Milestones Trust

Somerset Lodge

Inspection report

Perrett Way, Ham Green,
Pill, Bristol, BS20 0HE
Tel: 01275 372224
Website: www.example.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection was unannounced and took place on 07 and 09 December 2015.

There was a general manager in post, but this person was not registered. As the registered manager left in November 2015 the process for appointing a new registered manager had only just started. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manage left the service in November 2015 and Milestones Trust were in the early stages of replacing him.

Somerset Lodge is registered to provide care for up to 35 people with dementia or mental health needs. At the time of our inspection, there were 27 people living there. The general manager explained they had no plans to admit any new residents because they had a voluntary suspension on private placements. They said although they felt they had the correct number of staff on duty, they were employing high numbers of agency staff. The general manager explained the difficulties they had trying

Summary of findings

to recruit qualified nurses. At the time of our inspection, the home was also under local authority whole home safeguarding, which was not commissioning any new placements at the home. This is being kept under review by the local authority.

At our last inspection on 03 and 04 April 2014 Somerset Lodge was non-compliant with five Regulations;

1. Infection control (Regulation 12). This corresponds with Regulation 12 (2) (h) of the Health and Social Care Act 2008 Regulations 2014. The required improvements had been made.
2. The principles of the Mental Capacity Act (2005) were not being followed (Regulation 17). This corresponds with Regulation 11 of the Health and Social Care Act 2008 Regulations 2014. We did not see the required improvements had been made.
3. Protecting people from unsafe or inappropriate care or treatment (Regulation 9). This corresponds with Regulation 12 of the Health and Social Care Act 2008 Regulations 2014. We saw partial improvements had been made.
4. Supporting Workers (Regulation 23). This corresponds with Regulation 18 of the Health and Social Care Act 2008 Regulations (2014). We did not see the required improvements had been made.
5. Assessing and monitoring the quality of services (Regulation 10). This corresponds with Regulation 17 of the Health and Social Care Act 2008 Regulations 2014. We saw partial improvements had been made.

People's daily records were not maintained accurately and staff did not have the information they needed to be able to meet people's needs and reflect their preferences. Care plans contained personalised information but staff were not aware of this. Relatives were not given access to care plans, and people's preferences for gender specific care was ignored.

Fluid charts showed some people did not have enough to drink. Relatives told us their relatives were always hungry and thirsty.

The home relied heavily on agency staff. Staff supervisions had started to take place but staff had not received the training required by the organisation. Relatives told us they did not feel their relatives were safe because staff did not know how to look after them.

Staff did not make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Staff made decisions for people to use bed rails and relatives said they had not been asked to consent to this.

People had access to GP's who visited weekly. When people needed care or treatment from other healthcare professionals, this was sometimes provided.

People's privacy was not always respected. Activities were not tailored to individual tastes and most people were unable to take part in group activities.

Although relatives knew how to make complaints, they told us they were not responded to and no changes were made. Everyone we spoke with told us they did not have confidence in the general manager. Staff said the home had potential to improve but they were not supported.

Quality audits did not always pick up shortfalls in the service meaning the provider was not always responsive to the changes required. For example, the lack of accurate, effective daily records had not been identified.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found repeat breaches. We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

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.

People's daily records were not maintained accurately and staff did not have the information they needed to be able to meet people's needs and reflect their preferences.

Relatives did not feel their relatives were safe. Relatives did not think people were sufficiently protected from injuries and did not think their relatives were safe from abuse.

People were not cared for consistently by the same staff because the home relied on agency staff.

Staff had not completed the required safeguarding training and competency checks, or the required fire training.

Is the service effective?

Inadequate

The service was not effective.

People were not being given enough to drink meaning they were at risk of dehydration.

Staff had not received up to date training for subjects the provider had identified as mandatory. This meant people were at risk of being cared for by staff who may not know current legislation or guidance.

Although staff were aware of the principles of the Mental Capacity Act, they did not make sure people's legal rights were protected.

Is the service caring?

Requires improvement

The service was not caring.

Relatives did not feel people's privacy was always respected. People were sometimes left without sufficient coverings to maintain their dignity.

We saw staff watching TV rather than responding to people's needs.

We saw some staff caring for people in a kind, compassionate way. Some staff showed patience when looking after people.

Is the service responsive?

Requires improvement

The service was not responsive.

Although relatives knew how to make a complaint, they told us no changes were made as a result.

Relatives were not given access to care plans, and people's preferences for care was ignored.

Summary of findings

Care plans were personalised and contained a good level of information. Staff, however, were not aware of the information in them so were not able to provide care to meet people's needs and preferences.

Is the service well-led?

Inadequate 

The service was not well led.

Everyone we spoke with told us they did not have confidence in the general manager. Staff said the home had potential to improve but they were not supported.

Although staff had taken part in meetings recently, there were no minutes of these. As there were no records of what had been discussed or any actions that needed to be carried out, it was not possible to check if any agreed changes had been made.

Quality audits did not always pick up shortfalls in the service meaning the provider was not always responsive to changes required.

Milestones Trust had a clear vision for the home; however, staff were unable to tell us what these were.

Somerset Lodge

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 7 and 9 December 2015 and was unannounced. It was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience area of expertise was elderly people and dementia care.

Before the inspection, the provider completed 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. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

During the inspection we spoke with seven relatives about their views on the quality of the care and support being provided. We also spoke with the area manager, the general manager and nine staff including the cook and activity leaders. Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for four people. We looked at records about the management of the service including four staff files and the quality assurance file. We spoke with the local authority about the service after the inspection.

Inadequate

Is the service safe?

Our findings

People's daily records were not maintained accurately and staff did not have the information they needed to be able to provide the necessary care. Where care plans identified people needed to be checked during the night, it was difficult to see this had been done. For example, where care plans identified people needed to be checked every two hours, there were no specific records of these checks. However the daily records contained some records of checks being done, but not as frequently as stated in the care plan. One person's care plan said the person needed to be checked every two hours; we did not see records of these checks being done. Staff told us the person repositioned themselves. This meant where people may have needed some support during the night it was not possible to show this had been given. Another person's records showed they had been turned at 6am one day, but were not turned again until 2am the following day. Staff told us another person only needed to be turned every four hours; however this person was mostly turned two hourly. This meant people were at risk of developing pressure ulcers due to lack of turning. The quality assurance systems in place to monitor care and plan ongoing improvements did not identify all the shortfalls we found during the inspection. The last audit we saw took place in October 2015 and had not identified the lack of accurate, complete and up to date daily records. This meant the home had not made any changes to improve the daily record keeping and people were at risk of receiving poor care as a result.

One person had a wound on their toe which was protected by a fleece booty and padding on the foot of the bed. The wound assessment and evaluation form in their care plan was dated September 2015. We asked for the current wound assessment form but the nurse told us there wasn't one. This meant if agency staff had to cover a shift there was no information available to them about the treatment they should provide and no information about the treatment which had already been given. The relative of this person said, "My relative is not safe in bed, they bang their toe on the end of the bed, nothing is done to prevent this happening despite it becoming infected." After the inspection, the provider gave us information which showed they had made a referral to a specialist podiatry department in October. The risk assessment stated, "Staff to monitor success of booty and review every two weeks. Registered nurse to action any treatment needed and record appropriately." There were no records of any treatment provided.

There was no written information in care records for people who needed creams to be applied to them. Staff told us information about creaming people and turning them was shared during handovers and staff "knew when to apply creams." There were no records of creams having been applied. This meant agency staff may not have the information they needed to be able to provide good care. This also meant as there was no record of when the last application took place there was an increased risk of missing or doubling up applications. Another person had a hernia which care records said staff needed to monitor. There were no records of this being done. This meant any changes may not be noticed and the person may not receive the care they needed in a timely way. The nurse told us information would be shared during handover and would be recorded in the doctor's notes if necessary.

Training records we saw during our inspection showed most staff had not had the 18 month safeguarding knowledge and competency check as required by the home's policy. After the inspection, the provider sent us sign in sheets which showed staff attended safeguarding training in November 2015. Staff spoken with had a clear understanding of what may constitute abuse and would report to the nurse or the general manager. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff were not aware of who to report to, in the event they needed to escalate their concerns outside the organisation. Staff said, "If it wasn't dealt with I'd wait a month then go higher up." This meant there was a risk people could suffer abuse because staff were not aware of how to alert the local authority. Relatives said, "It wasn't safe to begin with" and "I'm not sure if people's possessions are safe. [Name] is always wearing different clothes, not always hers."

The audit from October 2015 identified a full fire drill evacuation was needed. This had not been completed at the time of the inspection. The general manager explained they held fire drills every three months and they assured us different staff took part. Accurate records of staff attendance at fire drills and dates when they were next due were not kept. The general manager told us they would be

able to see who had attended fire drills recently by going back through the attendance records. This meant the general manager was not able to say, for each member of staff, when they would need their fire drills repeating. There was also a chance that some staff may not have any fire drill practice because of the lack of attendance records. Training records showed all staff who had contact with people using the service had out of date fire training. Guidance from the Practical Fire Safety for Care Homes publication states staff should have at least annual refresher fire training. Three members of staff had not received any training since April 2014. This meant clear and accurate records had not been kept and records were therefore not fit for purpose.

The kitchen cleaning schedules had not been completed. Records showed work surfaces and the floor had been cleaned once a week. This meant it was not possible to guarantee the surfaces had been thoroughly cleaned and disinfected. Food temperatures had been recorded together with the fridge and freezer temperatures. This meant the records showed food had been stored and cooked at the correct temperatures and the risk of food borne infections was reduced.

There were no oral hygiene plans for staff to follow; therefore staff did not provide oral hygiene care on a regular basis. One relative told us it was not until a family member looked into their relative's mouth that they discovered a large dental abscess. They said this person had been refusing food from a spoon for more than four weeks. Another relative told us, "Staff did not recognise that my relative had toothache; I had to tell them and accompany them with staff to the dentist." A third relative said, "I took my relative to the dentist, they were horrified at how dirty their dentures were and said it would stop them eating and give them a sore mouth." We discussed this with the Area Nurse Manager, who recognised this was a problem and immediately started work on an oral hygiene care plan for staff to follow.

Most accidents and incidents which occurred in the home were recorded and analysed. We saw one person's care records which stated they had choked on food and staff had thumped their back. The records said an incident form had been completed for this; however there was no form for the date stated in the care records. An incident form existed for a similar incident but with a different date. This meant records did not fully reflect the full extent of the incidents and the person may not receive the support they needed as a result. There was conflicting evidence of understanding within the audit done in October 2015. The audit said there was evidence of revised risk assessments; however there was also the comment, "Unclear how this impacts on current care plans." This meant the person writing this did not understand how changes in risk may affect the level of care and support someone may need.

There was a lack of communication about medicines with relatives. Relatives said, "I queried my relatives medicines at one time and I was told she's not having much, it was all a bit vague."

Another relative told us they were concerned because their relative slept for much of the time and they thought this was because they were being overmedicated. They said they had requested a review of their care and medication from the mental health services but so far this had not happened. This meant there was poor communications for relatives around people's needs.

People's medicines were administered by registered staff. The homes quality audit from October 2015 noted that all qualified staff did not have up to date medicine competency records and the medicines policy had not been signed by all staff. Within a month of this audit, only two competency records had been completed at the time of the inspection. We saw from the information provided by the provider before the inspection that there had been 26 medicine errors. The general manager explained this was mostly because they had been using a local pharmacy and medicines were often out of stock. The home has changed suppliers as a result.

The checklist for care plans stated the care plans were reviewed monthly; however we found instances when care plans had been reviewed but not updated. One person's care plan said they were at risk of harming or being harmed by other residents, this was controlled by limiting the person's access around the home by use of keypads. The general manager acknowledged the situation had now changed and this person's care plan needed to be updated. This meant the person could be inappropriately prevented from moving around the home. Another person's profile had not been updated since 2013. This was also identified as a breach in the previous inspection due to lack of appropriate recording.

Inadequate

Is the service safe?

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. Some people were prescribed medicines on an 'as required' basis.

Two members of staff had had their competency assessed recently to make sure their practice was safe. We confirmed the nurses all had current registration with the Nursing and Midwifery Council (NMC), so they were able to practice. We observed the nurse on duty giving medicines to people. The nurse did not wash her hands before giving the medicines out. This increased the risk of spreading infection. They talked to people throughout the process and offered people a drink with their tablets. Where people's care plans identified they could refuse their medicines, guidelines were in place to deal with this. One person's relatives expressed concern about a medicine, a review of the person's medicines was arranged and the frequency of administration adjusted as a result. We observed one person, who had been shouting, being given oral medicines. Staff told us this medicine was given when they felt the person was in pain. Some people were not able to tell staff if they were in pain. We saw this person's care plan identified shouting as a means of communicating pain. Staff told us they monitored people's behaviour. One person's care plan described what staff should look out for when they were in pain, hungry or thirsty. Staff confirmed the kind of behaviours people would exhibit when they were in pain. This meant where people were unable to communicate if they were in pain, staff would know signs to look out for and pain relief could be given.

Care plans contained risk assessments for individual needs such as mobility, personal cleansing and dressing and behaviours that may challenge others. Where people needed specialist equipment to support their mobility, this was detailed in their care plan. The Head of Learning Disability Residential Services from Milestones Trust told us, "We are currently looking at risk assessments and I'm working with an occupational therapist to determine the most appropriate equipment for people. I've ordered new equipment already." Risk assessments gave information for staff how to manage the risks. For example, the control measures informed staff to talk to people through every stage of the support being given and if they were resistant, to leave the person in a safe and comfortable state and go back later.

Milestones Trust had a recruitment procedure for new staff which included carrying out checks to make sure they were safe to work with vulnerable adults. Staff confirmed they were not able to work with people until the appropriate pre-employment checks had been undertaken. We looked at four staff files; information about references and pre-employment checks were kept at head office and were made available to us later. The Area Nurse Manager explained staff should have meetings regularly throughout their probation, and probation could be extended if necessary. There were no records of these meetings. This meant staff may not be receiving the support and guidance they needed to be able to provide the care people needed.

Relatives we spoke with were concerned about which members of staff had been allocated to look after their relatives. Relatives told us, "My loved one is not always safe from abuse, staff do not know how to care for them" and "Other relatives who had installed a camera in their relative's room said as a result of video footage showing their loved one being abused, and several members of staff were dismissed. We discussed this with the general manager, who told us five members of staff had been dismissed and this had been reported to the Disclosure and Barring Service. This meant these staff would not be able to work in the care sector again. The relatives still had concerns about their relative's care and safety and said, "We visit often and vary the times, we dread to think what would happen if we did not" and "We try to see who will be on duty on the following days to see if it will be safe to have a day off." Other relatives said, "Our relative was always very fearful and always said, 'I'm scared'. She used to whisper to us and be really careful about what she was saying. We couldn't leave her in the room; she'd want to come with us. It's better now."

Inadequate

Is the service safe?

Staff commented on the cleaning regime in the home. Staff said, “A cleaning routine needs to be done so furniture can be deep cleaned” and “If someone wets the chair, the top is wiped but it’s not deep cleaned.” Other comments included, “Cleaners work really hard and don’t stop, they haven’t got enough time.” During the inspection we observed the home to be clean and odour free. After the inspection, the provider sent us copies of cleaning schedules which covered all areas of the home. There were gaps in the record of cleaning carried out. For example, the clinic should have been cleaned every other day, but the record did not show it had been cleaned that week. This meant although the environment looked clean there was the potential for infections to be spread because cleaning was not carried out according to the checklist provided.

Inadequate

Is the service effective?

Our findings

Relatives told us their relatives were always hungry and thirsty when they arrived and they bring in food to supplement what is provided. One relative said, "Recently my relative was so dry and thirsty when I arrived they drank copious amounts of squash." We saw people who remained in their rooms did not always have a drink available. Daily records for diet and fluid intakes showed some people had less than one litre of fluids each day. Two records showed two people had as little as 300ml and 250ml each in one day. The Institute of Medicine guidance is for the average man to drink around three litres of beverages per day, and the average woman to drink around two litres per day. This meant people were at risk of dehydration.

We observed lunch in the dining room. Most people were able to eat independently and staff sat by people who needed assistance. One person was missed out when puddings were given out, however they were able to draw attention to this and was given one. When ice cream was served as a pudding, this was given out at the same time as the main course and was melted by the time people were ready to eat it. This meant people were not able to fully enjoy their meal time experience. Although staff knew people which people needed their drinks to be thickened, they told us they were not aware of different thickening consistencies. This meant people may be given the wrong consistency and may choke as a result.

We saw weight records which showed three people had lost weight and were considered to be nutritionally at risk. Two relatives told us they were concerned with the amount of weight their relatives had lost. We looked at weight records where people had lost weight and saw one person had been overweight, and on the day of the inspection their BMI was 19. BMI is a measurement of a person's height and weight and identifies if people are in the normal, underweight and overweight ranges. The general manager assured us they were monitoring this person's weight carefully because they were borderline underweight and the person would be referred to the GP if they lost any more. This person's relative was very concerned with the amount of weight they had lost. Another person had also been overweight and was now in the normal BMI range. Their relative said although their relative had been overweight it had not been their choice to lose weight. The general manager explained people would be provided with supplements by a GP if necessary. Relatives told us, "When I bring cakes in she wants to eat them all in one go, she says she's hungry and she's lost so much weight", "I've brought food in for [name] but I can't be sure she'll have it. I brought food in before and found it in the fridge days later" and "They don't cater for her cultural needs." We saw this family brought food appropriate to the person's cultural needs in for them.

We saw comments in one person's care plan giving feedback to the home from a relative regarding meals was that there was room to improve the menus and food. They said, "Rice pudding was served cold, bacon was inedible it was so hard and there was a rubber fried egg." We did not see the home had done anything about this. Relatives we spoke with said, "The food was absolutely terrible, but it's getting better and "Meals are not nutritiously planned and residents do not get enough to eat." We saw menu's which showed a variety of food was offered. Two relatives told us small triangles of sandwiches and quavers with a cold desert are served every tea time. Other comments from relatives included, "Mum refuses to eat but the carers are very good, they know what she will and won't eat" and "I can't say the food's bad, but they could have more variety, it's the same old thing every week." One member of staff described the food as being 'disgusting' and said, "I wouldn't eat it."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

One relative told us their relative had been put on a soft diet without their knowledge and, when questioned, the staff could not find any evidence of why this was indicated. Staff later told the relative it had been done because they had mentioned that some bacon was hard and overcooked. This meant people were given inappropriate diets that they had not been assessed as needing by someone with the skills and knowledge to do so, and relatives or the person had not consented to. The Area Nurse Manager said, "We will be looking at how the cook does textured diets and what information is available to them."

Care plans gave information about the support people needed during mealtimes, but did not give information about the kinds of food people liked and disliked. This

meant people may not be served foods which appealed to them and consequently may eat less. Where people's care plans identified they needed a record kept of their diet and fluids, these were in place.

A list of people's dietary requirements was available in the kitchen. We spoke with the cook who was aware of people who needed specialist textured diets and people with diabetes. The cook told us they knew about people's likes and dislikes from information given to them by families. This meant the cook relied on relatives telling them what foods people liked. Without clear records of people's likes and dislikes they may not be offered their preferences if different staff were on duty. They said, "We can get the information from some care plans as well if the information is in care plans that come with people into the home." The cook told us they had completed an accredited training course which gave them the skills to ensure meals were nutritious. At lunch time we saw that people were able to choose where they ate their meal. Hot drinks and biscuits were served mid-morning and afternoon. Relatives said they would like to see cakes served during the afternoon. They said they had fed this back to the general manager and nothing had been done.

Relatives did not feel staff had the training and skills to care well for their relatives. They told us, "There seem to be a lot of agency staff." Staff said, "Staff have been hampered by the number of agency and bank staff", "We're working so hard, but we're short staffed. Everyone works individually and there's no team spirit" and "There are a few staff who are unsuited to this kind of work." This meant people did not have care provided consistently by staff who knew them well. Other comments included, "There a few staff who will work with their friends and will leave if their friends aren't in. The same people are able to leave early all the time" and "We can have an amazing shift with the right staff." We discussed this with the Head of LD Residential Services who confirmed they were aware of staff management issues and these were being addressed. This meant people could be affected by the poor atmosphere in the home caused by staff not working together as a team.

The Area Nurse Manager said most staff had not undergone a thorough induction programme to give them the basic skills to care for people safely. Staff told us their induction had been "all right" and "It's not been managed." Staff told us they had recently completed manual handling training and said, "We weren't shown any practical things like helping someone up out of a chair", "We picked a box up and put it down. I wasn't impressed with the training, it confused me more" and "The trainer was useless, and when asked to show us how to assist a person from a sitting to a standing position, was unable to do so." Staff also said, "Milestones training is not good and the manager is aware." This meant the training given to staff did not give them the skills they needed or the confidence to be able to assist people appropriately. On the day of the inspection we did not see anyone being repositioned by staff, either manually or with the use of hoisting equipment. We did not see anyone being taken to the toilet or back to their room for personal care. We saw one person sitting in a chair who was in the same position all day. This meant the person was at increased risk of developing a pressure ulcer. A relative said, "Because of a lack of suitable seating, residents are kept in bed." The provider had identified this issue and had arranged for individual assessments for seating to be carried out. We saw additional seating had been ordered as a result.

We spoke with nine staff; none of them had completed any dementia training. This meant staff were providing care for people without the specialist training they felt they needed. Training records showed 32 of 40 staff with direct access to people were out of date with most mandatory training, according to the home's requirements. The Area Nurse Manager told us a programme was being put in place to be able to bring staff up to date with training required by the home. The October 2015 quality audit said the training schedules were being overhauled and the Area Nurse Manager explained therefore that all staff had been enrolled on a nationally recognised qualification called the Care Certificate, which gives staff the basic skills to be able to provide care. This meant staff were providing care without the training identified by Milestones Trust as being mandatory.

The Area Nurse Manager and the general manager confirmed they used a high level of agency staff. Relatives told us, "It's always different staff", "There's no one key person we can talk to" and "There seems to be quite a lot of staff, but not always the same ones." Other comments included, "Continuity of staff is very important, there's a definite improvement" and "They've got a job keeping staff." There were enough staff on duty to meet people's needs, using a combination of permanently employed and agency staff. We saw some agency staff were employed on a contract basis so they were regular members of staff.

Inadequate

Is the service effective?

There were always qualified nurses on duty to make sure people's clinical needs were monitored and met. Relatives said, "Sometimes there are not enough staff employed, especially at weekends, there may only be one employed staff member, so no continuity of care, even all trained nurses are from an agency. There is a lack of management, lack of senior staff, and lack of experienced carers because they will take anyone." The high reliance on agency staff meant people were not getting continuity of care, and were being cared for by staff who may not be familiar with their care plan or their needs; this could compromise their safety.

Staff performance and development needs were not being regularly reviewed. Staff supervisions had started to be put into place but were not being carried out as frequently as required by the organisations policy. The one to one guidance notes said one to ones were supposed to take place every six to eight weeks. Supervisions are an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They are also a chance for any poor practice or concerns to be addressed in a confidential manner. Not having regular one to ones in place meant that staff did not have dedicated time to talk through any issues about their role or the people they provided care, treatment and support to. Failure to regularly review staff performance could have an impact on their effectiveness to provide the appropriate care and support. This was previously a breach of Regulation 23 under Health and Social Care Act 2008 (Regulated Activities) 2010 when inspected in April 2014.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with had a clear understanding of the Mental Capacity Act 2005 (the MCA). We checked whether the service was working within the principles of the MCA. Staff were able to tell us about the main points of the MCA and about the need to hold best interest meetings to make decisions for people. Staff said, "It protects people and gives them rights to decide about their treatment and care" and "People are deemed to have capacity until it's proven otherwise. They can take risks and have choices."

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 any conditions on authorisations to deprive a person of their liberty were being met. Where people had DoLS authorisations in place these had been correctly completed. Staff did not make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. We did not see any records from best interest meetings. Where one person had bed rails in place, two members of staff had made this decision. This effectively meant the person was being deprived of their liberty without the proper authority. The general manager told us family had been involved in the decision where bed rails were used for another person, however there were no records of this best interest meeting and decision. Where care plans said best interest meetings had taken place, we did not see paperwork to support this. Relatives said, "Staff haven't approached me for consent." This was a repeat breach because lack of evidence of best interest meetings and staff making decisions about the use of bedrails for people was a breach of Regulation 17 in their previous inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The home arranged for people to see health care professionals according to their individual needs. Two GP's visited weekly to attend to people's healthcare needs. Where people were at risk of malnutrition and developing pressure ulcers, the home used nationally recognised tools to monitor people's risk. We saw people were sometimes referred to other healthcare specialists, such as speech and language therapists for swallowing assessments, when these were required. Families took people for dental appointments if necessary. Relatives told us, "We took [name] to the dentist; the dentist was shocked at how dirty [name's] teeth were. They told us it would make her mouth sore and would stop her from eating" and "[Name] is supposed to see a podiatrist, we don't know if she has or not because no-one tells us anything." We saw this person's

Is the service effective?

care plan; there were no records of oral hygiene and the person had lost a substantial amount of weight. This meant the person's sore mouth could have stopped them from eating. Relatives also told us, "We're invited to come and talk to the GP when they visit" and "They get a GP quickly if needed."

Relatives told us new agency staff shadowed a member of staff, usually another member of agency staff, until they become familiar with routines. On the day of the inspection we spoke with a new agency carer who said they had had training with their agency. They had brought their training competency record with them. This meant the general manager knew the training that had been provided and the member of staff was able to undertake tasks appropriate to their training. It was difficult to distinguish between agency and permanent staff because staff wore a variety of uniforms and some staff did not wear any uniform. This meant it was difficult for people and relatives to identify staff who could help them. One relative commented they thought an agency staff member dressed inappropriately. On the day of the inspection we saw staff inappropriately dressed, and mentioned this to the general manager. No action was taken at the time, however they told us this would be addressed.

We attended the afternoon handover where people's needs and current conditions were discussed. The number of staff available and where they were working was also discussed. This meant any shortages could be identified and additional staff requested.

Requires improvement

Is the service caring?

Our findings

People's privacy was not always respected although staff told us all personal care was provided in private. Some relatives did not feel privacy was always provided and said, "My relative is not always given 'private time' when they need to be alone, and staff's attitude to this is disturbing." When this was raised with the general manager they acknowledged this person needed to be able to spend time in private. Another relative said, "There is no dignity or privacy. The bedroom door is always open and they are exposed to all, wearing just a pad and a polo shirt." Another relative said, "Some staff are kind, and treat my loved one with dignity and respect, they joke and laugh with them. When this happens it is lovely and I go home settled, but with others I can tell by my loved one's body language and the look in their eye that they are not happy." Staff explained how they ensured people's privacy was respected and said they would make sure that doors and curtains were closed when giving personal care. Staff were aware of issues of confidentiality and told us they did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

Relatives said, "There's very little for them to do. They watch films and have dancing, that's all," and "They don't take into account what people like and can do. I told them she loved gardening, they said there was a patch she could do and they'd sort it out." We saw this person's care plan; there was no record of them enjoying gardening. This meant something that was important to the person was ignored and the person had less personalised activity time as a result. There was a garden built from lottery funding, although relative's told us it was not used a great deal. Relatives said, "The manager said that staff do not think to take residents out there." We were told by relatives that the television was usually on in communal areas with programmes of the staff's choice. On two occasions when we walked into the lounge areas we found staff watching TV. One relative said, "Staff never sit and chat, they know nothing about [name] nor are they interested in them." Other comments included, "She's not doing a lot, watching films mostly" and "There used to be activities going on." We saw posters which listed the activities provided. The activities programme for November only showed activities on 13 days; one of these activities being 'cooked breakfast'. There were ten activities planned for December, most of these of a musical nature. This meant activities were not tailored to individual tastes. During the afternoon there was a music session with outside entertainers; nine residents attended including the two people from an earlier craft session. This meant the majority of people living in the home, 18 people, did not take part in the activities provided. Staff told us, "People need more activities and they do not have enough to do" and "They get bored, which leads to challenging behaviour." The home had a large activities area, comprising a large room with a comfortable seating area for quiet activities and a separate craft area; there was also a kitchen. Four Activity Co-ordinators worked part-time, covering Monday to Friday. There were no planned activities at weekends.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We spoke with two of the activity co-ordinators during the inspection, and saw two people participating in a craft session. The provider was involving the local community in the home because there were links with a local school and children visited recently to sing Christmas songs. The activity staff were in the process of creating a Santa's Grotto in an area of the home.

One relative said they told the general manager that after hearing a member of staff speaking sharply to a resident, they had intervened on the resident's behalf and said they would now prefer it if this member of staff did not provide personal care to their relative. Another relative said, "Staff attitude is not good, they speak to residents like naughty children." This meant staff did not understand the needs of the people they were caring for and people did not receive support in a kind and caring way. A third relative said, "I was told by the manager my relative was in their room all the time vegetating. I asked why they were not doing something about it and I was told, "I cannot change things overnight, they [staff] would all leave." Relatives told us, "Staff were rude at one time, but it's slightly better now", "There have been lots of changes, there's a lot of agency staff" and "Staffing has got a lot better; there were challenges but its better." One letter from a relative said, "The carers are extremely helpful." A note from another relative thanked staff for the wonderful care they gave and said, "It is not often that you witness such kindness, love and care. All of you were amazing."

During the inspection we observed people being cared for in a caring manner. Staff addressed residents by their given

Requires improvement

Is the service caring?

name and spoke to residents in an appropriate volume and tone of voice. One person who liked to walk around the unit was seen accompanied by a member of staff who answered their repeated questions in a patient and compassionate manner. Residents walking around the home appeared to be clean and appropriately dressed.

Most people had a dementia or mental health condition and were not able to communicate their wishes. This meant people needed support to express their views and be actively involved in making decisions about their care, treatment and support. People were not involved in planning their own care or making decisions. Six of the seven relatives we spoke with did not feel they were listened to and were unhappy about poor communications between them and the home. This meant relatives views and people's views about their care were not taken into consideration.

Relatives told us they were able to visit at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private.

Requires improvement

Is the service responsive?

Our findings

Relatives we spoke with said they would speak to the general manager to make a complaint if they needed to. Posters on the walls gave people information how to make a complaint and explained the process and the time the process should take. Some relatives had written to head office to make complaints. Relatives said, "I wasn't happy with the care and wrote to head office to complain about what was going on, I was told they were sorting it out. They said they'd spoken to staff and it was resolved, but nothing's changed" and "We had a meeting, they admitted the way they tried to cover everything up was horrendous. We're not happy with Milestones explanations; they were very dismissive of people's concerns." Another relative said, "I've attended two relatives' meetings and expressed concerns about inappropriate remarks made by the Chairman of the meeting." These comments related to a relatives meeting held following information discovered when a relative used a hidden camera, attended by senior staff from Milestones Trust. One relative told us they were unable to use the cupboard under the sink because there was no floor. They said they had raised this several times but nothing had been done. This meant pads used by the person were stored behind the bedroom door because the cupboard could not be used, where visitors to the room could see them, compromising the person's privacy and dignity. Another relative told us they had raised concerns with the general manager and said, "He listens but nothing is acted upon." This meant when people raised concerns the service did not always listen and respond to concerns in a way people were happy with. The quality audit from October 2015 showed no formal complaints had been received in the previous year. This meant people's complaints were not being recorded and the information from complaints was not being used to improve the service.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff did not always respond appropriately to people's changing needs. On two occasions during the inspection, we went into a lounge and found staff watching TV. The first time, the member of staff immediately began talking to a person next to her. The second time, in the evening, three members of staff were all watching TV and ignoring people in their rooms who were screaming intermittently. We asked staff if they knew why people were so distressed, they told us, "They always scream like this, this time of night." One person was sitting in the lounge with the staff, staring into space with no interaction between them. We checked and found people were safe, but distressed.

Staff had not read care plans and did not know personalised information. Relatives told us, "My mum would prefer a female carer, but we've not been asked about this" and "Staff do not respect my relative's preference to having a bath and not a shower, nor the requested gender of carer." One person's care plan recorded they liked a glass of warm milk and biscuits before going to bed at night, and they liked to be cosy with a fleece blanked under the duvet. Another person's care plan said they liked to have the light off. Staff we spoke with were unable to tell us about these people's preferences. When asked about care plans relatives told us they were aware of them but said, "Nobody takes any notice of it whatsoever." One relative told us although they had been involved in best interest meetings as an appointee of the court of protection they do not see the care plan or know where it is kept. Two relatives told us, "I've asked to see the care plan but we were told we'd have to put it in writing" and "I've never seen it." Other relatives said, "We came here for a review and I asked for a copy, but I've never been given one. It was supposed to be a care plan review but I never saw the care plan." Care plans we saw contained no evidence of relative's involvement in the care planning process. This meant relatives were not given the opportunity to ensure people's preferences were recorded so staff could use the information to provide a personalised service. One relative said, "If we wanted to see the care plan I think we could." The lack of collaboration with relevant people was a breach of Regulation 9 in the previous inspection.

Staff we spoke with were able to answer specific questions on some aspects of task oriented care for several people, such as how they liked their drinks, care of skin and repositioning. However they told us this information was not obtained from care plans. They told us they did not have time to read care plans, the information came from verbal handovers. This meant staff knew about task oriented needs as discussed in handovers, but did not know about personalised information in care plans.

Care plans had not been checked for accuracy. For example, we saw one care plan with standard phrases such

Requires improvement

Is the service responsive?

as a reference to a specialised form of feeding and talking about a member of the opposite sex. One person's care plan gave an outline of their medical history and information about current concerns. However, this document was not dated, so it was not possible to tell if the concerns were historic or current.

Relatives we spoke with expressed grave concerns about their relatives care and told us they were "greatly worried about it". Relatives said, "Some staff are kind but they have no interest in residents; they do not go into their rooms and talk to them. Everything is very task orientated", "My relative was always in a wet or soiled pad when I arrived to visit despite the time of day" and "My relative looks unkempt; clothes are not ironed; teeth are never cleaned; hair so matted it had to be cut because I could not get a brush through it." This meant the care provided to people did not meet their individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Care plans gave staff strategies for managing people's behaviours and described how people liked to be supported; however staff told us they did not read care plans.

The Area Nurse Manager showed us questionnaires they had recently devised to be able to seek the views of relatives and staff. They said they wanted to identify the most important things from relative's viewpoints. They told us, "I'm looking for honest feedback and people can submit the forms anonymously if they prefer." One had been returned. They said, "Staff are very helpful and responsive to us and we always feel very welcome when we visit. On three occasions I've been invited to join in with resident's entertainment." Relatives told us they had not been asked for feedback previously but we saw there was a comments box in the hall. The Area Nurse Manager had been recently appointed by the provider to ensure the service received additional support and clinical guidance.

Inadequate

Is the service well-led?

Our findings

Accurate records and schedules were not always kept. People's daily records were not maintained accurately. This meant there was a risk care and treatment would not be provided because there was high reliance on agency staff who did not have the information they needed. The high reliance on agency staff meant there was a greater risk to people as they could be cared for by staff who did not know their support needs or preferences. Records of when staff needed refresher fire training were not kept and kitchen cleaning schedules had not been kept, meaning it was not possible to guarantee the kitchen surfaces were thoroughly clean. Not all accidents and incidents were recorded and there was a lack of understanding of how changes in risk may affect the care and support a person may need.

There was a lack of communication by the provider with relatives. Although the home's complaints records showed no complaints had been received, relatives told us they had raised concerns which had not been dealt with. Relatives were not allowed to see care plans and staff were not aware of the personalised details in them. This meant the quality assurance and clinical governance was not effective and did not drive improvement.

Risks around people's hydration and care needs were not always being managed well and people were at risk of suffering dehydration. Relatives were concerned about their relatives' weight loss. There were no oral hygiene plans in place so staff did not provide oral hygiene care; some people had sore mouths as a result.

Training and competency checks had not been kept up to date. Trained staff giving out medicines had not all had competency checks completed by the organisation. Most staff were out of date with training and staff expressed concerns about the training they had been given. Best Practice was not always followed as staff were making decisions about the use of bedrails which amounted to unauthorised deprivation of liberty for one person and no records had been kept of best interest decisions.

Audits had failed to identify the concerns we found which amounted to breaches of the regulations, such as the risks of dehydration to people and the lack of accurate recording. Actions taken to improve practice as a result of the audits included changing the pharmacy to reduce the number of medicines errors and ensure medicines were always available when people needed them. New equipment had been ordered and there was a strong commitment to recruit and train new staff, including a registered nurse as clinical manager. The Area Nurse Manager said, "We will be bringing in external people to do audits." Relatives said, "It was fantastic at one time, then it was horrendous, now it's getting better."

We observed tension between some staff and relatives. Relatives we spoke with were uneasy around some staff and declined to speak in case they were overheard. Relatives told us, "We didn't like coming here at all due to the attitude of staff, but they're not unfriendly now", "Staff will talk to you if you talk to them" and "They're a lot more approachable than they used to be." Relatives described the atmosphere at the home as being, "Dead", "Solemn" and "Lacking passion."

Staff told us they thought the home had "huge potential" but said, "There's no support. The manager is approachable but doesn't do what he says", "I think he listens but doesn't take it on board" and "This home needs too much improving for one person, it needs someone experienced in this kind of environment." Other comments included, "In order to fix things something needs to be done at managerial level" and "Appreciation for what we do would go a long way."

Relatives told us they did not have confidence in the general manager and said, "I do not have confidence in the manager" and "He is full of excuses." Relatives also told us they felt the general manager did not respect boundaries. They told us this was because the general manager had spoken with them about new staff appointments. Other comments included, "He listens but does not act" and "He tells people what they want to hear but does not put it into practice." Relatives gave us examples where they had been told something would be done and they were still waiting. One relative said they asked for a copy of the care plan and were told they could have one, however they were still waiting for this. Another relative was waiting for information about their relative's diet.

Staff told us they had taken part in a staff meeting recently. Staff said, "We gave the manager a list of what we wanted changing" and "We've not had any feedback; no minutes and no date for another meeting." We asked to see the minutes of the staff meeting but none were available. We found two meetings had taken place in October; one for nurses on 1 October 2015 and one for carers on 8 October

Inadequate

Is the service well-led?

2015. This meant there were no records of what had been discussed or any actions that needed to be carried out, and consequently it was not possible to check if any agreed changes had been made.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. Senior staff had been brought in to oversee and improve services and support the current general manager. This included the Head of Learning Disability Services who had been brought in to support the service on a regular basis. The Area Nurse Manager said, "There are many things I have to turn around. I'll be setting up regular meetings with all staff including night staff and kitchen staff and will appoint leads for dementia, infection control and medicines management" and "I'm setting up clinical supervisions when I will be observing practice. We will be looking at skin care, oral care, people's glasses and hearing aids." This meant the Area Nurse Manager recognised some of the problems and was taking steps to improve the situation.

Milestones Trust had a clear vision for the home. Their vision and values were communicated to staff via posters on the walls throughout the home. However, staff we spoke with were unable to tell us what the values were. This meant although there were posters on display, staff had not been reminded of them.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Accurate and complete records were not maintained for each person.** Regulation 17 (2) (c) **Systems and processes did not enable the registered person to assess, monitor and improve the quality and safety of services.** Regulation 17 (2) (a) **Systems and processes did not enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.** Regulation 17 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of service users was not met.** Regulation 14 (1) **The nutritional requirements for food appropriate to their cultural background was not met.** Regulation 14 (4) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate support, training, supervision and appraisal.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service user's privacy was not respected. Regulation 10 (2) (a) Service users were not supported to maintain their independence and involvement in the community. Regulation 10 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not enable and support relevant persons to understand the care or treatment choices available.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 9 (3) (c)

The provider did not enable and support relevant persons to make, or participate in making decisions relating to service users care or treatment to the maximum extent possible.

Regulation 9 (3) (d)