Chartwell Care Services Limited

Milligan Road

Inspection report

244 Milligan Road
Leicester
Leicestershire
LE2 8FD

Tel: 01162442004

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Milligan Road is a residential care home providing personal care to 8 people at the time of the inspection. The service can support up to 8 people.

People's experience of using this service and what we found

Right Support: Risks were not always identified or assessed which put people at risk of harm. Incident forms were not always completed when staff had used chemical restraint on people. There was no analysis of these incidents to identify trends or prevent re-occurrence. People did not always receive their medicines as prescribed. Protocols for 'as required' (PRN) medicines used for agitation were not always detailed to provide staff with guidance. which put people were at risk of not having their medicines as prescribed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: Systems and processes were not operated effectively to ensure safeguarding incidents were investigated or outcomes completed to assess the safety of the service and prevent future occurrences. The provider failed to identify or manage risks posed by people's health conditions. People living with diabetes did not have care plans that reflected their current needs or inform staff how to mitigate known risks associated with the person's diabetes.

The service had enough appropriately skilled staff to meet people's needs and keep them safe. Good relationships were noted between people and staff and positive engagement was seen. All bedrooms were of single occupancy with communal areas available. People were seen choosing where they wanted to spend their day either in their own rooms or communal areas.

Right Culture: There had been a lack of consistent oversight at the service. We identified a number of shortfalls at the inspection. These included investigations, audits and monitoring and the operation and management of the service. The atmosphere in the service was homely and people and staff fed back that it was a family. Staff had received training for working with autistic people and people who have a learning disability. Staff meetings and supervisions were held and provided an opportunity to raise concerns and ask questions.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 6 March 2019).

Why we inspected
We received concerns in relation to the medicines management, staff conduct and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Milligan Road on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to consent, safe care and treatment, safeguarding people from abuse and improper treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Milligan Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Milligan Road is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Milligan Road is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 3 days and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
Not everyone who lived at the home was able to share their views with us. As a result of this, we spent time observing interactions between people and the staff supporting them.

We spoke with 9 members of staff including the nominated individual, regional manager, manager and 6 care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a range of documents including people's care plans and risk assessments, 3 staff recruitment records, training records, DoLS records and mental capacity assessments. We also reviewed audits, governance and medicines records. We conducted checks of the building, grounds and equipment.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people were not always fully assessed or mitigated by the provider. For example, 1 person's risk assessments were dated March 2021 and from the previous service they had lived at. These risk assessments were outdated and did not reflect the person's current needs. Not having up to date risk assessments put people at increased risk of harm.
- Where people required support with diabetes, the provider had not developed an accompanying care plan for these people to guide staff on how to safely support them with this aspect of their care. Diabetes can cause major health complications and requires close monitoring and awareness of the signs and symptoms of ill health. This meant people were at risk of staff providing unsafe care and not identifying signs of deterioration in their health condition.
- Daily monitoring records were not always in place or adequately completed to monitor people who were at risk due to their health needs. For example, monitoring a person's blood glucose level for diabetes. This meant the person was at increased risk of a deterioration to their health.

Using medicines safely

- People did not always receive their medicines as prescribed. For example, 1 person was given a drug at a different dose to what was prescribed with no authorisation to do so. This placed this person at a serious risk of harm as staff acted without having reviewed the appropriate documentation to guide them.
- Protocols to help staff know when to give 'as required' medicines were not always in place or did not contain personalised guidance for staff as to when to administer the medicine. For example, for people who were prescribed medicine to support with agitation, there was no clear guidance for staff on when to administer. This meant people were at risk of not having their medicines as prescribed, and a risk that the medicine was not being used to effectively manage agitation.
- Medicines were not always stored safely. We found medicines with expiry dates, such as insulin were not dated on opening. These medicines only had a short shelf life once opened. Therefore, we could not be assured that the medicines were still suitable for use. This placed people at risk of receiving unsafe medicines.
- Staff did not record that medicine skin patches had been checked as still being in place. This risks the patch medicine coming off the person's skin and this removal not being recognised in a timely way. This removal of the patch would impact the person's access to their medication.

Preventing and controlling infection

- We were not fully assured that the provider was promoting safety through hygiene practices of the premises. On inspection we identified that a mattress was heavily soiled and malodorous. Records to

demonstrate that regular checks were carried out on mattresses could not be located.
● Cleaning schedules and records of cleaning were not always completed or regularly monitored.
● The external clinical waste bin was observed to be unlocked on all 3 days of inspection. On day 1 of inspection it was overflowing, with clinical waste bags on the slabs as it was too full. The bin was emptied but remained unlocked for the duration of the inspection.

The provider failed to ensure correct procedures to monitor and mitigate people's risks were implemented and failed to ensure medicines were administered safely. This was a breach of regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems in place to protect people were not always effective. Safeguarding concerns had been recorded as being reported. However, there was no evidence of investigations or outcomes completed by the provider to assess the safety of the service and prevent future occurrences.
● Accidents and incidents were not always reviewed regularly, meaning patterns and trends were not identified. For example, the provider had failed to review incident forms and therefore had not identified that they were not always completed for the use of chemical restraint. Chemical restraint is the use of medicines to subdue, sedate, or restrain a person. Without the documentation detailing why chemical restraint was used we did not know if least restrictive strategies had been implemented by staff to protect people's human rights.

Systems and process in place monitor and record safeguarding concerns were not effective. This placed people at risk of harm. This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe. One person said, "I'm very safe here." A relative also told us, "We trust them with [person]."
● Staff told us they felt confident that the management team would respond appropriately to any concerns. Staff were also confident in whistle-blowing outside of the organisation if they felt the management team did not act on concerns raised.

Staffing and recruitment
●Sufficient staff were available during our inspection to meet people's needs. We observed people being responded to in a timely manner. Staff told us that they felt there were enough staff to support people living at the service.
● Staff were recruited safely to the service. Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service (DBS) prior to starting at the service. A DBS check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Agency staff were used at the service. However, the agency staff were effectively deployed around the service to ensure they had permanent staff to support them as needed. Rotas demonstrated these agency staff were usually arranged on long term bookings. This meant these agency staff were used repeatedly, allowing some consistency for the people at the service.

Visiting in care homes

- The provider was facilitating visits for people living at the service in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We found the service was not working within the principles of the MCA.
- People's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been undertaken; however, they were not always clear about whether the person had capacity or not. For example, 1 person had been assessed as lacking capacity. However, the information recorded in their assessment did not support this. The answers the person provided in the assessment did not demonstrate they lacked capacity.
- Although mental capacity assessments had been recently reviewed, information contained within them was sometimes contradictory. For example, 1 person's assessment suggested that they were unable to communicate decisions. However, the information recorded by the assessor did not support this as the answers documented were in contradiction to this.

The provider had not complied with the principles of the Mental Capacity Act. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had made appropriate DoLS applications which had been authorised. Some authorisations contained conditions which the provider must meet. However, authorisation paperwork for some people

was not readily available at the service during the inspection. This meant the management did not have full oversight of DoLS and did not have a record of what conditions were in place for all people.
● Where people's DoLS authorisations contained conditions the provider must meet, these were not always met. For example, 1 condition required the provider to regularly schedule catch ups with a relative, but this was not happening. This meant we were not assured this person's human rights in relation to their DoLS condition was being respected.
● People faced unnecessary restrictions as information in their DoLS was not reflected in their care plans. For example, 1 person's care plan recorded they were at risk of absconding and required constant monitoring, including when they went to the toilet. However, their DoLS did not cover restrictions for constant supervision including the toilet, stating they would willingly return to the home. This incorrect guidance placed the person at risk of being unnecessarily restricted with strict supervision.

Systems and process in place to protect people's human rights in relation to their DoLS were not effective. This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported with their health and access to health services, but some health needs may not have been fully met.
● People's health conditions had not been consistently assessed and care plans developed. This meant staff did not have guidance about a person's health condition and how this impacted them and their care and treatment needs. This is addressed in the safe section of this report.
● Staff supported people to arrange and attend appointments with their GP, hospital consultants and community nurses as needed. We saw evidence of people's health needs being responded to appropriately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans varied in consistency. Whilst some were detailed, and contained personalised information specific to people, others contained inaccurate information. This meant staff could not rely on care plans for this information needed to provide safe care.
● People's needs were assessed before they moved into the home. Staff told us that before a new resident moves into the service, they have a team meeting to discuss the person's needs. One staff member said, "We have a meeting and go through everything. We get to know them in these meetings before they come."

Staff support: induction, training, skills and experience
● Staff were supported with induction and training programmes to provide people with safe care. One staff member told us, "During my induction I had a mentor and did shadow shifts."
● Staff told us they received supervision and feedback as part of their development. One staff member said, "I find the supervision interesting. During supervision my strengths are preached, and my shortfalls are identified if needed."
● Staff had received mandatory training in key areas, this was mostly up to date and included training for working with autistic people and people who have a learning disability. The manager had plans in place to ensure all staff were up to date with training.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they were happy with the meals provided to them and that they had enough to eat. One person said, "It's very nice food. We have a lovely menu."
● People were involved in choosing their food, shopping and planning their meals. One staff member told

us, "We ask [people] what they would like to eat for the week, and we take them shopping to buy their food. If they change their mind, then we will always offer an alternative." This encouraged people to have choice and control.

● Food stocks, storage and management were found to meet best practice guidance. The service had a 5 star rating with the food standards agency, meaning they were compliant with expected practice.

Adapting service, design, decoration to meet people's needs

● People had been supported to personalise their bedrooms. Bedrooms appeared very comfortable and reflective of people's personalities and taste. However, some of the furnishings were tired and in need of updating.

● Living areas were bright and clear, providing people with space to move freely around the home.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider failed to effectively monitor the quality and safety of the service. The provider's quality assurance systems and processes failed to address the serious concerns we found in relation to managing people's healthcare needs and medicines. These failings put people at significant risk of harm and improper treatment.
- Reviews on people's care plans had failed to identify concerns we found. People did not have care plans and risk assessments in place for complex health conditions which meant there was a risk they would not receive consistent care in line with their needs.
- Reviews on people's mental capacity assessments failed to identify the concerns we found. People's mental capacity care plans contained contradictory information and guidance for unnecessary restrictions.
- There was no system or process in place to monitor DoLS authorisations. For example, 2 people's DoLS paperwork was missing and could not be found. This meant the provider did not have the dates of the DoLS authorisations, or knowledge of any conditions that may be in place. This lack of oversight did not fully protect service users from being unlawfully deprived of their liberty.
- The provider had cleaning schedules and audits in place, however these were not effective meaning risks were not identified. For example, audits failed to identify that mattress checks and cleaning schedules were not consistently completed. The manager acknowledged the shortfall with cleaning processes and advised this was currently under development and would be reviewed.

Continuous learning and improving care

- Governance processes were not always effective to evidence reflective practice taking place within the service. The lack of oversight meant issues were not always identified and plans were often not implemented to remedy these issues.
- The provider did not give the manager an appropriate handover as to where documentation was kept and what required improving. There were multiple folders in place containing people's records and service documentation which led to difficulty locating and accessing information throughout the inspection. Staff members were often unsure which folders contained the requested information.
- The system for learning lessons was not always reliable or robust. The provider did not have an accurate overview of what was happening in the service because incidents, accidents and safeguarding were not always documented, investigated or acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others
● Systems and processes were in place to gain the views of people and relatives through reviews and meetings. However, these had not been carried out for several months.

There was a significant lack of governance and oversight of the quality of the service provided to people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff meetings were held to give staff opportunity to express their views and opinions on the day-to-day running of the service. One staff member told us, "I always make suggestions, such as day trips for the residents to go on and it gets arranged. We go on lots of outings and day trips." Records of the meetings demonstrated staff were able to make suggestions and key information was shared which included updates on the service.
● We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider responded to the concerns identified and gave us assurance they were committed to driving improvement in leadership and care delivery in the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team understood the duty of candour and their legal responsibilities to inform people and agencies when concerns are raised or when something has gone wrong.
● The management team were open and honest during the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager had recently taken over the management of the service. Staff told us the manager was open and approachable. One staff member told us, "[Management] are very approachable. If I have any problems I don't hesitate."
● The culture of the service was positive, and people were supported to be independent and pursue activities they enjoyed. We observed people being supported to access the community to go shopping and out for lunch.
● Staff told us that they enjoyed working at the service and felt supported by their peers and the management team. One staff member said, "It's like a home from home." Another staff member told us, "It's a lovely place to work to be honest."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not complied with the principles of the Mental Capacity Act.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the health, safety and welfare of people were not managed safely. Information was not always relevant and up to date which put people at risk.

The enforcement action we took:

A warning notice has been issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not complied with the principles of the Mental Capacity Act.

The enforcement action we took:

A warning notice has been issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, evaluate and improve their practice to monitor and improve the quality of the service and keep people safe.

The enforcement action we took:

A warning notice has been issued to the provider.