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Milestones Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Milestones Care on 19 September and 3 October 2018. Milestones care 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. Milestones Care accommodates up to four people in one building. On the day of our inspection, four people were living at the home; all of these were people with support needs related to mental health conditions or learning disability.

This was the second time we had inspected the service since they registered with us in October 2014. At our July 2016 inspection we rated the service as Good. At this inspection we found the safety and quality of the service provided had deteriorated. This was the first time this service had been rated as Inadequate.

There was no registered manager in post at the time of our inspection. The previous registered manager had left the service in June 2018. 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. There was a service manager in post at the time of our inspection, they were in the process of registering with CQC. We will monitor this.

During this inspection we found the service provided at Milestones Care was not safe. Risks associated with people's care and support had not always been effectively assessed or mitigated. Risks such as choking and smoking were not managed safely, this placed people at risk of harm. Opportunities to learn from accidents and incidents had been missed. Environmental risks, specifically, fire risk, were not always managed safely.

People were not properly protected from abuse and improper treatment, referrals were not always made to the local authority safeguarding adults team and there was a risk people's allegations may not be taken seriously. Safe recruitment practices were not always followed. There were enough staff to ensure people's safety. Overall, medicines were stored and managed safely and the environment was clean and hygienic.

People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible; the policies and systems in the service did not support this practice. People did not always have timely access to support from health professionals. Staff did not have up to date training in some key areas. This meant there was a risk that people may receive care and support from staff who did not have the necessary skills and qualifications to support them effectively. Although people told us they had enough to eat and drink, risks associated with eating and drinking were not always managed in a safe way.

Overall, people had choices in relation to their day to day support; however, people's preferences were not always acted upon. Relatives told us they were not always informed about people's care.
We received some feedback that changes in the staff team lead to a lack of continuity in care. People's need

for advocacy support to help them express their views had not always been identified. People told us staff were kind, caring and respected their right to privacy. We saw positive interactions between staff and people living at the home. People were encouraged to be as independent as possible.

Each person had a support plan in place which detailed their needs and preferences. However, records did not demonstrate that support was always provided in line with directions in these plans. There was a risk people's complaints may not be treated in a fair and equal manner. Further work was required to ensure the provider met their duties under the Accessible Information Standard.

People were provided with a range of opportunities for social activity. People's diversity was respected and supported. People had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans.

The service was not well led. There was a lack of effective leadership at Milestones Care. Governance systems were not adequate which meant areas of concern were not identified or addressed. The provider had failed to investigate and learn from serious incidents. Where areas for improvement had been identified, the provider had not always taken effective action to ensure people's safety. The provider had not ensured that staff had a good knowledge of their roles and responsibilities. People and their relatives were not given the opportunity to get involved in the running of the home. There had been a failure to notify CQC of some events within the service. Staff told us they were involved in the development of the home.

During this inspection, we found five breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks associated with people's care and support had not always been effectively assessed or mitigated. Environmental risks were not always managed safely. This placed people at risk of harm.

Opportunities to learn from accidents and incidents had been missed.

People were not protected from abuse and improper treatment. Action was not taken to protect people from staff who may not be suitable.

There were enough staff to ensure people's safety.

Overall, medicines were stored and managed safely. The environment was clean and hygienic.

Is the service effective?

Inadequate

The service was not effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

People did not always have timely access to support from health professionals.

There was a risk that people may receive care and support from staff who did not have the necessary skills and qualifications to support them effectively.

People told us they had enough to eat and drink. However, risks associated with eating and drinking were not always managed in a safe way.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's preferences had not always been acted upon. Relatives told us they were not always informed about people's care.

We received some feedback that changes in the staff team lead to a lack of continuity in care.

There was a risk people may not have appropriate access to advocacy services to help them express themselves.

People were encouraged to be as independent as possible. People told us their right to privacy was respected.

People told us staff were kind and caring and we saw positive interactions between staff and people living at the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support was not always provided as planned.

Further work was needed to ensure people were provided with information which was accessible to them.

Complaints and concerns were not handled in line with the provider policy.

People were provided with a range of opportunities for social activity. People's diversity was respected and supported.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective leadership at Milestones Care. Governance systems were not adequate which meant areas of concern were not identified or addressed.

The provider had failed to investigate and learn from serious incidents.

People and their relatives were not given the opportunity to get involved in the running of the home.

There had been a failure to notify CQC of some events within the service.

Staff told us they were involved in the development of the home.

Milestones Care

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.

Prior to our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We did not request a Provider Information Return prior to our 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. However, we gave the provider opportunity to share information with us during the inspection.

The inspection was undertaken by two inspectors. During our inspection visit, we spoke with two people who lived at the home and the relative of one person. We also spoke with four members of care staff, the deputy manager, the service manager, the regional manager and the provider.

To help us assess how people's care needs were being met we reviewed all, or part of, four people's care records and other information, for example their risk assessments. We also looked at the medicines records of all four people, three staff recruitment files and a range of other records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

People were at risk of choking. Choking risks had not been effectively assessed or mitigated. Records showed one person had recently had a serious choking incident, requiring medical intervention. Their support plan identified the risk of choking and directed staff to cut food into bite sized pieces and ensure it was soft and moist. However, records did not demonstrate staff had followed this guidance. There had been no referral to speech and language therapy for professional (SALT) advice when the person was identified as at risk of choking. Furthermore, there were no records of action taken after the choking incident to reduce risk, there had been no referral to SALT and weekly records continued to document that the person was served a high-risk diet. Two other people had also been identified as being at risk of choking but again food records did not evidence that guidance in risk assessments was followed. This failure to safely manage risks placed people at risk of harm.

People were not protected from the risks associated with smoking. One person living at the home was a smoker and was observed to have burn marks in their clothing. We observed the person smoking outside in the garden at regular intervals throughout our inspection. Staff were unable to observe or supervise the person due to the layout of the garden. Although there was a risk assessment in place it did not cover the risk that the person may set their clothes alight. This placed the person at risk of serious injury.

Environmental risks were not always managed safely. People were not adequately protected from the risk of fire. The fire risk assessment had been completed by a member of staff who had not had any recent specific training in this area to ensure their competency. This had also been identified in a recent audit conducted by Nottinghamshire Fire Service. During our inspection we observed the fire risk assessment had not been reviewed following the advice from the fire service. This failure to act to improve fire safety at the home placed people at risk of harm.

There had been a failure to learn from accidents and incidents. Consequently, action had not always been taken to reduce future risk. For example, records documented a recent incident involving a visitor to the home who had posed a risk to people living there and staff. Records showed the police had been called and the person was banned from the home. Despite this serious incident, there was no risk assessment to protect people and staff should this person return. This placed people and staff at risk of harm. In addition, we found the approach to recording accidents and incidents was inconsistent. Some serious incidents had not been recorded on incidents forms, but some minor incidents and altercations had. This meant opportunities to review and learn from incidents may be missed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse and improper treatment. Safeguarding incidents were not always identified or referred to the local authority safeguarding adults team. A behaviour chart documented a physical altercation between two people living at the home. The person's support plan directed staff to remain one step ahead and remove other residents to prevent harm. However, the behaviour record did not

evidence staff had followed this advice. This incident had not been identified or investigated by the management team. The provider had also failed to inform the safeguarding adults team about the above choking incident. This meant there was a risk safeguarding incidents may not be appropriately investigated.

There was a risk that allegations made by people living at the home may not be appropriately investigated. One person's support plan documented they were known to raise false allegations. During our inspection, this person raised concerns to us about the practice, attitude and behaviour of a staff member. We shared this with the regional director who told us the person was known to make false allegations, they told us this meant allegations were hard to investigate due to a tendency to "exaggerate" or "lie." Records documented an incident involving allegations against another staff member. Although the management team were aware of this there had been no formal investigation into concerns. This posed a risk that allegations may not be taken seriously and therefore not investigated.

We were concerned that people may be subjected to restrictive measures. A behaviour chart recorded that one person had become agitated when out with staff. Staff had recorded on the form, 'Due to [name's] behavior my senior has said he will not be going to Skegness at the weekend.' This person's support plan documented that they were reliant upon routine and predictability to maintain their wellbeing and preserve their mental health. A change to their planned routine may have caused them significant distress. Other records documented staff 'reprimanding' service users in response to behavioural incidents and deteriorations in their mental health. This form of behaviour control was not an appropriate technique for managing the behaviours of adults with complex mental health needs. The provider told us this was a recording issue and said they had followed up with the staff member involved.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not been taken to ensure people were protected from staff that may not be fit and safe to support them as safe recruitment processes were not always followed. Risks posed by staff who had criminal convictions were not adequately assessed or managed. Consequently, there was no evidence that the provider had any measures in place to mitigate potential risks posed to people living at the home. This placed people at risk of harm. The provider told us they would put a risk assessment in place.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff available to meet people's needs and ensure their safety. People living at the home told us there were enough staff and this view was also shared by most staff. A member of staff told us, "There are enough staff." We reviewed rotas and found that, overall, there were enough staff on shift. Two or three staff were on day shifts and there was one member of staff on at night who was supported by an on-call manager who could be contacted in the event of an emergency. However, we found people were not always provided with the one to one support that was commissioned for them. We have reported on this in the section, 'Is the service Responsive?'

Overall, medicines were stored and managed safely. Medicines systems were organised and medicines records were completed to demonstrate that people had been given their medicines as prescribed. We found some minor issues in relation to administration directions for creams. One person was prescribed a cream to be applied three times a day, but records showed this was only applied once a day. The deputy manager told us this was due to the label on the medicine not being updated. Another person was prescribed a cream, but there were no directions of where, when and how to apply the cream. The deputy

manager told us they would take action to address this. Staff were trained in the administration of medicines and regular checks were carried out to ensure medicines were managed safely.

Adequate hygiene practices were followed and overall the environment was clean and hygienic. Most staff had training in infection control and basic food hygiene. The Food Standards Agency had inspected the home in April 2018 and given it a food hygiene rating of five, which means 'very good'. We observed the kitchen area to be clean and well maintained and staff followed food hygiene procedures.

Inadequate

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been correctly applied to ensure decisions were made in people's best interests. Mental capacity assessments had not been completed in all required areas. This meant people's capacity to consent to restrictions on their freedom had not always been formally assessed. One person had restrictions upon cigarettes. Records showed occasions where this restriction had resulted in the person's behaviour escalating. Despite this, the person's capacity to consent to this restriction had not been assessed. Another person had restrictions placed upon their access to some foods when their mental health deteriorated. Again, their capacity to consent to this had not been assessed. This meant we could not be assured that decisions made in people's interests were the least restrictive option and posed a risk that their rights under the MCA may not be protected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS had been made as required. However, the local authority DoLS team had not been updated when additional restrictions had been imposed upon people's rights. This meant DoLS applications did not contain full information about people's care to enable the local authority to effectively prioritise applications.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have timely access to support from health professionals. The management team did not have sufficient knowledge of when and how to make referrals to specialist health professionals. Three people who lived at the home had been assessed as being at risk of choking. The regional director told us the risk assessments had been put in place as a precautionary measure as all three people had some risk factors. They had not recognised that care staff did not have the required expertise to assess and mitigate the risk of choking. Consequently, no referrals had been made to Speech and Language Therapy (SALT) for professional advice. It is of further concern that the management did not know how to make a referral to the SALT team. The deputy manager asked us how to make a referral to SALT as they were not sure of the local arrangements and would have to search on the internet.

There was a risk people may not receive person-centred care and support when they moved between different services. For example, 'hospital passports' had been developed for each person living at the home.

Hospital passports are designed to share information between care homes and hospitals, to ensure care is person centred. However, these did not always contain key information about people's support needs, such as choking risk. Furthermore, the service manager was not aware of hospital passports so there was a risk these may not be used as intended.

Risks associated with eating and drinking were not always managed in a safe way. Records showed one person had unhealthy eating habits, such as missing meals, bingeing and making unhealthy choices. There was no care plan or risk assessment in relation to this. Food records documented staff had, 'offered nutritionally balanced diet' which had been declined by the person. There had been no recent referrals made to specialist health professionals for advice about how best to support the person. We also saw the person had a health condition that may have been related to their food choices. No analysis of the person's diet and health condition had been completed to identify any trends.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk that people may receive care and support from staff who did not have the necessary skills and qualifications to support them effectively. Although staff told us they had enough training, record showed some staff did not have up to date training in key areas. Records showed that, of the 10 staff employed, two staff had no training in techniques to safely support people when their behaviour escalated and the training of six other staff was out of date. Only two members of staff had up to date training in this area. This training was important for staff as records documented incidents where people tried to hit, throw things and scratch staff. Staff did not always have the required competency to deal with challenging situations. For example, one incident record documented a person was punching staff. Staff were recorded as 'running out' of the person's room. This was not an appropriate way of safely managing a person's behaviour.

In addition, records showed staff had attended multiple training courses in one day. For example, one member of staff attended all the following courses in one day; safeguarding, moving and handling, MCA, DoLS, food hygiene and nutrition, first aid, health and safety, fire safety and infection control. This meant staff may not have in-depth knowledge in these areas. Indeed, during our inspection, we found concerns in some of these areas such as the implementation of the MCA and safeguarding.

Despite the above concerns about managing dietary risks, people told us they had enough to eat and drink. People told us they could choose and prepare their own food. One person said, "If I want to go pick my food I just have to say and they give me a lift. I give them a list and they follow it. They can all cook what I want."

The home was adapted to meet people's needs. Milestones Care is situated in a residential property, which has been adapted to accommodate the service. There were three bedrooms and an office upstairs and a fourth bedroom, lounge, conservatory and communal kitchen downstairs. People also had access to a well-maintained garden.

Requires Improvement

Is the service caring?

Our findings

People's relatives told us they did not always feel involved in people's care and support. One relative told us, "If I ask them, you'll be updated. They don't go out their way to tell me. I don't mind the small things, But it's the big things too." Overall, we found that people were involved in day to day decisions about their care and support. However, timely action had not always been taken to act upon people's choices and decisions. Records showed one person had stated they wished to attend health appointments unsupervised. An action was recorded in February 2018 which stated an assessment of the person's mental capacity was required. However, at the time of our inspection no capacity assessment had been completed and the person still attended health appointments with staff.

We received some feedback that changes in the staff team lead to a lack of continuity in care. A relative told us a member of staff was going to teach their relation to play dominos. The staff member left, but this was not passed on so the person did not receive this support.

There was a risk people may not have appropriate access to advocacy services to help them express themselves. Advocates are trained professionals who support, enable and empower people to speak up. Although there was information about local advocacy services available to people living at the home, staff had not made any referrals. There was one person who may have benefitted from advocacy to enable them to express their dissatisfaction with services. However, there was no evidence that referral for advocacy had been considered.

People were supported by staff who were kind and caring in their approach. Throughout our inspection we saw positive interactions between staff and people using the service. People spoke positively about the approach of staff. One person said, "They're nice, they help me." A relative told us "[Person] seems to have a really good relationship with staff." We observed staff treated people with respect. They were patient and friendly and people looked relaxed in their company.

People's support plans recorded their preferences for how they wished to be supported as well as their history, likes, dislikes and what was important to them. People told us they were involved with care planning and there was evidence in records of involvement in some areas. Overall, staff had a good knowledge of people's preferences. For example, one person told us staff regularly supported them to visit their family member's grave. Staff showed concern for people's wellbeing and they responded to their needs for reassurance and support. For example, we saw one person became anxious about a health appointment, staff provided support and reassurance which reduced the person's anxiety. The person later told us "[Staff member] is nice if I worry." Support plans contained information about how people communicated and explained why they communicated in a certain way. Plans gave clear instructions on how staff should respond to them appropriately. We saw staff understood how people communicated and used this to inform their support.

People were encouraged to be independent . Staff showed they were caring while promoting this independence. One person liked to go into the community alone. Staff knew that this could be difficult for

them and had a care plan to follow if there were any issues. This person gave an example of staff responding quickly and compassionately at a time where they needed support. Other people were supported to maintain their independence around the home, for example with meal preparation. Care plans detailed people's strengths and levels of independence so this could be promoted in daily support.

People's right to privacy was upheld. Care records informed staff how to respond sensitively to people's care needs. People told us that this was reflected in day to day care. One person told us "I can go to my bed and put my feet up if I need time out." During our inspection we saw people go to their rooms for privacy if needed. Staff considerately checked on their wellbeing if this happened.

People's relatives and friends were welcomed into the home. A relative told us "I see (person) once month. They seem settled. I'm not worried about leaving them." Staff could tell us who was important to the people living there. There were no restricted visiting hours for people to visit the service.

Requires Improvement

Is the service responsive?

Our findings

Each person had a support plan in place which detailed their needs and preferences. However, records did not demonstrate that support was always provided in line with directions in these plans. For example, food records did not document people had been provided with the food recommended in their care plans. Behaviour records showed staff did not always follow guidance to safely manage incidents. Furthermore, the provider received additional funding for each person living at the service to deliver one to one support. This additional support was to ensure people's safety and to ensure their social and emotional needs were met. Records did not evidence that this support was used as intended. For example, records for one person showed that one to one support was being used to fulfil routine care tasks such as giving the person their medicines or running a bath for them. This meant there was a risk that people's needs in other areas were not being met.

There was a risk people's complaints may not be treated in a fair and equal manner. Although people felt able to complain, we found that the provider did not formally investigate or record their complaints in line with their complaints policy. Records showed, and staff told us, that one person frequently raised concerns and complaints. However, none of these concerns had been recorded or investigated by the provider. This meant there was a risk complaints and concerns may not be appropriately addressed.

Further work was required to ensure the provider met their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The provider supported people who had a variety of communication needs. We found information was not accessible to the people using the service. This meant people did not have access to information about how to make complaints or report abuse and their care plans were also not accessible to them. The provider advised they planned to create more accessible information. During our inspection, they created a new accessible complaints procedure, they planned to check this with external specialists before using it.

People were provided with a range of opportunities for social activity. One person told us, "We go to the disco on Wednesday, we have a good time and I have a shandy if I want one." A relative said, "The best thing about the service is [person] goes out every day, which they love. They get to go the shop and day trips to Skegness. Keeping [person] occupied works well." People spoke positively about the activities they took part in and staff knew their interests. We saw staff ask people what they would like to do with their day. If people needed support to decide, they were given suggestions relevant to their interests. Activities included a variety of day to day domestic tasks, social activities and trips out, such as going shopping or day trips.

People's diversity was respected and supported. People's cultural, spiritual and religious needs had been explored in care planning. For example, one person was supported to attend services at a local place of worship. This was flexible based upon the person's mood and wellbeing. Records showed that staff sometimes supported another person to cook culturally appropriate meals.

Although the service was not supporting anyone who was coming toward the end of their life at the time of

our inspection, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans.

Inadequate

Is the service well-led?

Our findings

There was a lack of effective leadership at Milestones Care. There was no registered manager in post at the time of our inspection but there was a service manager who had been in post since June 2018. They managed Milestones Care and three other homes owned by the provider. The service manager told us they spent one day a week at Milestones Care. They felt this was sufficient; however, we found they lacked knowledge of the needs of people living at the home and the day to day operation of the home. For example, they advised us that only one of the four people living at the home had a learning disability, however records showed three of the four people had a learning disability. Furthermore, people were not always aware of who the manager was. A relative told us, "I couldn't tell you who the manager is. No one has introduced themselves as the manager."

The management team had a limited competency to undertake robust and comprehensive risk assessments. This was evidenced by several risk assessments referred to in the safe section of this report which did not effectively mitigate risk. This gave us further cause for concern about the competency and skill of the leadership team and this placed people at risk of harm.

There was a lack of effective governance systems which meant areas of concern were not identified or addressed. The regional director told us they had not conducted a formal audit at Milestones Care since April 2018. This meant the issues identified in our inspection had not been identified or addressed by the provider. This had resulted in ineffective management of the home.

There were no formal audits of support plans or record keeping. The regional director told us there was no structure in place for how and when to audit support plans and added that they were in the process of creating an audit. However, this lack of audits meant the deficiencies we found in care records had not been identified and addressed before our inspection.

Systems to review and learn from practice in the home were ineffective. Care records such as incident forms, behaviour charts and weight records had not been effectively reviewed or analysed. For example, one person's weight chart recorded they had lost over a stone in four days. This had not been identified by the management team and so had not been investigated further. This had resulted in a failure to identify where further action was required to protect people from harm.

Where areas for improvement had been identified, the provider had not always taken effective action to ensure people's safety. For example, in early 2018, the local authority had identified a failure to assess and manage risks posed by staff who had criminal convictions. They discussed this with the provider who assured them action would be taken. However, at our inspection we found this remained an area of concern.

The provider had failed to implement learning from serious incidents. In December 2017 there had been a serious incident at one of the provider's other homes. The local authority safeguarding adults team investigated this and made recommendations about improvements that were required to care records.

Despite this, we found identical issues at Milestones Care during our inspection. This demonstrated a failure to apply learning across the organisation and placed people at risk of harm.

The provider had failed to investigate serious incidents. The week before our inspection there had been a serious choking incident. Although the regional director told us they had discussed this with the management team there was no formal investigation into the circumstances leading to the incident and consequently there was no plan detailing what would be done to prevent the same thing from happening again. This placed people at risk of further harm.

The provider had not ensured that staff had a good knowledge of their roles and responsibilities. This had a negative impact upon people's care and support. Staff did not understand the concept of 'one to one' support. One member of staff told us, "It's talking to people and giving them time to talk to you." The failure to ensure staff understood the purpose of their roles had resulted in one to one support hours being used to undertake routine care activities.

People and their relatives were not given the opportunity to get involved in the running of the home. A relative told us, "I'm never invited to meetings. I've never been asked what I think of the service. I'll tell them what I think when I go, but no one asks." The provider told us there was no formal process in place to consult with people and their relatives but said they were developing a questionnaire to assess people's satisfaction with the service.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a failure to notify CQC of some events within the service, which the provider is required to by law. We found the provider had failed to notify us of an occasion where the police were called to the home. We had also not been notified of a serious choking incident. A failure to notify CQC of such incidents has an impact on the ability of the CQC to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they were involved in the development of the home. Records showed staff attended regular meetings and could give their feedback, formally and informally. One member of staff explained they had made a suggestion to try to reduce a person's anxiety. They told us, "That's being sorted now, they listen to suggestions."

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the home and on their website.

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 There had been a failure to notify CQC of some events within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 205 were not respected. Regulation 11 (1)

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 Risks associated with people's care and support had not always been effectively assessed or mitigated. Environmental risks were not always managed safely. This placed people at risk of harm. Opportunities to learn from accidents and incidents had been missed. Regulation 12 (1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Regulation 13 (1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective leadership at Milestones Care. Governance systems were not adequate which meant areas of concern were not identified or addressed. The provider had failed to investigate and learn from serious incidents.

	People and their relatives were not given the opportunity to get involved in the running of the home. Regulation 17(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Action was not taken to protect people from staff who may not be suitable. Regulation 19(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.