Millennium Care Limited

Millenium Care Limited - 1 Old Park

Inspection report

Old Park Road
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11 October 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9 and 11 October 2018 and both days of the inspection were unannounced. When we last inspected in July 2017, the service was rated Good.

Millennium Care – 1 Old Park Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 10 people in a converted Victorian building across two floors. People had access to a large garden at the rear of the building.

Millennium Care – 1 Old Park Road had been built and registered before Registering the Right Support (RRS) had been published. The provider had not developed the service in response to the values that underpin RRS or changes in best practice guidance for providers of learning disability and autism services. These values and guidance includes advocating choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen. We found the service did not always conform to this guidance and values when supporting people.

There was a registered manager in place at the time of the inspection. However, they were not present in the home in the two months preceding the inspection. A deputy manager was overseeing the running of the service with support from senior management at provider level. 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.

The premises and equipment were not always maintained in a safe condition. Areas of the home were unclean. People were not adequately protected from the risk of infection as staff were not always adhering to basic infection control procedures.

People's health, safety and wellbeing was at risk because management at home level and above failed to adequately assess risk and provide sufficient guidance to staff on how to keep people safe from harm. We observed poor moving and handling practices during the inspection.

Medicines were not stored, documented and administered safely.

The provider did not always adhere to the Mental Capacity Act 2005. Where restrictive practices were in place, such as use of video monitoring and administering medicines covertly, documentation was not in place to ensure this was in the person's best interests.

People were not consistently supported by staff in a respectful and kind manner. Care records contained insensitive terminology regarding people's behaviours due to their learning disability or mental health

condition.

People were not always receiving care in line with their needs and preferences. Although reviewed regularly, some care plans contained inaccurate or insufficient information. There was a lack of meaningful activities observed for people who remained at the service during the day.

People were not always supported to eat and drink. There was a lack of drinks at mealtimes and some people did not receive support to eat and drink in a timely manner.

There were not always enough staff deployed in the service to consistently meet people's needs. Care staff were deployed to non-care tasks such as cooking and cleaning. Staff were safely recruited.

Overall governance of the service was ineffective. Despite regular quality checks completed at both service and provider level, these had failed to identify the concerns identified on inspection. Where these checks had identified concerns with aspects of care delivery, sustained improvements had not been made.

Staff had received regular training, supervisions and an annual appraisal. However, we found that not all staff were competent in areas such as ensuring infection control and assisting people with moving or transfer.

People were supported to access medical services such as the GP and district nurse. However, we found instances of a lack of timely referrals to specialist health professionals.

There was a complaints procedure in place which included oversight at provider level. People told us they would speak to staff if they had any concerns.

Overall, we found significant shortfalls in the care provided to people. We identified seven breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found one breach of Care Quality Commission (Registration) Regulations 2009. Warning notices were served on the registered provider and registered manager for breaches of Regulation 12 (safe care and treatment), Regulation 15 (premises and equipment) and the registered provider was served with a warning notice for breach of Regulation 17 (good governance).

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.

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. There were not enough staff deployed at the service to meet people's needs.

The service had failed to identify and address risks to people's health and well-being.

Medicines were not being managed safely.

People were not always protected from environmental and infection risks.

Staff were knowledgeable around what to do if they had safeguarding concerns.

Staff were safely recruited.

Is the service effective?

Requires Improvement

The service was not always effective. People were not adequately supported to have sufficient drinks.

The service was generally compliant with the Mental Capacity Act 2005, however we found instances restrictive care practices in which there was no documentation to support that the decision had been made in the person's best interests.

Staff received appropriate training, but did not always put this training into practice.

Staff received regular supervisions and an annual appraisal.

People were supported to access routine health services such as the GP.

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not always treat people with dignity and respect. People's privacy was not always respected.

People living at the service had developed friendly and caring relationships.

People were supported to maintain contact with their families. Relatives told us they were welcome to visit the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always supported to access meaningful and stimulating activities.

Some care plans contained inaccuracies and did not provide staff with sufficient guidance on how to work with people when they displayed behaviour that challenged.

There was a complaints process in place and complaints were investigated and resolved informally.

Is the service well-led?

Inadequate

The service was not well-led. The provider did not have effective systems and processes in place to assess, monitor and improve the service.

The provider had not submitted all required notifications to CQC.

Although people told us they felt safe living at the home, they raised dis-satisfaction with certain aspects of the service they received, namely around food and activity provision.

Staff and residents' meetings took place on a regular basis.

Millenium Care Limited - 1 Old Park

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.

The inspection was prompted by a notification of an incident which was reported to the local safeguarding authority and police. At the time of the inspection, the incident was subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the service. Following the inspection, CQC were informed that the police investigation concluded with no further action.

This inspection took place on 9 and 11 October 2018 and was unannounced. The inspection was carried out by two adult social care inspectors, a Specialist Advisor in Learning Disabilities to CQC and one 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 and they assisted the inspection team by speaking to people who used the service and observing care delivery in communal areas.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

We observed staff supporting people in communal areas. During the inspection, we spoke with three people living at the home, the deputy manager, team leader, company director, operational consultant, five support workers and a registered manager from another registered care service owned by the company director. Following the inspection, we spoke with three people's relatives by telephone.

We reviewed records associated with the running of the service which included five people's care plans and risk assessments, 10 people's medicines records (MARs), five staff files, staff rotas, training records and quality assurance records.

During the inspection, we spoke with one visiting health professional. We spoke with the local authority safeguarding and learning disabilities team before and after the inspection.

Inadequate

Is the service safe?

Our findings

Medicines were not always managed safely at the home. We found that stocks of medicines were accurate to the medicines recorded. We found three instances of gaps on MARs where an entry had not been made to confirm the administration of a medicine. Staff confirmed that on the dates, people had been in hospital, however the reason for the gap in entry had not been documented on their MAR.

We identified concerns with how medicines were stored. Medicines were stored in a locked cabinet in the dining area. Each person's medicines were stored in a basket named for that person. Some prescribed lotions and creams were stored in people's bedrooms. We found cream and liquid medicines were not dated when opened and found for one person, two opened cream medicines had passed their expiry date. For another person, we found a bottle of liquid medicine used to treat seizures had no opening date indicated and no dispensing label to indicate that the medicine belonged to the person. The person's initials were hand written on the bottle. We found bottles of liquid medicines to be sticky. For one person, the dispensing label on their medicine had become blurry which made it difficult to read their name.

We identified concerns with the management of how 'as required' medicines were administered and documented. When required medicines are medicines that are prescribed to people for things like pain relief or to relieve anxiety and are only given when necessary. For one person, we found that they were administered 'as required' anti-anxiety medicine on a frequent basis in the two weeks preceding the inspection. On 4 October 2018, the person was administered the medicine twice, three and a half hours apart at 8.00am and 11.30am. On 7 October 2018, the person was again administered the medicine twice. The handover notes for 7 October 2018 stated that the person was settled all day. Support staff were administering a tranquilising medicine on a regular basis without clear guidance or support from specialists. There was a risk that this person could be having withdrawal effect of the medicine if the anti-anxiety medicine is given for a few days after a period of regular administration.

For a second person, we found that a prescribed 'as required' (PRN) medicine to relieve anxiety and agitation had expired in May 2018. For a third person, we found that there was no PRN protocol for the use of pain relieving medicine. Overall, we found that there was a lack of protocols in place for the use of PRN medicines.

For another person, we saw three medicines in their basket in the medicines cabinet which were not documented in their MAR. The deputy manager told us that the person bought the medicines over the counter and staff were administering these medicines. These medicines were not counted, labelled or documented in the person's individual medicines or homely medicines list. No protocols or guidance had been documented to provide support staff with guidance when these medicines should be administered. Where people had been prescribed cream or lotion medicines, no body maps or guidance was available to support staff on where to apply these medicines.

A person told us on 11 October 2018, that they were suffering from constipation, in pain and that they did not receive regular medicine to assist with their symptoms. We saw that they had been prescribed a liquid

laxative, Lactulose. The record of visit to GP on 5 September 2018 and the printed MAR stated that the medicine was prescribed as three 5ml spoons twice per day. Handwritten on the MAR was 'If required.' The handwritten entry was not initialled or counter signed by staff. The person's MAR documented that prior to 11 October when they asked and received the medicine, they had last been administered Lactulose on 21 September 2018. The deputy manager told us that the medicine was PRN and the person would receive the medicine if they asked. We asked for confirmation of the type of prescription for the medicine, however this was not supplied following the conclusion of the inspection. We could not be assured that this person was receiving their medicine, as prescribed.

For another person, their MAR contained an emergency epilepsy protocol dated 2001 and recommended an anti-epileptic medicine to be administered in a certain way. Good practice would be for people's epilepsy care plans and protocol for rescue medications be reviewed yearly by either a GP or epilepsy specialist. This person's physical health needs had changed significantly within the past year and the home had failed to review the person's care needs with regards to their epilepsy.

On 9 October 2018, we saw staff put a person's medicines into their food. Administering medicines in this manner had not been documented in the person's care records, nor was an agreement in place to confirm that the appropriate medical professionals had sanctioned this course of action.

We observed poor infection control practices. On 9 October 2018, in the kitchen, we found opened packets of cooked meat stored in the fridge beside a prescribed medicine. The meat products had not been covered or labelled with an opening date. This was shown to the company director who arranged for the food to be appropriately covered and medicines removed and placed into a medicines fridge in the manager's office. We observed a senior staff member prepare sandwiches for lunch. They did not wash their hands beforehand or use an appropriate food board.

We observed a staff member, whilst in the middle of personal care in a person's bedroom, enter the lounge wearing the gloves they were using to deliver personal care and assist another person by pulling their hands into a seated position and rubbing their exposed lower legs and place a blanket on them. The staff member then returned to the other persons bedroom to continue with person; care. This placed the person at risk of cross-infection as the staff member had not removed their gloves prior to assisting the person.

On 9 October 2018, in the presence of a senior manager, we found six instances of urine stained and malodorous bedding and mattresses. On 9 and 11 October 2018, on three occasions, we found urine soaked chairs. On one of these occasions we saw a staff member wipe the chair with a disinfectant surface spray and the chair was left outside to dry. This method of cleaning would not have removed the urine soaked into the chair. On 11 October 2018, we found that a person's wheelchair was malodorous of urine and unclean.

On 9 and 11 October 2018, we found bathrooms and toilets without adequate handwashing facilities, which included hand wash and hand drying equipment. At the feedback section of the inspection on 11 October 2018, we discussed this and were advised by the deputy manager and the company director that this was because of the behaviours a person displayed due to a diagnosed medical condition which meant that they may try to ingest chemicals. We were advised that people could wash their hands in their bedrooms if needed.

We found that risks associated with people's health and care needs were not always assessed and did not always provide guidance for staff on how to mitigate known risks. We also found instances of staff not adhering to the information contained in people's care plans and risk assessments which placed people at risk of harm.

We also observed concerns with health and safety measures in place to ensure that people were protected from the risk of injury and avoidable harm. On 9 October 2018, we observed instances of staff using poor moving and handling techniques to assist people to mobilise, for example, we observed a staff member pull people into a seating and standing position by pulling them under their armpits. We fed back our concerns on day one of the inspection and on day two of the inspection, the deputy manager told us that refresher moving and handling training had been booked for staff to attend.

On 11 October 2018, the deputy manager showed us where cleaning chemicals were stored. We were shown an unlocked room on the second floor, beside where the manager's office was located. The deputy manager advised us that people did not access the second floor and were not at risk of harm because of access to chemicals. On 11 October 2018, we observed two people independently access the second floor to enter the manager's office. One of these people had a diagnosed health condition which meant that they were at risk of ingesting non-food items.

On 9 October 2018 we saw two people, who had an unsteady gait and were at risk of falls, wearing inappropriately fitting and unsupportive footwear. On the second day of the inspection, we saw that one of the people had been purchased new shoes and slippers.

For one person, we saw that their identified risks were choking, injury from moving and handling, pressure ulcers, dehydration and seizures. Their care records, which included care plans and risk assessments did not provide any clear feeding support guidelines to enable staff to minimise the risk. At lunchtime on 9 October 2018, we saw a staff member feed this person by placing large spoonfuls of food into their mouth. We intervened and requested that staff use a smaller spoon with smaller amounts of food as the person was at risk of choking. We also observed that drinks were not offered in between mouthfuls. A referral had not been made to a Speech and Language Therapist to review how this person should be supported to eat and drink safely. There was no risk assessment in place for the use of a hoist or sling to ascertain how many staff were required to safely hoist this person. There was a care plan in place for shower and bathing dated 19 September 2018, however there was no guidance given to staff on the safe use of a hoist or sling for when this person was being showered.

The person's care record for dehydration stated that small amounts of drinks should be given every two hours, however the care record did not provide guidance for staff on safe positioning for feeding or giving drinks when this person was in bed. We saw that staff were monitoring fluid intake but there was no guidance documented on what the recommended daily fluid intake was and what staff should do if there was poor fluid intake. In the week preceding the inspection, we saw documented fluid intake amounts vary from 320ml to 1200ml.

On 11 October 2018, at lunchtime, a person, who was identified as at risk of choking was given a whole sandwich by a staff member to which another staff member intervened and cut up the sandwich. This person was not supervised to eat and was observed to put large amounts of food in their mouth at once and cough.

Another person required the use of oxygen for a medical condition. On 9 October 2018, we found the tubing, nasal tube and face masks to be unclean and on one occasion lying on the bedroom floor. On a second occasion they were found lying on an unclean chair in the bedroom. There was no notification at the front door or on the persons door that oxygen was present. The support staff reported that they had had no training on the safe use of prescribed home gases and were unable to tell us what the correct settings should be for the oxygen flow. They reported that they just turned the oxygen on each day. This placed the person at risk of harm as staff supporting the person with this care need had not been adequately trained.

The above demonstrates significant shortcomings in the safe management of medicines, infection control and ensuring people were protected from the risk of harm, which was a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified concerns with the overall maintenance and cleanliness of bathrooms, toilets, bedrooms and communal areas. Over the two days of the inspection, we inspected all ten people's bedrooms in the presence of a senior staff member. We found urine stained and malodorous pillows in six people's bedrooms and urine stained and malodorous mattresses in five people's bedrooms. We found a coating of dust on one person's bedding and instances of dusty sinks.

The ground floor toilet and walk in shower room was very unclean. The toilet seat was broken and loose. Due the lack of ventilation (both natural and mechanical), there was a build-up of mould and dirt on tiles and there was an overpowering odour emanating from the room which spread into communal areas when the doors were open. The pull cord was stained.

The bathroom off the entrance hall on the ground floor was found not to be clean. The pull-cord was stained. There was a coating of dust on the bath. There were unidentifiable red/brown splashes on the wall to the top left of the sink. The cold tap was not working.

On the first day of the inspection, we found the entrance door to the lounge to be damaged. The door frame was loose from the wall and there was a hard strip at the bottom of the door which had sharp edge sticking out. This placed people at risk of injury.

On the first day of the inspection, we found three chairs in the lounge to be sticky and heavily soiled with food debris and spilled liquids. We discussed the environmental concerns with the management team in place at the time of the inspection, and some initial remedial actions were taken which included the ordering of new mattresses and bedding and repair of the broken door. We saw that one replacement chair had been ordered prior to the inspection and the provider had a supply of new chairs in storage which were produced during the inspection.

The above demonstrates a failure to ensure that the premises and equipment used in delivering care to people was clean, fit for purpose and maintained to a safe standard. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not effectively deployed at the service to ensure people's care needs could be met. Rota's confirmed that during the day, three support staff were on duty in addition to the registered manager and deputy manager. On the days of the inspection, the registered manager was not present, however representatives from the providers management team were present. Staffing levels did not support the tasks assigned to care staff, which included providing or prompting personal care, meal preparation, administering medicines, cleaning, laundry, supervising and assisting at mealtimes where people required assistance to eat and providing one to one assistance when people displayed behaviour that challenged. There was no designated cooking or cleaning staff employed at the service. This impacted on the cleanliness of the service, the mealtime experience and how staff interacted with people. We observed, particularly at mealtimes, people who required assistance with eating were delayed in receiving support with their meals, as staff were responsible for preparing and serving food. For example, during one lunchtime, lunch was served at 12.30, a person who required staff support to eat was not supported until 12.55pm.

This meant that staff were not always readily available to provide people with assistance when needed. This

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

People told us they felt safe living at 1 Old Park Road. Feedback received from people included, "I feel safe and I don't worry" and "I feel safe." Similar feedback was received from relatives. Staff were knowledgeable around types of abuse that could occur in a care setting and where they could report any concerns to. A staff member told us, "Where there is a vulnerable adult we protect them. This is physical abuse, verbal abuse, money. CQC can help, together with safeguarding." We saw that the provider had made necessary safeguarding referrals to the local safeguarding authority and CQC.

We looked at how accidents and incidents were recorded and investigated at the service. We also looked at if learning points were identified. There were systems in place for documenting incidents and how those were escalated to the relevant authorities and CQC, if required. Most of the incidents documented related to where people had displayed agitated behaviours and how they were dealt with, which included one to one staffing and the administration of PRN medicines. We identified one instance of where the provider failed to notify CQC of an incident of serious injury. This will be elaborated on further in the 'Well-led' section of this report.

Systems were in place for the safe recruitment of staff. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas, electrical and water safety.

Requires Improvement

Is the service effective?

Our findings

People were not always supported with their nutrition and hydration needs. Two people told us, "Sometimes I am hungry. There isn't enough food for me" and "It's okay, we get food at mealtimes." When asked if they received regular drinks, we were told, "I use the tap in my room" and "I ask for drinks and they get one for me. Sometimes I wait all morning." We observed drinks such as water and tea offered to people on occasions on the days of the inspection. During the inspection, we observed two lunch sittings and one evening meal sitting. At lunch on 11 October 2018, four people were in the dining room. Lunch was served at 12.30 however, three people were not offered a drink until 12.40 and one person until 12.50. At the evening meal, people present in the dining area were not offered drinks.

On 9 October 2018, we saw that two people required staff support for eating and drinking and were supported in the lounge. We observed that for the lunchtime meal on 9 and 11 October 2018 and on the evening meal on 11 October 2018, both people were not offered drinks whilst staff assisted them with feeding. People were also not provided with cutlery prior to the serving of the meal which could affect their ability to eat the meal. On two occasions the inspection team intervened and asked that drinks were offered to both people. This was a failure to ensure service users' hydration needs were met.

People were provided with sandwiches at lunchtime. On both days of the inspection, we observed that people were offered a choice of two sandwiches. On 11 October 2018, a large platter of sandwiches was put on the table in the dining room and once the service users had picked up three or four quarters each, the platter was removed. It was unclear where the rest of the food went and no other food was provided to accompany the sandwiches. Some people were offered a yoghurt dessert afterwards, but not all people.

We observed a staff member say to a person, "I need to tell the doctor you are eating well, what will you eat today?" The person was given a banana, one quarter of a sandwich and yoghurt to eat. They were also given a cup of tea. The person was observed eating some of their banana and then gave most of it away to another person who ate the remainder of the banana. The person entered the lounge area with some of their food and sat beside a member of the inspection team but there was nowhere to place their sandwich, yoghurt or drink. The inspector located a small table for them to use for this purpose. We saw that in the lounge, there was a lack of surface space, such as side tables, for people to put drinks or food. The person told us that they were unable to eat as they had stomach pains. Their care plan contained contradictory information regarding their eating and drinking. Information contained in the care plan included, 'Possibility of constipation due to [Person] poor diet', 'Has a normal diet', 'Has a very good appetite' and 'Staff to ensure that [Person] follows a well-balanced diet with high fibre and low fat.' The person's risk assessment stated that staff should monitor their eating and drinking, however there was no food or fluid charts in place for this purpose.

On 11 October 2018, we observed a person being supported by staff to eat their lunch. The person required full staff assistance in this regard. At 12.55 in the dining room the person was served lunch which was a chopped ham and pickle sandwich mixed with double cream in a bowl. We observed that the person was not supported to eat and at 13.00 left the table. A staff member followed the person and attempted to feed

them whilst they were standing up. The person entered the lounge and sat on a chair in a slouched position. The staff member proceeded to feed the person large spoons of food. No drinks were offered between mouthfuls. The person's care plan dated 20 September 2018, stated that the person required staff support with eating and drinking to avoid choking and required semi-solid food cut into pieces. There was no information contained in their care records to support the mixing of cut up sandwiches into double cream. When asked about this, the deputy manager and company director told us that that was how the person preferred to eat their food mixed with double cream, however, this was not documented in their care plan as a preference.

The above demonstrated that people were not always supported to maintain adequate nutrition and hydration. This amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Care records contained evidence of best interests assessments completed by the registered manager. However, we found two instances of restrictive measures in place for people which had not been documented in the person's care records, nor a best interests decision taken. For one person, this was the use of a video monitor in their bedroom facing their bed which the service used to monitor seizure activity.

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 had the appropriate legal authority and were being met. We saw that where a person's liberty had been deprived, an application had been made to the local authority for authorisation.

Staff told us and records confirmed that staff received a regular supervision and an annual appraisal from the registered manager. A staff member told us, "Yes, [appraisal] helpful, of course. They discuss my progress and my future training. I would like to do more manual handling. I have done but I would like more."

A relative told us that they thought staff were competent and trained. They told us, "They understand [Person] very well. They can spot when [Person] is unhappy." A person told us, "They are okay, they just do it." On inspection, we received training records from the deputy manager which listed nine support staff. The training courses listed on the records included first aid, food hygiene, epilepsy, moving and handling, infection control, challenging behaviour and medicines administration. We identified concerns with the competency of staff in areas such as moving and handling and infection control, as described in the Safe section of this report. The deputy manager confirmed that as a result, staff were booked to attend refresher training in these areas.

At the time of the inspection, people had been living at the service for many years, therefore their pre-admission assessments were not reviewed as part of the inspection. However, their care needs were re-

assessed on a regular basis which formed the basis of a care plan. This is elaborated on further in the Responsive section of this report.

Records confirmed that people were supported to attend routine medical appointments such as the dentist, optician and GP. However, we received mixed feedback from people when we asked if they were supported to see a doctor. One person told us, "I ask and they see how I feel the next day. The doctors come sometimes." People's care records under health professionals was updated with the information and actions from the visit, however, we saw that care plans were not always updated following the visit. For example, one person had been supported to attend a GP appointment on 4 October 2018 for skin redness, the record documented that the GP had advised that the person was developing a pressure ulcer and prescribed cream. We asked the deputy manager for documentation around the monitoring of the person's skin, such as body maps and risk assessment. We did not receive these documents, following the inspection. The deputy manager told us that the risk assessment for this person would be updated as a priority.

People had access to a large accessible garden area which was well maintained and had seating. People's bedrooms were personalised and contained photos and mementos. Some people were observed on inspection to access their bedrooms as and when they pleased to watch television or listen to music.

Requires Improvement

Is the service caring?

Our findings

We observed instances of staff engaging with people in an undignified and insensitive manner. On one occasion, a staff member told a person to sit properly on their seat in a commanding tone. On another occasion, we observed a staff member tell a person that they needed to have a shower as the inspectors were in the home. We observed instances of staff supporting people with moving or transfer by not engaging with or informing the person what they were doing.

One person displayed repetitive behaviours and we saw on more than one occasion, staff members mimic the word the person was saying when entering the communal lounge. We also saw examples of insensitive language used in people's care records and in staff supervision documents. In one person's care record, we saw their behaviours described as, 'odd', 'unacceptable' and 'inappropriate.' We saw in a staff supervision record in June 2018, where people's behaviours were discussed, one person was described as 'the worst.'

We also observed a person alert a staff member that another person had fallen asleep in their chair, despite the staff member being in the same room at the time they did not notice that the person had fallen asleep. The staff member then went to get support cushions for the person whilst they slept.

We found that people's dignity was not respected because they did not have a pleasant environment to live in, for example people were sitting in chairs that were visibly unclean and sleeping in stained and malodorous bedding.

On both days of the inspection, a person's sling was observed to be hung over a shower chair stored in the room. It was found to be damp and cold on touch on both days, which would be unpleasant for the person being supported in the sling.

There was a video monitor in a person's bedroom which was transmitted into the lounge. The video monitoring was used to alert staff if the person had a seizure, however this had not been documented in the person's care records to explain why this was the most appropriate way to monitor if the person had a seizure. The video screen could be seen by other people living at the home and visitors which meant that the person's privacy and dignity was not upheld.

We concluded that people were not always treated with dignity and respect. The above is in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some caring interactions between the people living at the service. One person spoke to other people and reassured them throughout the day. We observed them comfort another person who had become upset and emotional at a mealtime.

People's religious and cultural backgrounds were documented in their care records and whether they required support to practice a faith. One person told us that they wanted to attend church on a more regular basis but that staff were too busy to take them. We fed this back to the deputy manager who told us that the

person was offered the opportunity to attend church on a regular basis.

There were no restrictions on relatives visiting the home. We spoke to three relatives by telephone after the inspection who told us that they were always welcomed into the home. We saw that one person regularly went to visit their family and another person was supported to maintain telephone contact with their family daily.

We received a mixed response from relatives around whether they were involved in people's care reviews. Two relatives told us they were involved in a yearly review with the home and one relative told us that they had yearly reviews with professionals involved but not with the service. All relatives spoken to told us that they were kept informed and updated on an ongoing basis by the home.

Requires Improvement

Is the service responsive?

Our findings

Recently updated care plans were in place which provided guidance to staff on how to support people in areas of care such as maintaining their physical and mental health, activities of daily living such as eating and continence, social activities, mobility and behaviour that challenged. Care plans contained a summary of the person's likes, dislikes and family background with photographs of the person and their family.

We identified instances of where care plans were not reflective of people's current health circumstances or contained inaccurate information. For one person we saw that their care record documented the use of oxygen. This was not accurate, as this person did not require the use of oxygen which was amended.

For another person, their behaviour management plan stated that staff should 'discourage inappropriate behaviour by diverting [Person] to do something that [they] like.' The care plan did not state how staff should do this and what activities the person liked to do. Their care plan further stated that they should be supported and engaged in activity to minimise boredom, again, the persons activities were not detailed.

We received mixed feedback from people regarding the activities on offer at the home and how they spent their time. One person told us, "I like to watch TV, go out." A second person told us, "I like to go out so I don't get bored. It can be boring and noisy here. A third person told us, "I like dancing." On both days of the inspection, we observed that approximately half of the people went out on a day activity leaving the service in the morning at approximately 10.30am and returning in the evening. On the first day, it was to a local garden centre and on the second day, it was to the park and lunch. We saw that some people attended a local garden centre on a regular basis. The deputy manager told us that they helped to water plants and pick fruit. One person told us, "[Garden Centre] it's alright. They got dogs and chickens. We look around. They got an apple tree. You pick the apples."

For people who remained in the home, we saw little in the way of organised activities based on people's preferences. We observed staff present in the communal areas. However, for significant periods of time, staff operated in a supervisory capacity and did not engage people in meaningful activities or conversation. On one occasion, we saw that a staff member present in the garden with people was on their mobile phone. We raised the lack of activities with the deputy manager in the afternoon of day one of the inspection and following that, we observed staff engage some people in board games and a ball game. On the second day of inspection, we observed staff engage people in hand massage, playing with sensory toys, offering people different toys, playing a puzzle with one person and offering people a choice of music channels. A staff member told us, "We have a plan. But it changes as we are needed here and there. Tonight, is music and TV." A person told us "Yes, it's alright, they just put the radio on."

For one person, their care plan stated that they attended a day centre five days per week and went to the beauty salon to have their nails done. The person was no longer attending day centre. Their care records documented 19 activity records between January and September 2018 which included 10 trips to the garden centre and five drives. The person told us that they did not go to the beauty salon and that a chiropodist visited the service. Their care records documented that they had their nails painted four times in

the past 15 months. This meant that the person's care plan had not been updated to reflect up to date activities the person engaged in.

The above indicated that people did not always have care which was responsive to their needs or preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had recently been on holiday with the service to the seaside. They told us that they had enjoyed themselves. We observed one person being supported by staff to attend the local pub on the evening of the inspection for dinner and "a pint." They told us they were looking forward to it.

A complaints procedure was in place at the service and easy read versions of the complaints process was available in people's care files. We asked people if they felt comfortable raising concerns. People told us they would go to a named staff member if they had any concerns. Relatives told us that they had contact details and would raise concerns if they felt they needed to. Complaints recorded related to people raising concerns about the absence of staff and noise levels. Records demonstrated that people were supported at the time by staff and the issues were resolved locally. There was an oversight of complaints and details of complaints were considered under the providers quality monitoring processes.

At the time of inspection, end of life care was not provided at the service. People's care records contained information regarding people's end of life preferences, should they or their family choose to discuss.

Inadequate

Is the service well-led?

Our findings

People gave us mixed feedback about living at Millennium Care – 1 Old Park Road. We asked people what they liked the most and what they felt could be improved. Feedback included, "I like working in the garden. I water and tidy up", "The outings and being in my room with my music on", "I want to do things like go shopping and do some cooking" and "I'm bored, there is no one here to talk to." People told us that they knew the staff and the management team. Relatives spoke positively of the staff and management team. Feedback from relatives included, "[Deputy Manager] has been very good. He's given full updates" and "[Well-led] yes absolutely. I think they are doing very well." Staff spoke positively of working at the service and the support they received at service and provider level. Feedback from staff included, "If I have a question they always have good feedback" and "Yes, very supported."

There were systems in place, at both senior management and home level, to monitor the quality of the home and identify areas for improvement. Regular documented checks at service level included a monthly infection control audit, medicines audits, audits of service user and staff files. At senior management level, documented checks included quarterly checks of the environment, health and safety, medicines, service user files, finances, activities, training and supervisions. However, despite the systems in place to monitor quality of care, we identified significant concerns around the effectiveness of such checks.

Infection control audits were ineffective. Regular audits checked cleanliness, food storage, bathrooms, bedrooms and communal areas. An infection control audit on 15 September 2018 identified that bedrooms and communal areas were clean and free from unpleasant odours. The audit identified that that the bathrooms were clean and well maintained, free from mould and odour. This condition of the bathroom was identified as a significant concern at this inspection. A senior management audit on 28 August 2018 identified that the shower room required a deep clean which was signed off as completed on 12 September 2018. On 21 August 2018, an audit identified that a bathroom and one bedroom was not clean and malodourous. The bedroom was noted to have been cleaned on the same day. There was no identified action resulting from the concern found regarding the bathroom. Despite previous audits identifying some of the concerns around cleanliness found on inspection, sustained improvements of these areas had not been made as observed throughout the inspection.

A client file checklist was completed in August 2018. This checked when care plan reviews were due and whether aspects of care planning such as care plans, risk assessments, DoLS, health checks had been completed. Risk management oversight at the service was ineffective at both provider and service level. Referrals to appropriate health professionals had not always been made when people's care needs changed or when a new risk was identified. Risk management plans did not always provide sufficient detail for staff to keep people safe from known risks. This was a failure to maintain accurate contemporaneous records of care provided and a failure to assess and mitigate risk which audits had failed to identify.

In the daily recording records for one person, staff recorded daily bowel habits. It was recorded as a tick with no reference to what this tick meant as regards frequency and type of bowel movement such as The Bristol Stool Chart. The Bristol Stool Chart classifies stools into different categories to enable a person or health

professional to monitor bowel health. There was no care plan for constipation even though it was indicated that constipation was a risk in the person's care records. There was no guidance for when to seek medication support or what the service user's bowel habits were to indicate constipation. This was a failure to maintain accurate contemporaneous records of care provided and a failure to assess and mitigate risk.

Despite regular documented checks of the premises and equipment at both senior management and home level, we identified significant concerns with the cleanliness and condition of some aspects of the premises such as the downstairs shower room, lounge door, beds and communal areas. This meant that people were living in an unclean and unpleasant environment. It is noted that initial remedial actions such as the replacement of the chairs and the ordering of bedding took place on 9 and 11 October 2018, it was of concern that these concerns had to be raised during an inspection before action had been taken.

Medicines audits were ineffective. Despite regular audits at both service and provider level, we identified significant concerns with how medicines were managed. We identified concerns around the storage of medicines and administration and recording of 'as needed' medicines. We found that clear guidance regarding creams and topical medicines was not always available to staff administering these medicines.

There was no documented management oversight of people's mealtime experiences and how staff should be deployed to meet people's needs which meant that some people were delayed with being assisted with eating and drinking. We observed that people were offered little choice and not provided with adequate drinks. We observed poor feeding practices which placed people at risk of choking.
Oversight of staff competencies in areas such as medicines administration, infection prevention and control and moving and lifting were not robust. We observed that people were not always treated with dignity and respect.

The provider failed to have systems and processes in place to assess, monitor and mitigate the risks to people's health, safety and welfare. This constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified CQC of significant events on an ongoing basis, such as serious injury, DoLS notifications and safeguarding concerns. However, prior to the inspection, because of an ongoing safeguarding investigation, we became aware that a person sustained a serious injury in March 2018 which the provider was required to inform CQC of and had failed to do so. Following the inspection, the operations director and registered manager advised that they assessed the incident and decided that it did not fit the criteria of a serious injury. However, this was not correct.

The failure to notify CQC of incidents as required by law is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Records we saw confirmed that resident's meetings took place monthly and topics discussed included holidays, excursions, maintaining good personal hygiene and menu choices. The minutes were detailed in their notes and actions. Staff were given clear guidance and instructions on their roles and responsibilities and topics discussed included medicines management, management of challenging behaviour and staff completing regular checks at night.

We were advised on inspection that an annual survey had recently been carried out to obtain feedback from people and relatives on the quality of care. A relative told us that they completed an annual survey.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (2) The provider had failed to notify CQC of an incident of serious injury to a person who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) People were not always receiving care which met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10(1) People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14(1) The provider had not always ensured the people's nutritional and hydration needs were

met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The provider had failed to ensure there were sufficient and effectively deployed staff to ensure people's care needs were met.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) The provider had failed to ensure that medicines were managed safely, risks assessed and people were protected from the risk of infection.

The enforcement action we took:

We served a warning notice on the registered provider and manager on 14 November 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15(1) The provider had failed to ensure that the premises and equipment used was clean and properly maintained.

The enforcement action we took:

We served a warning notice on the registered provider and manager on 14 November 2018

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) Systems or processes were not robustly established and operated effectively to assess monitor and improve both the safety and quality of care that people received. People's care records were not accurately maintained.

The enforcement action we took:

We served a warning notice on the registered provider on 14 November 2018.