Mr & Mrs J Fieldhouse

Millfields Residential Care Home

Inspection report

Mill Lane
Nevison
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West Yorkshire
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Tel: 01977690606

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 31 May and 3 June 2016 and was unannounced. The service was last inspected on 9 August 2013.This was a focussed inspection and the service was found to be compliant with all health and social care regulations.

Millfields Residential Care Home provides accommodation, personal care and support for up to 38 older people, some of whom might also have a physical disability and or dementia. On the day of our inspection there were 29 people living at Millfields.

There was a registered manager in post at the time of our inspection. A registered manager is a person who was 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 found the standards of care in the service had deteriorated significantly since our last inspection. There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was not secure as there was no lock on the front door and a glass panel in an external fire door was smashed

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The registered manager and staff had limited knowledge of their responsibilities in regard to the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS.) particularly with regards to lasting power of attorney.

We found risk had not been adequately or accurately assessed in relation to moving and handling. Risk assessments did not reflect the current needs of people or describe the equipment which was required.

Equipment and furniture in the home was in need of repair. There was a lack of cleanliness throughout the service and a malodour was present throughout the building.

Medication was received and stored correctly, however we saw that two tablets had been dropped on the floor. This meant people were not supervised sufficiently when taking medications. We saw that prescribed creams and lotions were not being signed for, this meant there was no way of knowing if they had been applied.

We found people in the service were not treated with dignity and respect. Bedroom doors were left open when people were using commodes. We saw people were being supported to get dressed before five am and then getting back into bed in their day clothes.

The people living in the service were not asked for their consent for care to be carried out.

Decision specific capacity assessments were not carried out for the people living in the service to measure whether they were able to make their own decisions and which decisions they were able to make.

The registered manager was unaware of their responsibilities in regards to the MCA and DoLs. In regards to lasting power of attorney the manager was not aware that documentation was required to determine which decisions the power of attorney related too.

The registered manager was not always aware of safeguarding incidents. We saw that staff were recording incidents but not making the manager aware. This led to a lack of management oversight.

There was a lack of meaningful activities. We saw people sleeping in chairs throughout our inspection. We saw chair exercises offered to people, however this did not keep people's attention. The room lay out meant the person delivering the class had to move around to explain the exercise to each individual, losing the attention of others.

The manager told us there had been no complaints and no documentation regarding complaints. However we found reference to complaints in meeting minutes, demonstrating that complaints had not been actioned in line with the company's policy.

We saw audits for medication, hourly rounds, accident and incidents, and safeguarding. However they were not robust or accurate and no analysis or learning was taking place.

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 time frame. 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 or 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

The security of the building was compromised as there was no lock on the front door. This meant any one could walk straight in to the service and people living at the service who were vulnerable could leave the service unaccompanied.

Incidents involving people causing harm to others were not recorded correctly and the manager did not always have oversight of these incidents.

Equipment and furniture was lacking in cleanliness.

Some equipment was dangerous and posed a risk to people using it. We asked the manger to remove this equipment.

Medication was not administered in a safe manner.

There were not enough staff to meet peoples needs.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had had training in the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLs)

The registered manager was unaware of their responsibilities in regards to the MCA and DoLs.

Food and fluid were not completed accurately.

Staff supervision was in place in line with company policy,

The building was not adapted to meet the needs of people living with dementia.

Is the service caring?

Inadequate

The service was not caring

Staff did not respect peoples privacy and dignity, walking in to rooms with out knocking.

Bedrooms doors were open. We observed tow people using commodes in their bed rooms with the doors open.

We heard staff announcing they were taking people to the bathroom.

People were not supported appropriately with personal care needs.

Staff did not recognise peoples religious and cultural needs.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in planning their care.

My life had not been filled out so staff did not have information about people likes and dislikes or their life history.

No meaningful activities were offered.

Complaints were not documented or dealt with line with the company policy.

Is the service well-led?

Inadequate

The service was not well led

The manager was not aware of all incidents that occurred in the service.

Quality assurance processes were poor and in accurate.

The senior management at the home had failed to communicate incidents of concern to the CQC as legally directed to do so.

Millfields 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.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. We had not asked the provider to complete a Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we looked at care plans and risk assessments for seven people, four staff recruitment files, complaints, concerns, accidents and incidents records, policies and procedures, records of audits which had been carried out in the last 12 months, safety certificates and daily care records.

We spoke with five people who lived at the service, three visitors to the service, and six care staff, two domestic staff a member of kitchen staff, assistant manager, the registered manager and the registered provider.

Inadequate

Is the service safe?

Our findings

We asked people living at Millfields if they felt safe living there. One person told us "Yes I do but I prefer to keep my own company in my room." We asked peoples relatives if they felt their relative was safe at Millfields. A relative told us "No, not since the fire officer asked for the lock to be removed from the front door they [the person's relative] can get out now, they have been outside about eight times." We looked at the person's care file and found three incidents documented. We discussed this with the registered manager who told us "they don't go far, just out of the door." We asked the registered manager about the lock and they told us "it broke so we had it removed." However, the registered provider told us it was removed "due to fire regulations." We asked the provider for documentation in relation to this and were told "it was another home not this one."

As there was no lock on the front door, on the second day of our inspection we were able to walk in to the building and walk around unchallenged for 15 minutes. This meant the registered provider was not protecting people from avoidable harm, as the building was not secure. We discussed this with the registered provider who told us they treat it "similarly to their own home and so do not need to monitor the front door." This demonstrates a lack of understanding of their role in providing care for vulnerable adults. We reported our concerns to the local safeguarding team. We also asked the provider to ensure the service was secured. The provider has since informed us that a key pad lock has been installed.

Staff and the registered manager were able to explain safeguarding when asked, however we found this was not put into practice. We saw two instances of people causing harm to others documented in care files. This had not been reported to the registered manager, in line with the company's policy, which states staff should "document the incident and let the manager or on call know." The policy goes on to state "the manager will report any incident to the local safeguarding team." In the two instances we looked at staff had documented the incidents on anAntecedent-Behaviour-Consequence (ABC) Chart. This is a direct observation tool that can be used to collect information about the events that are occurring for a person within an environment. "A" refers to the antecedent, or the event that precedes behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence. In some instances staff had contacted the safeguarding team. However the registered manager was unaware of this and had not carried out any follow up or analysis of the events. We found that one incident had occurred in November 2015 however the manager was unaware of the incident until a visiting professional made them aware in March 2016. When the registered manager was asked about this they told us "I only know what the staff tell me."

The above examples demonstrate that the registered provider had failed to protect people from abuse. This was a breach of Regulation 13 (1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at risk assessments for four people in regards to equipment used. We found these lacked enough detailed information for staff to have detailed knowledge of how to support people. All four of the risk assessments had space for equipment and method to be recorded. Documented under equipment in all of the risk assessments was "hoist" there was no identification of which hoist and which sling had been

identified for that person. Under method the number of carers had been identified but no method for using the equipment. This meant we could not be certain staff knew how to support people to safely use equipment.

We saw a bath chair to which a lap belt from a wheelchair had been attached. This posed a danger to people, as the belt was designed for a wheelchair not the bath chair and would put people at risk when using the bath chair. We discussed this with the registered manager and asked that it be removed. We looked at four people's risk assessments for the bath chair and found none identified that a lap belt was required. We also looked at the manufacturer's instructions for the bath chair and it was not supplied with a lap belt. After the inspection we discussed this with the manufacturer who told us "Prior to 2009 chairs didn't have a belt, from 2009 all chairs have a belt supplied. Organisations who purchased a chair before this time can call us and request a belt. we will send out a belt and instructions for use.This meant the equipment being used was dangerous and unsuitable.

We saw a shower chair in the shower the feet to the chair had broken off and were in the shower tray next to the chair. This made the shower chair dangerous to use. On 31 May 2016 we asked the registered manager to remove this. When we returned on 3 June the chair was still in the shower with the broken feet next to it. We asked the assistant manager and the provider to remove the shower chair due to the danger it posed.

The above examples demonstrate a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the home was not clean. There was evidence of poor cleanliness throughout the building. We saw that the majority of the chairs in the lounges were stained. The lounge had a large stain on the carpet. We saw that the lounge had food debris, used tissues and cups with drinks in them left on tables. We found cups containing cold coffee and tea in corridors, and saw a drinks trolley that was stained and dirty in the corridor. Headboards in the bedrooms were stained, as were sinks in bedrooms. All moving and handling equipment we looked at was stained and in need of cleaning. All of the wheelchairs we looked at were stained with food debris and in need of cleaning.

We saw that a check list was in place for night staff to tick when they had cleaned the wheelchairs. However in most of the boxes night staff had recorded they were too busy to clean the wheelchairs. We saw commodes in people's rooms were stained with faeces as were toilet seats in communal bathrooms. Floors in bathrooms were stained. On the second day of our inspection we saw urine stains on a bedroom carpet. The home had a malodour throughout. We discussed these issues with the registered provider who told us "I am surprised by this. We have a good cleaning team."

The above examples demonstrate a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We found chairs in the lounge and dining room were ripped. A fire door had a smashed pane of glass on the outside. We asked the registered manager about plans to repair this. The registered manager told us "the fire officer is not concerned about it." We asked for documentation of this, however there was no documentation from the fire officer available . We asked the registered manager to ensure the glass was replaced.

We looked at nine wheelchairs of which four had broken heel straps, four had missing or broken lap straps, two had broken brakes, one had no sides, and one had a piece of the arm rest missing. The registered manager told us that the owner was responsible for repairing the wheelchairs . We asked the registered

manager to ensure that the wheelchairs were repaired and safe to use.

In two bathrooms we saw that light switches were missing the stopper leaving them looking like a piece of string. Emergency cords in bathrooms were missing their warning triangle and their stopper. This could cause a risk of people choking and or hanging themselves accidently. We also saw that they did not reach the floor meaning if someone fell to the floor they had no means of alerting staff . We discussed this with the provider and asked for the cords to be repaired.

We found a bathroom was used as a hair dressing salon with a shower over a sink and two large free standing hair dryers in the room. This demonstrated a lack of appropriate space for the hairdresser and a lack of respect for people's dignity.

We found hoists and wheelchairs stored in bathrooms. The assistant manager told us "we don't have much storage space we have to keep them in here." This meant if staff wanted to take any one to the bathroom the hoists and wheelchairs would have to be moved. For people who could access the rooms the hoists and wheelchairs posed a risk of entrapment.

The above examples demonstrate a breach of Regulation 15 (1) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were not enough staff on duty to effectively meet people's needs. On the first day of our inspection we noted that people looked unkempt and were sleeping throughout the day. On the second day of our inspection we arrived at seven in the morning. We found four people dressed in day clothes in their beds and 14 others up and dressed. It was unclear if this was everyone's choice. A member of night staff told us "we start getting people up at quarter to five, we have to. We wash and dress people then they can get back in to bed if they want to." Another member of night staff told us "Nights are busy. We have lots of jobs to do - getting vegetables ready for lunch, hourly checks, supporting people who need changing." We saw staff meeting minutes dating back to 2014 and staff supervision notes from staff raising concerns about people getting up so early in the mornings. We could not find any evidence that this had been addressed

We saw a notice in the laundry asking staff to "not automatically change bed sheets as staff cannot cope with the volume of work." A staff member told us "incontinence sheets are changed but bed sheets are not unless they are excessively wet."

We discussed staffing with the registered manager who told us "I use the RCN dependency tool to calculate how many staff on each shift. Currently we have a team leader and three care staff on shift during the day and at night, a team leader and two staff. If we need extra staff for instance if someone is on end of life care, I will allocate more staff to the shifts." We looked at the rota for a month and saw that staffing numbers had not changed although one person was on end of life care and one person had started to display more behaviour that challenged. This showed that the numbers of staff had not increased as the registered manager suggested they would with the needs of people living at Millfields.

We looked at Personal Emergency Evacuation Plans (PEEP) for five people. A PEEP is a document which details the safety plan, for example route, equipment, staff support, for a named individual in the event the premises have to be evacuated. All five of these stated that two members of staff would be required to help each person in the event of an emergency. These plans were not practical as the number of people who required two care staff and equipment to move them could not be met during the night.

The above examples demonstrate a breach of Regulation 18 (1) staffing of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014

Whilst we saw the storage and disposal of medicines was safe, the administration of medicine was not always safe. On the second day of our inspection we found two tablets on the floor in the lounge. The two tablets were at opposite ends of the room suggesting that two people had not been observed taking their medication. We gave the tablets to a senior carer who told us they would "make a note of it and send the medication back to the pharmacy." There had been no incident form or investigation completed in respect of this matter by the end of our inspection. On the first day of the inspection we found three peoples medication had not been signed for. We also noted that on the medication administration records (MAR) for creams and lotions it simply stated "carers administer." We discussed this with the registered manager who told us "We have a new system in place. We will have a separate MAR chart in bedrooms for the creams. It's not in place as yet for everyone." This meant we could not be certain that everyone who was prescribed lotions or creams had them applied as they were prescribed.

This was a breach of Regulation 12 (2) (g) safe care and treatment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at the recruitment processes which were in place. We found that the recruitment which had taken place was safe and that all necessary pre-employment checks had been carried out in line with the organisation's recruitment policy. This included references being sought from previous employers and a disclosure and barring service (DBS) check to ensure that people were suitable to work with vulnerable people. However one member of staff had started to work for the company in 2003 a Criminal Records Bureau check had been carried out. The CRB was replaced by the DBS in December 2012. The administrator told us "we don't re check peoples DBS there is no legislation to say we have to" This meant there was no system in place to ensure staff remained suitable to work with vulnerable people.

This was a breach of Regulation 19 (2) safe care and treatment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We asked people about the quality of the food. People told us the food was 'nice' or 'good'. People told us after lunch "I've enjoyed that" and "that was good." One person told us "I like the food I can choose what to have."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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. We asked staff about their understanding of MCA and DoLs. Some staff were able to tell us about the MCA telling us "it helps us understand what decisions people can make whilst one staff member told us " we make decisions for people or ask their family." And another told us "we can always ask peoples family if we don't know." Training records confirmed that out of 44 members of staff only 20 had received specific training in this area.

We looked at the records in relation to Deprivation of Liberty Safeguards (DoLS). These are measures which need to be put in place to protect the rights of people who have been assessed as not having capacity to keep themselves safe, and need to be restricted to maintain their safety and wellbeing. We found that a large number of the people who used the service had some level of cognitive impairment. We saw eight people had a DoLS authorisation in place and others had been applied for. However we did not find any decision specific capacity assessments in the care files we looked at. Assessment of mental capacity is specific for each individual decision at any particular time. People are considered to lack capacity if they have an impairment which causes them to be unable to make a specific decision. The person should be able to understand, retain and weigh the information provided and communicate their decision.

Whilst eight people had DoLs in place and more had been applied for there was no lock on the front door. This meant people who were deemed as lacking capacity, and in need of protection, and with the restrictions of a DoLs in place, could leave the building unaccompanied. We saw that one person had been able to leave the building on at least three occasions. This demonstrated a lack of understanding of DoLs and the restrictions which should have been in place to protect people. We asked the registered provider to ensure the building is secure at all times.

We saw in one person's care notes that the person's relative had Lasting Power of Attorney. A Lasting Power of Attorney (LPA) is a legal document that lets you appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on your behalf. There are two types of LPA: health and welfare and property and financial affairs. One or both of these can be chosen. We asked the registered manager for

the documentation showing which LPA was specified; they told us "We don't have this; it's for the family. We don't ask for it." This meant the registered manager and staff were unaware of which decisions should have involved the person's relative.

In the care files we looked at we saw that none of the people had been asked for or had given their consent to their care. There was no evidence that they lacked capacity to do so . We did see in one file a family member had been asked to give their consent however there was no evidence that the person themselves lacked capacity.

The above examples demonstrate a breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

We observed lunch being served. We saw the menu was handwritten on a white board and a menu card on each table. These had just one option for each course. However people were asked what they would like and given two choices with picture cards to help them choose. We saw tea and coffee being offered throughout the day. We saw that staff went around the people in their rooms to ensure they had drinks throughout the day. However we looked at food chart audits and found that entries were missing, for example one person had only two meals each day documented on 13,14,15 April 2016. This demonstrated that people's food and fluid intake was not being monitored accurately. which meant we could not be sure that people were supported to eat and drink sufficient amounts to meet their needs.

This was a breach of Regulation 14 (1) meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had been referred to health services including GPs, district nurses and speech and language therapy services when necessary. Although one member of staff told us "it's getting difficult to get people an appointment with their GPs." This demonstrated that people using the service received additional support when required for meeting their care and treatment needs

We asked staff if they received regular supervision, and staff told us that they did and records which we reviewed confirmed that this was the case. All staff had received four supervision sessions a year in line with company policy. This showed that staff were receiving regular management supervision to monitor their performance and development needs. However we found concerns were not being actioned. In one supervision record, we saw staff had raised concerns that people were getting up early. No action had been taken to remedy this.

We found that the design and layout of the building was not adapted to the needs of people living with dementia. The lighting in corridors was poor. Signage was of poor quality and not dementia friendly. We found a carpet with a rip which was a trip hazard. We pointed this out to the registered manager who subsequently glued it in place. People's rooms were not personalised and duvet covers were all the same. This meant people living with dementia may find it difficult to locate their own room. We saw that the calendar in the dining room was set at March 2016. Having clocks and calendars set to the correct date and time helps people rationalise daily routines. We discussed this with the manager who informed us they were unaware of this and it was the responsibility of the kitchen staff to check it.

There was a reminiscence room in set up next to a lounge. The room had pictures and items of interest from the 1940s onwards. The use of reminiscence rooms is to help people living with dementia by triggering memories. We did not see this in use during our inspection.

Inadequate

Is the service caring?

Our findings

We asked people if they were treated with dignity and respect one person told us "I most certainly am. I choose to stay in my room. They [the staff] respect that." Another person told us "The staff are very nice. They keep asking me to join in but I prefer not to."

Whilst staff told us how they would treat people with dignity and respect by knocking on doors before entering, we observed staff walking into rooms without knocking or knocking but not waiting for an answer. On the first day of our inspection we noted that people were asleep in the lounges throughout the day. We discussed this with staff who told us "people get up early. The night staff support them to get up and dressed." We saw in staff meeting minutes, and staff supervision that staff had complained that they did not like waking people early in the morning. We could find no evidence that this had been actioned as no changes had been made. On the second day of our inspection we arrived at seven am and found most people up and dressed for the day with four people in bed in their day clothes. A member of night staff told us "We start to get people up and dressed at quarter to five if they choose to go back to bed, they can." Another member of night staff told us "We have to start getting people up early as there are only three of us on duty and most people need two members of staff to assist them."

On the second day of our inspection we saw two people in their rooms using commodes with the door open. We also observed staff loudly announcing that they were taking people to the bathroom. This meant people's dignity and privacy was not being respected.

The hairdresser used a toilet as a salon; the toilet was set up with a hairdresser's sink with shower over it and two large free standing hair dryers. It also meant there was no appropriate space for the hairdresser to work demonstrating a lack of respect for people's dignity.

We heard a relative say "if you could see yourself you would be mortified." Referring to the fact the person had not had a shave for a few days. Another relative was heard to say "Oh look, that's on back to front." This showed that staff had not taken time to ensure people were supported with personal care and dressed appropriately.
The above examples demonstrate a breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the care notes of a person who was identified as requiring end of life care. There was no evidence that the person had been involved in planning their care. There was a note suggesting relatives were to be invited in to discuss this, however no documentation to support that this had happened.

We asked staff how they maintained the cultural and religious needs of people who use the service. One member of staff told us "We don't have that here" Whilst another said "It's Pontefract, we don't have ethnic minorities here." On looking at care notes we discovered two people from Germany, one of whom told us it would be nice to speak German with someone. We discussed this with the registered provider who described our observations as "nonsense." We saw that one person had requested to see a lay preacher on

Sundays however we could find no record of this in care notes. This demonstrated that peoples cultural and spiritual needs were not being met.

People were not involved in their care. The care plans we looked at contained a form called 'My life' which had sections for people's life history and their likes and dislikes. However in the files we looked at these had not been completed. This meant that staff did not have detailed information to help them support people. People were not supported to express their views and were not actively involved in making decisions about their care, treatment and support . We asked people if they had been involved in their care planning. One person said "no" another told us "No, they do what they have to."

The above examples demonstrate a breach of Regulation 10 (2) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We spoke to people who used the service, and they told us, "I'm bored I don't know what's happening." "It's boring." "I don't go out." One relative told us "it would be nice if staff had the time to take people out."

We saw that care was not person centred. We looked at people's care records and saw they were lacking in detail, contained contradictory and conflicting information in a lot of cases and did not give a clear picture of the individual who they related to. For example we saw a person who required specific equipment; however this was not documented in any of their care plans or risk assessments In one person's care plan there was a section on severe swelling of legs, however there was no evidence of a care plan to enable staff to help the person manage this condition.

One person was described as having short term memory problems; however no mental capacity assessment had been carried out. We saw that the person's relative had signed consent to care forms but there was no documentation evidencing Lasting Power of Attorney (LPA). The same person had a history heart failure however their Do Not Attempt Cardio pulmonary resuscitation (DNACPR) status was documented as unknown. This meant the service did not know how to treat the person in the event of a cardiac arrest. People, or their families or clinicians, may opt not to have Cardio Pulmonary Resuscitation. (CPR.) Patients' health records should be marked with DNACPR to ensure health professionals are aware of how to treat the person in the event of a cardiac arrest.

Some care plans contained a life history, which was lacking in detail and gave very little information about the life the person had led and what was important to them. Two of these were not filled in the files we looked at. We saw there was also inaccurate information in the care records. For one person there was a recorded Waterlow score of 18 which puts people in the high risk category however the person stayed in bed which would give them a score of 21 and put them at very high risk. A Waterlow score is a tool used to determine how high the risk of someone developing pressure areas is, depending on factors which are known to increase the risk. This meant that the person was not being adequately monitored to prevent pressure areas as they had not been identified as being of particularly high risk and therefore the appropriate checks were not in place.

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

We saw a plan of activities displayed in the reception area of the home however it was displayed from the end of the month backwards which could be confusing for people reading it. During our inspection we saw there was one planned activity in one of the lounges. This was a group chair exercise session run by an outside agency. 14 people were in the lounge but six were asleep and three people did not seem to understand what was happening asking "What's going on?", "Who's here? And "What's this rubbish?" We saw that the room was not laid out well for this activity as chairs were back to back. The person leading the exercises could not see everyone. This meant they had to walk around to each person and explain the exercise individually losing the attention of others as they did so.

We heard one person asking "Are there any jobs? What can I do?" Staff told the person "You can peel the spuds later" and "We will save the washing up for you." No meaningful activity was offered. We asked staff about this and they told us. " They are happy if they think there are jobs to do." We looked in the persons care plan and could see no documentation to support this.

The registered manager told us an activity co coordinator was employed three days a week and when they were not in, staff would lead activities." We did not see staff leading activities during our inspection. We asked the assistant manager about activities. They told us "They [people living at Millfields] come in to the dining room and do baking. Well, they don't bake; we give them buns and icing." We found no evidence of this documented in people's notes.

We asked the registered manager about complaints and found none had been recorded. The registered manager told us "I deal with issues informally." These had not been recorded. We saw from staff meeting minutes that a paramedic had complained about the lack of cleanliness of wheelchairs. This was the only documentation in regards to the complaint. We saw from staff meeting minutes that team leaders were being informed of complaints that were not being acted upon this demonstrated that complaints had been made but not recorded or acted on. The minutes from a managers meeting identified that peoples relatives had complained that the building "looked tired and old fashioned." Again this was the only documentation regarding the complaints. Demonstrating that complaints had been made but not recorded or followed up in an open and transparent manner.

This is breach of Regulation 16 (1) receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. 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 asked people if the manager was visible in the service one person told us "I think so but I couldn't tell you their name." One relative told us they " felt they could go to the manager with any issues but had not needed to". Staff told us the manager was "approachable " and "open to suggestions." One staff member praised the level of training they had received and another was pleased by how flexible the registered manager had been when their circumstances changed.

We asked to look at the auditing which had taken place over the past 12 months. We found that whilst audits had taken place they did not identify issues or any action to be taken. For example the lounge audit in May 2016 did not identify a large stain on the carpet or the chairs which were ripped. The monthly corridor audit had not identified a rip in the carpet or the smashed glass in the fire exit.

The wheelchair audit had picked up that some brakes needed tightening and some tyres were worn. However it had not recorded the missing footplates, one wheelchair with a rip in the side or the lap belts being tied in knots which we identified during our inspection. There was no evidence of any action taken in regards to the brakes or worn tyres. The nightly wheelchair decontamination record stated on many occasions" did not have time". No action had been taken to clarify why this was or to find time to clean the wheelchairs.

An audit of the hourly rounds, a document used to identify that each person has been seen and any care given, had not been filled in. A 'post it' note was attached asking staff to read review and sign the hourly rounds for March, April and May 2016.This means that had an issue arisen during that period it had not been picked up on or recorded in a timely manner and staff were being asked to record events long after they had occurred which would compromise the accuracy of the documentation.

We were shown care plan audits which were last completed in September 2015. These identified that people had not been involved in their care planning or reviews. There was no evidence on how this would be rectified.

The audit of accidents and incidents was inaccurate as we found incidents were not always recorded on incident forms. This meant the provider had no overview of accidents and incident and was therefore unable to identify any trends or put measures in place to prevent re occurrence.

This demonstrates that whilst audits were in place, they did not accurately assess and monitor the service, no outcomes were documented to show how the audits would be used to improve the quality and safety of the service.

The above examples demonstrate a breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was significant evidence that the provider had failed to notify the Care Quality Commission of incidents which had taken place, which under the terms of their registration they had a duty to report, this included a person on a DoLs leaving the building. There was also evidence there had been a large number of incidents where people who used the service had hurt other people in the home which had not been reported correctly. When asked about this the registered manager told us "I only know what the staff tell me."

This was a breach of regulation 18 Notification of other incidents. Care Quality Commission (Registration) Regulations 2009: Regulation 18