection in April 2017 had left and most staff spoken with told us they had not felt supported or listened to by the provider's management team. One staff member told us, "I feel supported by my colleagues but not the managers." Another said "I feel positive about [manager] coming back (they had previously worked at the home)."

There had been minimal management oversight to manage shifts effectively to ensure people's needs were

responded to, and potential incidents and accidents avoided. Arrangements to assess and monitor the quality and safety of people were not effective. There continued to be concerns regarding staffing arrangements at the home. People's needs were not consistently met safely, effectively and in accordance with their wishes. We were told staffing levels were calculated based on people's dependency needs. However, we saw people did not always experience positive outcomes and we therefore questioned the effectiveness of the staffing assessment tool.

Staff had not had regular supervision meetings with their manager where they could discuss how they felt, and as a result, didn't feel valued or listened to. The new manager told us, "My biggest challenge has been coming in to find things not done quite as they should have been. There is a lot to get through. I have asked for support from the management team." They told us of plans to address regular staff supervision meetings.

Some staff group meetings had taken place but these had not taken place regularly. Notes of a staff meeting in September 2017 showed staff had been told about areas where they needed to improve. However, there was limited information to show staff had been asked for their opinions of the service to demonstrate their involvement in decisions and to show their views were valued by the provider.

Quality monitoring systems to assess, monitor and mitigate risks were either not in place or were ineffective. Information that was available to the provider had not been properly analysed and monitored to ensure people received care and treatment that met their needs. This included systems and processes to monitor people's health. We identified risks related to people's nutrition and skin that were not safely managed. One person had a serious wound that nurses were not aware of. This had resulted in the wound not being sufficiently assessed and acted upon placing the person at risk of ill health. Detailed records of people's weights were not available from April 2017. This meant any concerns relating to people's weight, linked to their nutrition, could not be identified in order for appropriate action to be taken.

We found routine quality and safety checks were not sufficient. For example, people were left without accessible call bells during the morning. A hot trolley was left unattended for a short time but long enough for a person to touch it placing them at risk of burns. These had not been recognised at the time by staff to ensure they were swiftly acted upon.

Care records were not always effectively completed or read by staff to ensure people received good, consistent care. For example, records were not available to determine if people who lacked capacity had been fully assessed. Staff duty rotas were insufficiently clear for us to determine how many staff were on duty at any given time. For example, some staff names contained the letter (T) after them with no code to state what this meant. There was a box with the words "Need" written in it (to indicate staff were needed for that shift) but it was not always clear what staff, if any, had covered the shift.

The provider had forwarded satisfaction surveys to people and we were told there was a process to generate a report on the feedback people provided so that any actions needed could be carried out and communicated to people at 'resident' meetings. However, despite this being the expectation, management staff told us feedback had not been collated from surveys completed and no action had been taken in regards to managing any comments. They told us of plans for this to be completed.

Most people we spoke with told us they did not recall being asked to attend a 'resident' meeting or being asked to complete a quality survey so that they could offer their opinions of the home. One person told us, "They have resident meetings, they have never asked me to go... Never done a survey." Another told us, "Never heard of residents meetings or questionnaires." This meant people didn't always feel involved in

decisions regarding the running of the home.

Some relatives told us there were relative and resident meetings held at the home and they had received questionnaires to offer their opinions of the home, but others were not aware of these suggesting communication across the home may not be fully effective. One relative told us, "There was a relatives meeting, my [relative] went, not sure when. There's been loads of questionnaires, one two or three months ago." A second told us, "Don't know about any resident meetings."

When we asked relatives about their comments of the home, one told us, "They need to give the carers more help. They could give them (people) more attention and have a natter." A second relative told us, "The atmosphere could be better, based on when I come... They need to improve communication with residents and more stimulation." One person we spoke with stated they would score the home eight out of ten and told us, "I would like to be more active in my mind, but it's difficult." They told us this was because the social activity programme at the home did not provide sufficient opportunities for them to be socially and mentally stimulated.

The service worked with key organisations such as the local authority, GP's, dentists and other health professionals to support care provision. Sometimes this had not been effective. For example, we were told by one visiting health professional that their advice had not always been followed. This had resulted in a negative outcome for the person in regards to their nutritional support.

This was a breach of Regulation 17 Good Governance (HSCA 2008 (Regulated Activities) Regulations 2014.

Some people were positive in their comments of the home despite us identifying areas needing improvement. One person told us, "They make my relations welcome" and I can't think of anything specific to improve. I'm well looked after, good staff, well fed." Another told us, "I get what I want, they do what I need."

Some people and relatives were aware of the recent changes in the manager. One person told us, "I know the manager, she is very nice." A relative told us, "It's a brilliant atmosphere, there's a new manager, I haven't met her, started last Thursday." We looked at the provider's audits undertaken to check the quality and safety of the service people received. Audits included checks on the management of medicines, environment, health and safety issues and staff training. Although the new manager had only been at the home for around one week, they had completed an audit of medicines which had identified several areas which needed improvement and action was in progress to ensure they were addressed. The manager gave assurances there would be ongoing regular audits of medicines to make sure people received their medicines safely and as prescribed.

The provider's managing director and management team were open and transparent regarding the challenges the home faced. They told us following our inspection visit, a review of staffing arrangements had been undertaken. They said they were committed to making and sustaining the improvements needed and stated their management team, known as the "Resident Experience Team (RET)" would be visiting Milverton Gate care home to review a number of aspects with regards to the quality of care. They told us the RET would be providing management support to the new manager as required. The managing director told us of their commitment to ensure care staff and the nurses were appropriately supported to enable people's needs to be met safely and effectively. We were advised staff supervision meetings had recommenced to help reinforce to staff their responsibilities, what was expected of them, and to check any training and development they needed was addressed.



The new manager told us they were keen to move the service forward and make the required improvements. Action plans submitted to us following our inspection visit showed the provider was taking positive steps to address the concerns we found. However based on the history of the service we remain concerned that any improvements will not be sustained. The provider took the decision following our inspection visit to stop further placements of people at the home so they could focus on making the required improvements.