Care and Normalisation Limited

Milestone House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Milestone House is a residential care home for people living with learning disabilities and/or autism and physical disabilities. The care home accommodates 11 people in one adapted building.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
People continued to be at risk of harm as there was a lack of effective risk management of their care and the safety of the environment. Staff did not know how to evacuate safely in the event of a fire. Medicines continued to not be managed safely. People were at risk of serious harm from a lack of infection prevention and control in relation to Covid-19. Staff were not wearing masks, gloves and aprons in line with government guidelines.

People did not receive person centred care and care was not given in line with best practice guidance or regulation. 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. Staff had not had the induction, training and support required to ensure they were competent to keep people safe and meet their needs.

The provider had failed to make the improvements we identified in our September and November 2019 inspections and therefore people remained at risk of harm. The provider had failed to ensure there was effective management of the service. There was a lack of effective systems to ensure risk management and oversight of the quality of care people received. Incidents were not effectively reviewed and there was a lack of engagement with people, their loved ones and staff to ensure improvements were identified.

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 21 January 2020) 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 enough improvement had not been made and the provider continued to be in breach of regulations.

This service has been in Special Measures since 20 January 2020.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulations 9 (person centred care), 12 (safe care and treatment), 17 (good governance) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 found that all of the areas we inspected relating to previous breaches which had resulted in warning notices being served, continued to be in breach of regulation. This included breaches in relation to risk and medicines management, staffing, person centred care and monitoring and management of the quality of the service.

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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service remains 'Inadequate' and the service therefore remains in 'special measures'. We will continue to take action in line with our enforcement procedures. This means we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Milestone House

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Warning Notices in relation to Regulation 9 (Person centred care), Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by two inspectors and another inspector supported the inspection off-site by making phone calls to staff and commissioners.

Service and service type
Milestone 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager (who is also the provider) has been absent from the service since 23 March 2020 and has delegated responsibility to a manager on-site.

Notice of inspection
This inspection was announced on the day thirty minutes before we arrived. This was to check the status of the home in relation to the Covid-19 pandemic.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from two local authorities who commission the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this

information to plan our inspection.

During the inspection
We spoke with seven members of staff including the manager, shift leaders, care workers and the chef. We were unable to use the Short Observational Framework for Inspection (SOFI) due to social distancing restrictions during the COVID-19 pandemic. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records. We looked at three staff files in relation to staff recruitment. A variety of records relating to the management of the service, including fire and safety checks were reviewed. We requested various documents to be provided to us following the inspection to reduce the time spent on site in response to the COVID-19 pandemic.

After the inspection
We continued to seek clarification from the manager to validate evidence found. Up until the 16 July 2020 we continued to review evidence we had received. We looked at policies, medicines records, staff rotas, training data and quality assurance records. We spoke with three relatives about their experience of the care provided and received feedback from another relative. We spoke with two members of staff, a local commissioner, two professionals who regularly visit the service and the fire service.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about safe care and treatment. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At our previous two inspections in September and November 2019 risk assessments and systems were either not in place or not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had failed to mitigate the risks to people. People were still at risk of receiving inappropriate care. Risk assessments were still not kept up to date or did not always reflect the care provided. For example, some people were at risk of constipation. Staff did not always complete people's bowel charts and did not follow guidance related to this. One person's records suggested they had not had a bowel movement for nine days. We spoke to the manager about this who was unable to confirm if this was correct. However, senior staff told us this was quite usual for this person. Care plans detailed to contact the person's GP after five days and this had not occurred. In addition, the risk assessment identified that constipation increased the person's risk of having a seizure and to follow the protocol for this. There was not a protocol in the person's care plan.
● Risks around one person not eating and drinking regularly were still not managed effectively. Monitoring records were still not completed consistently, and fluids were still not totalled to enable an overview. The provider had put some 'suggestions' in place to manage this, but these had not been incorporated into the person's care plan and were not consistently being followed. For example, staff were not recording in detail their interactions to encourage the person to eat.
● Risks around one person with behaviour that challenged were still not effectively managed. The health and social care professional involved with this told us these risks had not being managed at all. All 10 incidents of behaviour that challenged recorded between 14 May 2020 and 7 July 2020 were when one person received personal care. It was clear from the persons health conditions that they experienced pain when mobilising but there had been no clear and consistent pain management for this. There were strategies in the behaviour guidelines to follow such as giving the person something to hold onto when being rolled for personal care, but records did not show whether this was done, and whether it was

successful. All responses to these incidents were the same and there was no evidence positive strategies were used.

● Risks around people's skin integrity were not managed. One person's risk assessment detailed to review their Waterlow score regularly as this was high risk, but this had not been done. A Waterlow score is an indicator of a person's risk of skin breakdown. The person's care plan showed they refused to allow staff to change their position in the night and they had an airflow mattress in place to minimise the risk of skin breakdown caused by this. However, we were told the person did not have an airflow mattress any longer as they did not like it. There was no updated information in the person's care plan as to how this risk was managed.

● People were still at risk of serious harm if there was a fire. An external fire risk assessment was completed in January 2020 and again (raised at both September 2019 and November 2019 inspections) highlighted the need for fire evacuation drills. This was an 'immediate action required' but had not been completed. The manager and staff confirmed these had not been done. Staff we spoke with gave varying ideas on how they would evacuate. New staff did not know how to evacuate. The provider could not be assured staff would know what to do in the event of a fire. In addition, fire equipment checks were not completed, and emergency lighting checks were not completed in line with the providers policy. The fire warden had not had any additional training for their role and five staff have had no fire training, two of whom were seniors. We raised our concerns with the fire service who have visited the service following our inspection and have placed a fire safety order on the home.

● There was a lack of environmental risk management to ensure people's safety. There was no gas safety certificate. People were at risk of scalding as no checks of hot water temperatures had been recorded since January 2020. The manager confirmed none had been completed. The provider had not followed their environmental risk assessment for this which reads, 'Staff to check temperatures before use' and 'Thermostatic mixer devices should be checked regularly, and temperatures recorded.'

● People were at risk of legionnaires disease. The provider had not complied with their own policies and risk assessment around the management of Legionella. There was no testing of water temperatures and maintenance. The manager confirmed this had not been done. Legionella is prevented by maintaining building water systems to reduce the risk of growth and spread through water temperature control and cleaning.

The provider has responded immediately to some concerns after the inspection. They confirmed the gas safety inspection was completed within a week of the inspection and Legionella testing was booked for 27 July 2020.

Using medicines safely

At our previous two inspections in September and November 2019 the provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Medicines were not managed safely which placed people at risk of harm. Medicines errors were not identified, and the provider did not have any oversight of medicines management. There were unexplained gaps in people's Medicine Administration Records (MARs) which included Clonazepam (used to prevent and treat seizures and movement disorders). This put people at an increased risk of seizures. Although medicines were counted on the MARs, there was no effective system in place and management oversight to

ensure people had their medicines as prescribed. For example, medicines audits had still not been completed, therefore these medicines errors had not been identified.

● People's MARs were not completed in line with best practice guidelines. There were inconsistent guidelines for staff which increased the risk of medicine errors. Some medicines were unclear if they were PRN (as required) or not. One person's MAR chart said to give paracetamol four times a day, but they had only received it twice in four weeks. Another person's medicine was PRN but was given on a regular basis and had not been included in their PRN protocol. Records relating to people's medicines to treat constipation and those for pain management in their care plan did not match what was on their MARs.

● There were no guidelines for staff in one person's care plan what to do when they refused to take their medicines. This included sodium valproate which is for epilepsy. It is important to take sodium valproate regularly as missing doses can trigger a seizure. Staff had failed to manage and record variable dose medicines. This meant there was a lack of information as to what dose the person was taking and if this was effective pain management. One person had paracetamol and zapain medicines, one or two tablets as required but the dose was not recorded on the MAR. Another person had bisacodyl, one or two tablets, but the dose given was not recorded. There was no guidance in the PRN protocol how to decide on the dose required.

● One person's medicine, baclofen which they took at 8am, 12.30pm and 8.45 pm should be taken with food to reduce the risk of nausea. The person's food charts showed they had not always eaten during these times. There were no guidelines for staff on how to manage this.

● Staff's competency checks with medicines were not completed as per the providers policy. There were no records for this, only a list of dates. 11 staff (61%) needed medicine training, one of which was a senior administering medicine within the home.

Preventing and controlling infection

At our inspection in September 2019 the provider had failed to ensure the prevention of infections was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last Inspection in November 2019 we reported on some improvements with the cleanliness of the home. At this inspection we found serious concerns around the providers management of the prevention and control of infection in relation to the Covid-19 pandemic. Therefore, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The prevention of Covid-19 was not effectively managed which put people at serious risk of harm. Current Public Health England (PHE) and government guidelines had not been followed around Covid-19 with regards to staff wearing Personal Protective Equipment (PPE), social distancing and home testing. The PHE guidelines on PPE for staff displayed on the wall were not up to date. This was dated 2 April 2020 when masks were not required. Although there was plenty of stock of PPE in the home, staff were not wearing any PPE. This included the chef not wearing a mask in the kitchen. The manager informed us the decision had been made with the provider for staff not to wear PPE due to the residents not liking the masks. There was no evidence of how this impacted each person, or review, or consideration of other options. We have linked the manager up with another provider for advice around managing the use of PPE where people are uncomfortable with masks

● The manager said they had made a 'bubble' of the home and told us they had been very careful. They said they had reduced the risks by taking temperature checks for residents twice a day and for staff on arrival at the home; by regular handwashing; by providing masks to staff for use outside of work such as when they go shopping; and by not using any agency staff. The procedures they put in place had not mitigated the risks.

Staff were coming and going from the home and therefore it was not a 'bubble'. The provider agreed to change their policy and staff wore PPE during the rest of our inspection. The manager continued not to always wear a mask, and we had to explain this included them. However, they continued to not wear a mask consistently in resident areas and we saw in the kitchen they had this round their neck. We have informed the local authority of our concerns about the lack of use of PPE and they have been in contact with the home to reiterate the importance of this.

● Whole home tests kits had been provided to the home but had not been used to test people. A document provided to us at inspection recorded eight people refused, two people were unable to make the decision and one person was unable to respond. There was no evidence people were supported to make an informed choice about being tested for Covid-19. The manager told us people had been asked if they wanted to be tested; and for those people who did not have the capacity to make the decision, they decided not to as it is an invasive procedure. There was no best interest process completed for people on this. There was no use of other forms of communication, easy read information, pictures and records to show how this had been communicated with people. We have linked the manager to another provider who can advise around this and share their good practice. Not all staff had been tested, the manager said four or five staff had refused but they had not done anything to manage this.

● The home was clean. However, further work was needed to ensure staff training in infection control was up to date. Eight staff (44%) had not done infection prevention and control (IPC) training and five staff (28%) had not completed food hygiene training. It was essential during the covid-19 pandemic that all staff had received up to date IPC training to ensure they minimised the risks to people and themselves. Therefore, the provider could not be assured staff were competent, for example with how to put on and take off PPE safely.

Staffing

● There continued to not be enough staff on shift at all times to ensure people were kept safe and their needs were met. People had a range of complex healthcare needs, suspected dementia, physical disabilities, diabetes, epilepsy, and Huntington's disease and relied on staff to meet their needs. Records showed some shifts only had three staff when the provider had identified a minimum of four and staff confirmed this happened. In a four-week period during May and June 2020 there were at least eight shifts with only three staff. As some people required two staff for personal care this meant one staff was left to care for 10 people with high level needs. There was still no dependency tool to determine how staffing levels were identified.

● Staffing levels had been identified as a concern at both our September and November 2019 inspections. The risk of this had increased as the provider was not using agency staff as part of their management of Covid-19. The provider had clearly not been able to cover all shifts within their existing staff team. Whilst the manager informed us they helped at times, they worked nine to five, Monday to Friday and therefore there were clearly times when there were insufficient staff. This put people at risk of not receiving the care they needed at the time they needed it. Staffing levels had significantly impacted on the amount of choice and control people had.

There was not always sufficient staff to support people to stay safe and meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about person centred care and staffing. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our previous two inspections in September and November 2019 the provider had failed to ensure the care and treatment of people was appropriate and met their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People did not receive person-centred care. People were not supported in line with the principles of registering the right support. Systems at the service did not enable people to have maximum choice and control as some shifts only had three staff when the minimum is four. There was little evidence of daily activity. There was no communication with people during lunch or the creation of a positive dining experience. A health and social care professional told us how they had observed a lack of person-centred care when they visited.
● People with behaviour that challenged were still not supported in line with current best practice, positive behaviour support (PBS). PBS requires that analysis of incidents is used to ascertain if the person could be supported in a way which minimises the risk of distress and minimises the risk of reoccurrence. There had been no review or analysis of incidents in order to improve people's support and meet their needs. Five staff had not been trained in positive behaviour support and there was a reliance on guidance from external agencies. A health and social care professional had written some behaviour support guidelines, but records did not evidence if these were effective.
● Staff did not continually assess people's needs to ensure care plans were kept up to date or included all the information needed to inform staff how to support people's individual needs. Three people had the same protocol for managing constipation which were no longer relevant. Health and social care professionals had identified in March 2019 that care plans were generic and not person centred. No action had been taken to address this.
● The manager did not know who, if any, people had a Legal Power of Attorney (LPA) in place (to make certain decisions on their behalf) and this was not clear in people's records. We raised our concerns about this regarding the consent for the use of CCTV in the home again. There was still no evidence that people

had either given informed consent or a Best Interest Decision (BID) making process had been completed. People's relatives had been asked to consent, but this does not comply with the Mental Capacity Act 2005 as relatives cannot consent for others unless there was a LPA in place. This meant there was a risk people's loved ones were not always involved appropriately and legally and people's rights to choice were not respected.

● The manager told us a decision had been made to proceed with blood tests for one person using sedation. Previously there was some desensitisation work planned for this. However, it was decided at their review in February 2020 blood tests were urgent. There was no evidence of any BID for this. We spoke to one health and social care professional involved who was not aware this decision had been taken and had advised the home the least restrictive option would be desensitisation.

● People were involved with celebrations of events, such as birthday parties and a VE day party. Birthday cakes had been personalised to people's interests.

Staff support: induction, training, skills and experience

At our previous two inspections in September and November 2019 the provider had failed to ensure staff were suitably qualified, competent and skilled to meets people's needs. This 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 regulation 18.

● The provider had not ensured that staff were competent in their role. This meant the provider could not be assured that staff had the skills and qualification to fulfil their role and meet peoples' needs. Staff had still not received appropriate training and regular refresher training to support people living at the service. This included mandatory training in manual handling, first aid, safeguarding, fire, health and safety, equality and diversity and mental capacity. Five staff needed manual handling training, six staff needed safeguarding training, eight staff needed health and safety training and 11 staff had not completed mental capacity training. One senior care staff was overdue for most of their mandatory refresher training and had completed less than 40% of their training. Not all staff had received appropriate training around peoples' individual needs in behaviour that challenged (five staff needed), diabetes (12 staff needed) and epilepsy (nine staff needed).

● Staff did not have the knowledge needed to support people safely as they were still not receiving a full induction with competency checks. These were half completed or not available. New staff had not completed the care certificate when there was no evidence they had previous care experience. It is best practice for all staff new to care to complete the care certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected by care staff and should form part of an induction programme. Due to the nature of this targeted inspection we were unable to observe staff supporting people to determine their skills and competence. We tried to follow-up with more staff following the inspection, but they were unavailable or unwilling to talk to us unless they were at work.

● Staff had not received regular supervision and competency checks. Staff have only had one supervision since January 2020, and some were as late as May 2020. Seniors have had one or two supervisions since January 2020. Records did not evidence involvement and development of staff and were very minimal. There were no records of medicines or any other competencies completed.

● Staff were still not effectively supported when they were involved in incidents with people with behaviour that challenged. Staff were not given the opportunity to formally debrief and reflect on incidents where they had been physically assaulted. Guidelines were not kept up to date regarding the risks to staff. An ABC

record showed one person had pulled staffs hair but there was no mention of hair pulling in their behaviour support guidelines. There was still no opportunity for staff to formally reflect on their response to the persons behaviour against the guidelines to review if this was effective and learn from these incidents. An ABC chart is an observational tool to record information about a behaviour.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about good governance. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our previous two inspections in September and November 2019 the provider had failed to operate effective systems and processes to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was a continued failure in governance from weak leadership and management of the service by the provider. The current manager has been in post since January 2020 and had not made the improvements needed. The provider has been shielding due to Covid-19 since 23 March 2020 and has not maintained effective oversight of the new manager and the quality of the service.
●There remains a closed culture and a culture of blame. The new manager was not always open and honest about events and actions taken in the home. For example; when we asked for evidence of compliance around staff induction, the manager asked staff to complete the document in retrospect. When we asked why there was no incident forms completed for one person's behaviour that challenged, we were told there had not been any incidents but records clearly showed otherwise. Following inspection, the manager informed us they were taking disciplinary action for one staff around medicines, yet they had failed to support them and check their competence with this. The provider had refused to meet with us following this inspection to discuss the improvements needed and to offer reassurance around people's safety.
● The lack of effective governance has had a major impact on people as the provider had not ensured the delivery of high quality and safe care. The providers systems had not identified or addressed continued shortfalls found at this and previous inspections. Timely or appropriate action had still not been taken to ensure compliance with the Warning Notices we served from our inspection in September 2019.
● Audits, checks and observations were not used effectively to monitor and improve all aspects of the service. Only one audit had been completed, a recent infection prevention and control audit. Health and safety checks were not completed for fire safety, water temperatures and legionella. There had been no

oversight of this by the manager or provider. For example, call bell checks were not being completed and the manager confirmed this. The managers response was, "I know they work as (name of person) uses it a lot." However, this does not demonstrate all call bells are working within the home.

● Some senior staff had been empowered with task responsibilities for example, medicines, but the manager had not maintained any oversight of this or ensured they had the skills needed. The manager told us, "There were a lot of changes still to be done around monitoring and recording and working with information to make assessments." They also said, "Staff were coming around and understanding needs more as staff were institutionalised as they had been here a long time." And, "Staff have a history of not reviewing and assessing risk which will take some time to embed." However, the manager did not tell us what they had done to manage this, to have oversight of this and to improve this. When asked how they know people are safe they said, "People are safe as they appear happy, eat well, weights are good, and they laugh a lot."

● People and staff were at increased risk of avoidable harm because the provider was still not reviewing, analysing or learning from incidents. The provider had still not therefore identified any trends or patterns from falls or incident of behaviour that challenged. Incident reports had not been reviewed and staff had not been effectively debriefed. The incident reports which had been completed were inadequate as they did not consider how to prevent reoccurrence or suggest a review of the person's care plan. None had any written documentation to show there had been any learning shared with staff. Therefore, there were missed learning opportunities from accidents and incidents analysis to prevent re-occurrence of these. For example, if staff interaction had been successful to deescalate an incident of behaviour that challenged for one person.

● Accurate and contemporaneous care records were not maintained. People's care records including risk assessments, care plans and health monitoring records were not always accurate, up to date and were missing information. For example, daily monitoring records for people's food and fluid intake were incomplete. There had not been any auditing of care files to ensure the provider had oversight of this. This was important to ensure staff had the guidance they needed to provide and monitor safe, consistent support which meets people's needs. People were therefore at risk of not receiving safe and quality care.

● Regulatory requirements had not been understood by the manager and provider. For example, around the Mental Capacity Act 2005 and best interest decision processes when people do not have the capacity to consent to a decision.

Engaging and involving people using the service, the public and staff; Working in partnership with others

● The provider had not involved key stakeholders to improve the quality of the service. There was still a lack of feedback sought to learn from people and staff. People were not fully engaged with the service. There was still no effective system in place to seek feedback from people and their relatives on their views on their care and the service they received.

● Two surveys had been completed with relatives (however one lived abroad and would not be able to comment effectively). There was no evidence of any review or learning from these. There was little evidence of staff engagement, one staff meeting had been held since January 2020, but the minutes did not reflect any invitation of staff's ideas or comments.

● People's care and risk assessments had not been reviewed internally within the home. There was a reliance on external review with care managers and only two people had received this since January.

● There was a lack of effective partnership working with a health and social care professional who was referred to work with one person around their behaviour and desensitisation for blood tests. The health professional had arranged several visits and upon attending were not able to go ahead with their work as they were told there was not enough staff on-site.

● There was no communication with people and relatives to ensure they were aware of the results of our inspections reports and Local Authority quality monitoring, along with actions that were required. One

relative contacted us concerned when we asked for feedback again and clearly had not been informed of the homes Inadequate rating and inspection report findings. This demonstrates the providers lack of openness and transparency with people's loved ones about the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care and treatment of people was appropriate and met their needs and preferences. Regulation 9(1)(a)(b)(c)(3)(a)(d)

The enforcement action we took:

No further action was taken as the provider had made improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and systems were not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Ensuring that the premises used by the service provider are safe to use for their intended purpose. The provider had failed to ensure the proper and safe management of medicines. The provider did not ensure the prevention of infections was effectively managed. Regulation 12 (1)(2)(a)(b)(c)(d)(g)(h)

The enforcement action we took:

No further action was taken as the provider had made improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems must be established and operated

	effectively to ensure compliance; systems must enable the provider to assess, monitor and improve the quality and safety of the service. Systems to assess, monitor and mitigate risks to health safety and welfare of service users. Accurate, complete and contemporaneous records must be maintained. The provider must seek and act on feedback for evaluating and improving practice. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

No further action was taken as the provider had made improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed in order to meet the requirements. Regulation 18(1)(2)(a)

The enforcement action we took:

No further action was taken as the provider had made improvements.