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Mill Lodge Residential Care Home

Inspection report

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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 unannounced inspection took place on 02 and 05 February 2018.

Mill Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 16 people. At the time of the inspection, there were 11 people who received support with personal care as nursing care is not provided at this home.

The service was managed by a registered manager who is also one of the service providers. 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.

At the last inspection in October 2016, the service was rated 'Good'.

At this inspection we found that the quality and safety of the service had deteriorated. We found shortfalls in relation to the management of risks associated to receiving care. This was because staff had not always sought medical advice when people had suffered unwitnessed falls and had failed to report serious injuries to safeguarding authorities; quality assurance systems were not effective in identifying shortfalls or areas where the service was not meeting regulations and failure to drive improvements. There was a failure to notify the Care Quality Commission of serious incidents in the service and notifications of death had not been submitted.

We found there were five breaches of the Regulations. These were breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 16 and 18 of Care Quality Commission (Registration) Regulations 2009. You can see what action we told the registered 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, it 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 systems and processes for monitoring and assessing quality in the home to ensure people's safety and compliance with regulations were inadequate. There were medicine audits, care plan audits and health and safety audits however we found concerns that had not been identified by the audits. Internal audit and quality assurance systems had not been effectively implemented to assess and improve the quality of the service and to proactively identify areas of improvement.

Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. However, the risk assessments were not always reviewed in line with people's changing needs. In addition there was lack of appropriate risk assessments and risk management processes relating to the people who are at risk of falling out of bed.

Staff had received safeguarding training however, local authority and national safeguarding reporting guidelines had not always been followed. Some significant incidents had not been reported to the local authority and the Care Quality Commission. Accident and incidents had been recorded and staff had sought medical advice where required. We found this was not always consistent in all cases especially incidents involving unwitnessed falls. Improvements were required to demonstrate what support people had received following incidents such as repeated falls.

People received their medicines as prescribed and staff had been trained in the safe management of medicines. However, there were some shortfalls in medicine management practices in the home.

The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. However, some improvements were required to ensure staff understanding of the requirements of the Mental Capacity Act 2005 (MCA). People's consent to various aspects of their care was considered and where required Deprivation of Liberty Safeguards (DoLS) authorisations had been sought from the local authority. However, mental capacity assessments were not decision specific and DoLS conditions had not been fully met.

Recruitment checks were carried out to ensure suitable people were employed to work at the home. However, improvements were required to the recruitment procedures.

Care plans were in place detailing how people wished to be supported. People and their relatives were involved in care planning. However, this had not always been recorded. People's independence was promoted.

Feedback from people and their relatives regarding the care quality was positive. People who lived at the home told us that they felt safe. Visitors and people who lived at the home spoke highly of the registered manager and the owner who is also the provider.

There was an infection control policy and the risk of infection was adequately managed.

Risk associated with fire had been managed and fire prevention equipment serviced in line with related regulations.

The environment was clean and adaptations and decorations had been adapted to suit the needs of people living at the home.

The provider had sought people's opinions on the quality of care provided.

We observed regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. People's nutritional needs were met. Risks of malnutrition and dehydration had been assessed and monitored. Comments from people who lived at the home were all positive about the quality of meals provided.

We observed people being encouraged to participate in activities of their choice. People who lived at Mill Lodge Residential Care Home and their relatives, knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

Some staff had received induction and training. There was a policy on staff supervision and appraisals and staff had received regular supervision. We saw some staff were in the process of completing their training.

Staff told us there was a positive culture within the service. Staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people who lived at the home.

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 to the health, safety and wellbeing of people who used the service were not always adequately assessed and appropriately managed. People were not adequately protected from risks of falling from their bed.

There was a safeguarding policy and a whistle blowing policy. However, staff were not always aware of their duty and responsibility around safeguarding. Concerns were not always reported to the local authority and The Care Quality Commission.

People's medicines were not always managed in accordance with safe procedures.

People and their relatives told us they felt safe.

Risks of fire had been adequately managed. Staff recruitment procedures required improvements.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The rights of people who did not have capacity to consent to their care were not consistently supported. Authorisations to deprive people of their liberties had been submitted where required. However, DoLS conditions had not been met and mental capacity assessments were not always decision specific.

Staff had received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

People's health needs were met. However, specialist professionals were not consistently involved for one person.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives spoke highly of care staff and felt they were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always reviewed following significant incident such as falls and hospital admissions.

People had plans of care which included essential details about their needs and the outcomes they wanted to achieve.

Information was provided in an accessible manner to people with sensory impairment.

People had been provided with appropriate meaningful day time activities and stimulation to keep them occupied.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment. Complaints had been dealt with in line with policies and procedures.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of clear and systematic approach to monitor the overall quality of the service and compliance with regulation.

We found shortfalls relating to seeking consent, medicines management and audit systems in the home. Governance systems for assessing the quality of records relating to care delivery were inadequate.

Policies for assessing and monitoring the quality of the service were in place. However, the systems and processes were not robust enough to identify concerns relating to care.

There was a registered manager in post and people gave positive feedback about the manager and the provider.

The provider had failed to send notifications regarding events in the service including death notifications.	

Mill Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 02 and 05 February 2018. The first day was unannounced.

The inspection was prompted in part by a notification from the local authority of two incidents following which two people using the service sustained serious injuries. Both incidents had been investigated by the Local Authority Safeguarding team. One of these incidents had been brought to the attention of the police and referred to the Coroner who was undertaking further investigations.

The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls in the home. This inspection examined these risks.

The inspection team consisted of one adult social care inspector who is also the lead inspector for the service.

Before our inspection visit we reviewed the information we held on Mill Lodge Residential Care Home. We had been notified by the local authority safeguarding department of two significant injuries which had been sustained at the home as a result of people experiencing falls. We explored how risks were managed during care support. This included instances when people were supported in bed and walking around the home. We also explored the environment and any measures that the provider had put in place and procedures that staff had followed in response to the incidents.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is

information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Before the inspection, the registered provider had not submitted statutory notifications about incidents and events that had occurred at the service. A notification is information about important events, which the provider is required to send us by law. We contacted health and social care professionals who worked alongside the service for information. We also reviewed the information we held about the service and the provider. We spoke to community social workers.

We spoke with a range of people about the home including five people who lived at the home, three visitors and three care staff. In addition, we also spoke with the registered manager who is also the owner and the deputy manager.

We looked at the care records of six people who lived at the home, training records and three recruitment records of staff members and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People who lived at the home and their relatives told us they felt safe living at Mill Lodge Residential Care Home and with the way staff supported them. Comments from people who lived at the home included, "It's alright here they are good to me", and, "I do feel safe here and it's nice." A relative told us, "I think they did their best for [my relative] to keep them safe, I cannot fault them."

We looked at how accidents, falls and near misses were managed. We found accident and incidents forms had been completed and an analysis of incidents was carried out every month. We noted that there had been a number of falls in the home. Some of the falls were unwitnessed and some had been witnessed by staff. Records we saw showed that in some instances staff had sought medical advice from telemedicine service following an unwitnessed fall. However, this was not always recorded and was not consistent in all the records we reviewed. Staff had not always recorded the support they had provided people after the incidents such as post falls observations. 'Telemedicine' is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities or out of hours.

We also found, staff had been instructed by the provider to contact the local safeguarding officers following unwitnessed falls. However, in nine cases of unwitnessed falls that we reviewed, staff had recorded that they had contacted safeguarding and had not been able to speak to the safeguarding professionals as the department was closed. However, the local authority operates a 24hr emergency duty service so it was unclear as to why this was the case. The guidance did not prompt staff to consider seeking medical advice in line with best practice. This meant that people could not be assured they would receive timely and appropriate intervention following a fall.

We found incidents which had resulted in injuries and hospital admissions that had not always been reported to the Local Authority safeguarding team and the Care Quality Commission. For example, one person had an unwitnessed fall. At the time of the fall no medical advice had been sought however, after complaining of pain the person was admitted to hospital where it was discovered that they had fractured their finger. In another incident one person fell from bed and suffered a suspected hip injury however, no medical advice was sought. . We also found one person had suffered a significant fall which resulted in a significant injury. However, the service had failed to notify the local safeguarding authority or CQC. This lack of reporting meant people could not be assured the registered provider and the staff would obtain medical attention or raise safeguarding concerns to allow independent investigations by relevant authorities. We also found there was no evidence to demonstrate that the provider had referred the person to falls specialist professionals. This meant that people could not be assured they would always receive appropriate support to reduce risks around them.

We found three people had incidents of falling out of their beds. Staff had put protective measures in place in the event of a fall; however there was no evidence to demonstrate whether they had considered if other preventative measures such as bedrails were safe to use and reduce risks of falling out of bed. We discussed

this with the registered manager and two staff and they informed us that they had been advised that it was illegal to use bed rails in a residential care home. However, bed rails can be used in any care setting as long as risk assessments have been carried out to show it is safe to use them, people's consent to having bedrails had been taken into consideration and there is a plan of regular maintenance and monitoring of the bedrails once fitted. This meant that the registered provider had failed to consider all options available to them to reduce risks of falling from a bed which resulted in people experiencing further falls.

Health and safety checks had been carried out to inspect the safety of the premises; however, we found three bedrooms on the first floor were not fitted with window restrictors. Window restrictors are fitted to windows to reduce the risks of accidental, deliberate or self-harm and falls from windows arising out of people having a confused mental state. The shortfalls meant that people were not adequately protected from the risk of falling from windows. In addition the health and safety audits were not robust in identifying faults and ensuring they were rectified in a timely manner. We discussed the risks and shortfalls with the registered manager. Following the inspection they sent us records to show that all windows had been fitted with window restrictors.

Risk assessments had been undertaken in keys areas of people's care such as nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. However, this was not consistent. For example we found one person had suffered significant skin tears and bruising. Care staff had ensured this person received medical attention and assessed the person as being at high risk of skin breakdown. However, there were no written care plans or risk assessments to provide guidance to care staff on how to support the person to minimise the risks or any measures that were required to minimise the risks to this person's personal safety.

There was a safeguarding policy at the service and some staff had completed training in safeguarding adult's awareness. However, two staff had not completed their training. As noted above staff did not always report serious incidents to the local safeguarding authority. This meant that the systems for ensuring that lessons were learned were not robust. The registered provider had failed to ensure that staff followed the local safeguarding protocols and guidance and national guidance on the management of safeguarding incidents.

There were failings in the assessment of the risks to the health and safety of service users and measures to mitigate any such risks were not robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider ensured the proper and safe use of medicines in the home. There were up to date policies and procedures which defined and described the service's responsibilities in relation to medicines. However, the policies and procedures had not always been followed to ensure people received their medicines safely.

People were identified by a photograph on their medicines administration record (MAR) which helped to reduce the risk of administration errors. The MAR provided clear information on the prescribed items, including the name and strength of the medicines and dosage instructions. The care plans for medicines were mostly clear, up to date and appropriately kept.

We observed the staff on duty administering medicines during lunch time. Staff were patient and respectful with people. However, we noted that people were not asked if they wanted their 'when required' medicines also known as PRNs. This meant that staff could not ascertain whether people wanted the medicines or not. We found there were no specific protocols for the administration of medicines prescribed 'when required'

and 'variable dose' medicines (PRN). The protocols are important to ensure staff were aware of the individual circumstances when this type of medicine may need to be administered or offered. The registered manager showed us blank PRN records. The organisation's policy required that all people with PRN medicines should have PRN protocols. This meant that the provider had failed to follow their own policy to ensure the safe management of medicines.

Records we reviewed did not demonstrate how people's choice and independence to manage their own medicines was promoted or considered.
We checked the arrangements in place for the management and storage of controlled drugs which are medicines which may be at risk of misuse. We found appropriate secure storage was provided and that the stock levels were in agreement with the recorded balance. There were appropriate security arrangements to monitor the medicines cupboard. The fridge and the temperature of where medicines were stored was being recorded on a daily basis to ensure those medicines were stored correctly and safely. However, some medicines in use in the trolleys with shorter expiry dates once opened did not have the date of opening recorded on the containers. This meant there was no way of knowing when they would be out of date.

The registered manager had carried out monthly medicines audits. They also informed us that an audit had been carried out by an external pharmacist, once or twice a year. However, the medicines audits had not identified the issues and concerns we found during the inspection. This may expose people to risks of medicines mismanagement.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service had emergency contingency plans in place. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly. Fire evacuation drills were undertaken regularly to ensure staff and people were familiar with what to do in the event of a fire. All people had personal emergency evacuation plans (PEEPS). These are records that provide guidance to care staff should people who lived at the home ever need to be moved to a safer area in the event of an emergency.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit, staffing levels were observed to be sufficient to meet the needs of people who lived at the home. There were two care staff in the day and two care staff for night shift. Comments from staff included, "There are enough of us and we help each other, if we are struggling the manager helps."

We looked at staff recruitment processes. We reviewed the recruitment records of three staff members and found that safe recruitment procedures had been followed. We saw the required reference and character checks had been completed before staff worked at the service and these were recorded. Disclosure and Barring Service (DBS) checks had been carried out before staff started their employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. However, the files did not included proof of identity. The recruitment policy for the home required updating to ensure it reflected current legislation. We spoke to the registered manager who informed us that they had seen staff's identity records while applying for their DBS checks however they had not kept copies in the files. They informed us that they would obtain copies of identity documents and update their recruitment policy in line with regulations.

The home was clean with hand sanitising gel and hand washing facilities available around the premises. We found equipment had been serviced and maintained as required. For example records confirmed gas appliances and electrical equipment complied with statutory requirements and were safe for use.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and their relatives told us they felt their needs were effectively met. Comments included, "We have nice staff here, they will do anything for you", "The food is nice and they do ask you what you want", "Yes I'm happy here but it's not my home" and, "I have just seen a chiropodist this morning they come regularly and staff are good at arranging this."

All staff we spoke with told us they knew people so well because they had worked at the care home for a long time and because the home was small.

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 make 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 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.

When we undertook our inspection visit, five DoLS authorisation requests had been submitted to the local authority. One of the requests had been authorised to ensure staff can lawfully restrict a person to maintain their safety. The DoLS authorisation had three conditions that the registered provider and the registered manager needed to meet to ensure the person's care was less restrictive. However, we found the conditions had not been consistently met. We spoke to the registered manager who informed us that the authorisation was made recently and that they had been in touch with an advocate and the person's family to arrange how the conditions would be met. This would ensure that the service was working within the principles of the MCA/DoLS to support the person in the least restrictive manner while maintaining their safety.

People and their relatives informed us that staff sought consent and considered people's mental capacity while providing care support. There was an up to date policy in relation to seeking consent and mental capacity. Consent to photographs and medicines management had been completed. However, we found the mental capacity records we reviewed were generic and not decision specific. In addition, there were no best interest decision records, where people had been assessed as lacking mental capacity to make specific decisions. We spoke to the registered manager regarding their responsibilities in respect of mental capacity assessments and they assured us that they would take appropriate action to ensure the shortfalls were rectified.

People told us they could get up anytime they wanted and chose to spend time in their bedrooms if they wanted to. We saw one person had a 'Do not disturb' notice on their bedroom. Staff we spoke with were very clear that this should be respected and that the person was not disturbed unless it was absolutely necessary. There were processes in place to ensure there was no discrimination, including in relation to

characteristics such as culture, gender, religion, race or age. For example, the majority of the staff had received training in equality and diversity and were aware of the human rights principles. There was a policy to protect people against discrimination and harassment.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. We saw people who lived at the home had access to the front garden which was enclosed and safe for people to use. In addition, there were was a lounge and a conservatory for people to sit. We observed people moved around the building freely. We saw some people had brought their own furniture which helped personalise their bedrooms and made it homely for them.

Records showed that staff completed an induction when they joined the service. They had received regular supervision and appraisals. A significant number of staff had also received national vocational qualifications levels two and three and the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life. We noted that two staff were in the process of completing some of their training including safeguarding training. Five staff had up to date health and safety training and eight had completed first aid or basic life support training.

We observed staff supported people to eat their meals. The atmosphere was calm and caring and people were not rushed with their meals. All people appeared to have enjoyed their meal and had eaten very well. Staff offered a choice of drinks. They encouraged individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they did not like the meals on offer. People also choose to sit where they wanted. Comments about the food were positive. One person who lived at the home said, "The food is very nice and they do ask you what you want."

The care records we reviewed had a section which noted any special dietary requirements such as soft diet. Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals in order to increase their nutritional intake. People were weighed regularly. We found staff assessed people against the risks of malnutrition and made referrals to dieticians and speech and language therapists (SALT) where appropriate.

Care records we looked at contained information about other healthcare services that people who lived at the home had access to. Staff had documented when individuals were supported to attend appointments or received visits from for example, GPs and district nurses. Documentation was updated to reflect the outcomes of professional health visits and appointments. However, we found one person who had suffered frequent falls had not been referred to specialist professionals despite having suffered frequent falls. This meant that people could not be assured they would always have access to specialist professionals in a timely manner if they needed them.

Requires Improvement

Is the service caring?

Our findings

During our inspection visit we observed people were relaxed, happy, smiling and comfortable. We confirmed this by talking with people. For example, comments included, "It's very nice here, they are nice to me" and "It's nice, they are very good to me, I have no complaints about the care."
Comments from relatives included, "[My relative] has been looked after very well here" and "Staff are good with people here."

We observed staff engaged with people in a caring and relaxed way. For example, they spoke to people at the same level and used appropriate touch and humour. We saw people were dressed appropriately in suitable clothing of their choice and they were well groomed.

Some staff had received training which included guidance in equality and diversity. Staff were able to described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

We observed people being as independent as possible, in accordance with their needs, abilities and preferences. We observed people being encouraged to do as much as they could for themselves. For example, we observed people eating independently and walking independently around the premises. Staff explained how they promoted independence, by enabling people to do things for themselves.

Staff maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering. Staff also addressed people in their preferred names. Care records that we saw had been written in a respectful manner.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the home around their own busy schedules. We observed staff welcomed relatives with care and respect and they had a friendly approach. One relative said, "They always make you feel welcome."

We saw people were supported to express their views on matters that were important to them. We spoke with the registered manager about access to advocacy services should people require their guidance and support. The registered provider had information details that could be provided to people and their families if this was required. We also noted that one person had been receiving support from an advocate. This ensured people's interests would be represented and they could access appropriate services outside of the home to act on their behalf if needed.

Requires Improvement

Is the service responsive?

Our findings

People who lived at the home made positive comments about the staff team and the care and support they received at the service. Their comments included, "If they can't do it that minute, they'll come back to it right away" and "They are kind and caring." And "They are most attentive and do take me out now and again."

We checked how the provider ensured that people received personalised care that was responsive to their needs. We looked at care records of six people. The majority of the care plans we reviewed were detailed and written well. However, we found one person had a missing care plan for skin care. They had been assessed as a high risk of skin breakdown however there was no guidance on how their skin would be cared for to reduce the risks. We spoke to the registered manager and they informed us this would be rectified immediately. The provider needed to ensure that they maintained consistency in these records.

The care records had been developed, where possible, with contributions from each person and their family. They identified what support they required. People and their relatives told us they had been consulted about support that was provided before using the service. People's needs had been assessed before they started living at Mill Lodge Residential Care Home. This was to ensure that the home and staff were able to meet people's needs before they decided to admit them into the home.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Specific requirements for each individual had been identified. Assessments and associated documentation were personalised to each individual who stayed at the home. Although care plans had been reviewed and dated, they did not always cover the changes in people's needs. For example, one person had suffered frequent falls however, the reviews carried out did not show what measures had been considered to reduce or minimise the risks. In addition we noted that review of incident reports were not always person centred and in some instances records had been written in a way that held the person who was involved in the incident as being responsible. For example, some records stated that the incident could have been avoided 'if the person listened to staff', 'if the person stops walking around' or 'if the person asked for help, or if the person to use the buzzer'. We discussed this with the registered manager and they informed us staff were not aware how the statements recorded may come across and that they would review how they completed records. This would ensure people's records were written in a respectful and person centred manner.

The provider had introduced technology to support people to receive timely care and support. For example there was a wireless call bell system which allowed people to move around with their call bells and allow them to summon support from staff from wherever they were in the building. There was also working broadband and a telephone system that was easy to use and accessible to staff and people who lived in the home. They had signed up to telemedicine services.

People were supported to maintain local connections and important relationships. People were also actively encouraged and supported to maintain local community links.

We found staff had sought accessible ways to communicate with people in line with their communication needs to reduce or remove barriers. For example, we found various pictorial messages and signage in the home to help people with sight and cognitive impairment to ensure they could communicate effectively.

People had access to various activities to occupy their time. There was no dedicated activities co-ordinator to assist with activities. However, we observed staff offering people activities and engaging with people in a positive and inclusive manner, taking consideration of their choices and abilities.

People we spoke with knew how to make a complaint or raise concerns and felt comfortable to do so if needed. We saw people were encouraged to do so by information that had been posted in the home and was in the service user guide provided to them when they first arrived. People were confident to speak up. The service had a complaints' procedure that was made available to people on their admission to the service. Copies were on view in the service and had been written in a format that enabled people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people they would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. We saw there was a complaints process in place. It guided staff to ensure that concerns and complaints were used as an opportunity to learn and drive continuous improvement.

Records we saw demonstrated that the provider and the staff had considered people's preferences and choices for their end of life care. For example, there was a policy that asked staff to record where people wished to die, including their preferences in relation to their religious, spiritual and cultural needs. All records we reviewed showed that people had been offered the opportunity to discuss their end of life plans. We also found examples where the plans had been put into place. This showed staff had acted in line with the person's religion and wishes.

There was also guidance on communicating with families and professionals to support people towards the end of their life. Some of the care staff had received training that included guidance on how to support people towards the end of their life. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at Mill Lodge Residential Care Home. 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.

We looked at how the registered manager demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. The registered manager who is also one of the registered providers had established a formal auditing system to assess quality assurance and the maintenance of people's wellbeing. We saw that audits had been undertaken in various areas such as medicines and health and safety. They had also carried out analysis of significant incidents in the home. However, the audits systems were not robust to enable the registered manager to learn from shortfalls and to check whether they were complying with regulations. The health and safety audits carried out were not accurate or reliable. The audit had failed to identify the faults that we identified around the premises. For example we found health and safety audits stated that all windows were secured with window restrictors, however our observations showed this not to be the case. We also found shortfalls in medicines management and in the care records and accidents and incident records which had not been identified by the audits. In addition we found accident and incidents analysis carried out in the home had failed to identify that staff were not consistently following the local safeguarding protocols which included failure to report serious incidents to CQC and safeguarding.

There were poor systems and processes for assessing risks for people who were at risk of falling from their bed. The registered manager and the provider had not taken into consideration, all that was possible to reduce or prevent the risk. There was limited skill and knowledge on how to undertake robust risk assessments for considering alternative measures to reduce the risks such as the use of equipment including bedrails. In addition the systems for reviewing the incidents of falls was not robust to ensure lessons were learned from these incidents. This meant that people were at risk of experiencing repeat falls from their bed.

The registered manager had failed to demonstrate their knowledge and understanding of the regulations to enable them to provide adequate oversight and governance on staff and monitor people's safety.

At our previous inspection we rated the home 'good' in all domains and there were no breaches of regulation. However, at this inspection we found four breaches of the regulations. we noted that there had been a significant deterioration people's care and safety. This meant that the governance systems and processes in place did not enable the provider to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events related to people who lived at the home. We found that the registered manager and the registered provider had failed to notify CQC of the keys events that had occurred in the home. For example, they had failed to notify CQC of three deaths in relation to people they provided support for. The lack of death notifications meant that CQC could not effectively exercise its regulatory role by taking follow up action where required.

The service provider had failed to notify the Commission of three deaths occurring at the home This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

In addition the registered manager and the registered provider had failed to send notifications in relation to notifiable incidents and events in the home. For example we found four allegations of neglect, which had been investigated by the local safeguarding team, had not been reported to CQC. One of these allegations was substantiated as neglect. We also found on five occasions people had been involved in incidents which resulted in hospital attendance. On one occasion a person had broken one of their fingers and another person had suffered significant life threating injuries. The Regulations require registered providers to submit notifications of significant events to ensure that we can be assured they took the correct action to support people involved and to reduce re-occurrences. A notification is information about important events which the service is required to send us by law. The lack of notifications regarding these incidents meant that CQC could not effectively exercise its regulatory role by taking follow up action where required. We could not ascertain how incidents had happened and whether the provider had taken appropriate action to prevent or reduce occurrence in the future.

The service provider had failed to notify the Commission of a number of incidents at the home. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The failure to send notifications and to report safeguarding concerns meant that the provider had failed to demonstrate openness and transparency. In addition safeguarding issues had not been referred appropriately to the local authority and had not been dealt with objectively in the service.

We checked how people who used the service, the public and staff were engaged and involved in the running of the home. Residents and relatives meetings were arranged and saw minutes of meetings that took place in the home. There was a suggestion box for people and visitors to share their views about the home. There were quality assurance surveys carried out to seek people's views on the care provided. In addition, there were staff meetings. We saw the registered manager and the provider shared the challenges and expectations with staff during the staff meetings.

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide quality care. For example, we only received positive comments from staff and relatives and they included, "The registered manager is involved in the day to day running of the service. They will get involved if we are running short." Also, a relative said, "It's alright here, I can go and speak to the registered manager if I have anything to discuss."

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager was experienced and supported by a deputy manager. Care staff had delegated roles including medicines management, catering and domestic duties. Each person took responsibility for their role.

We looked at how staff worked as a team and how effective communication between staff members was

maintained. There was communication about people's needs among staff and management. We found handovers were used to keep staff informed of people's daily needs and any changes to people's care.

We found the home had maintained links with other organisations. They worked with organisations such as local health care agencies and the local commissioning group, local pharmacies, and local GPs. However, the links had not been effectively used to enhance the services they delivered and to support care provision, service development and joined-up care. For example, they had not consistently followed the local safeguarding protocols in sharing information about the increase in risks.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of people's medicines. The provider had failed to ensure that risks to receiving care and treatment were identified and managed robustly.-Regulation 12(2) (a) (b) (d) (g) (h) HSCA RA Regulations 2014 safe care and treatment.