Four Seasons (Bamford) Limited

Milverton Gate Care Home

Inspection report

Dawson Road (Off Aldermoor Lane)
Stoke
Coventry
West Midlands
CV3 1FU

Tel: 02476635799

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

Summary of findings

Overall summary

This inspection took place on 04 April 2017 and was unannounced. Milverton Gate Care Home is a nursing home providing care and accommodation to a maximum of 39 older people. On the day of our inspection there were 19 people living at the home, several people were living with dementia and other people had high level nursing needs.

When we inspected the home in October 2015 we found there were four breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

These breaches were in relation to the safe care and treatment people received; medicines were not administered accurately and at suitable times to make sure people were not placed at risk. People did not always adequately receive food and fluids to sustain their health and the provider did not continually assess, monitor and improve the quality of the service. There were also insufficient numbers of suitably qualified, experienced staff to meet people's care and treatment needs.

At our last inspection on 01 March 2016 we checked improvements had been made. We found sufficient action had been taken in response to the breaches in regulations. However, there were some areas where further improvements were required and the provider had plans in place for on-going improvements to be made.

At this inspection we found the improvements made had not been sustained and the provider was again in breach in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The home did not have a registered manager. 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.

Since our last inspection the manager had left and three separate interim managers had been supporting the home; there had also been two changes in the regional manager. This meant the home had not had a consistent managerial oversight. Continued changes in management had affected staff confidence and staff found this unsettling. The provider had recently recruited a new manager and a deputy manager and people, relatives and staff spoke positively about the new managerial team.

The provider had relied on high levels of agency staff as several permanent staff had left. This meant people did not consistently receive support from staff who they were familiar with and knew how people liked to receive their care. Some people and their relatives told us at times staff were not always available when people needed them. The provider had recently recruited permanent nursing and care staff to the service.

During our visit, most people's call bells were in reach but we still found three people who did not have access to theirs. We saw when people used them, staff mostly responded in a timely manner, however we observed one call bell took eleven minutes for staff to respond.

The provider did not consistently ensure people received safe care and treatment. Some risk assessments had not been fully completed and some staff did not consistently follow instructions contained in the risk assessment. Where risks were identified, for example where people were at risk of skin breakdown due to pressure or at risk of choking, most staff followed guidelines and correctly used specialist equipment to minimise risks.

Incidents and accidents were not consistently investigated thoroughly and the provider had failed to notify us, and the local safeguarding team, of notifiable events within the home. Staff we spoke with had an understanding of their responsibilities in relation to safeguarding.

Some people did not receive their medicines at times when they needed them. We found most medicines were administered, stored and disposed of correctly, however we identified some gaps on people's medication administration records (MARS). Some people required their medicines "as required" (or PRN) and protocols were not always available in people's medicine plans. Some care records did not evidence how their pain levels were formally being monitored or assessed.

People, healthcare professionals and visitors were mostly complimentary of the permanent staff and the care provided at the home. We saw staff engaged well with people. Most people looked well presented with clean clothes and hair and people's privacy and dignity was promoted. Relatives and friends were able to visit the home at any time.

Staff were kind and caring to people, but did not always have time to sit and talk with them. Most interaction with people who lived at the home was whilst staff carried out personal care tasks.

People mostly received the food and fluids they required to maintain their health although some people told us they did not always have drinks available to them. The home worked well with the dietician, GP, speech and language team, and other healthcare professionals to support people with their healthcare needs.

Most people and their relatives were happy with the care provided, but some felt staff did not respond to their needs as quickly as they would like. People told us staff respected their privacy.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were not always met. The provider had referred people to the local authority for an assessment when they thought the person's freedom was restricted and when they had been assessed as not having capacity to consent to this. However one application had not been submitted and some aspects of the Mental Capacity Act had not been acted on.

The provider had taken steps to improve the standards in the home by recruiting new staff, motivating existing staff, and was keen to promote an open and transparent culture. The new regional manager supported the managerial team and the provider's resident experience team (RET) was supporting the new manager and providing additional training to staff.

Regular quality audits of the home had not been consistently conducted to monitor and improve the care provided by the service however the provider was addressing this.

The provider's managing director and management team were open and honest regarding the challenges the home had been through and acknowledged that improvements were required. They were taking positive steps to address the issues we identified and to provide support to the new manager and staff to ensure stability for the home.

We found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Shortly after our inspection the provider sent us an action plan outlining the actions they were taking to address the issues we highlighted and continued to keep us updated of improvements being made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
People and relatives told us there were not always enough staff at times people needed them. People did not always receive care and treatment that met their individual needs and ensured their safety and welfare. Most staff understood what action to take if they had any safeguarding concerns. People did not consistently receive their medicines as prescribed. Risk assessments were not always completed although staff were knowledgeable about people's risks and how to support them

Is the service effective?

Requires Improvement

The service was not always effective.
Permanent staff had received training to deliver effective care, however staff training records were not up to date. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported with their nutritional needs but some told us they would like more drinks. People were referred to a range of healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not consistently receive personal care that met their individual needs. Individual staff members mostly interacted with people in a caring and respectful way but care was mostly task focused

Is the service responsive?

Requires Improvement

The service was not always responsive.
People were not always supported to pursue their hobbies and interests.
Care and support was not always provided in a way people preferred. People and their relatives were not consistently involved in the planning and review of care provided. People and relatives were given opportunities to share their views about the care and support received

Is the service well-led?

Inadequate

The service was not well led.
The home had undergone several management changes and there as inconsistent managerial oversight . The provider and management had not ensured systems in place to monitor the quality and safety of service were consistently completed. Some statutory notifications about notifiable incidents had not been submitted. Staff had not consistently felt supported by the provider. However, people and staff were positive about the new manager and staff morale had recently improved.

Milverton Gate Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 04 April 2017 and was unannounced. The inspection was undertaken by two inspectors, a specialist nursing advisor, 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.

Before our inspection we reviewed the information we held about the service. We looked at information we received from relatives, the local authority and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found this did not consistently reflect the service we saw.

During our visit we spoke with eight people who lived at the home, four relatives, and nine members of staff. This included nurses, care staff, the maintenance worker, the chef, and the activities coordinator. We spoke with three visiting healthcare professionals. We also spoke with the new manager and deputy manager of the home, the regional manager, the resident experience team (RET) manager, a member of the resident experience team (RET) and the managing director.

We spoke with commissioners of the service who told us they had regularly monitored the service and had identified the similar issues we found during our inspection visit. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We observed care and support provided in communal areas and we observed how people were supported to eat and drink. We looked at a range of records about people's care including four care files, daily records

for personal care, and fluid and food records charts for four people. We also examined 12 medicine administration records (MARS).

We used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We also looked at two staff files, staff training records and staff rotas In addition we requested information from the provider about audits conducted within the home to see what actions the provider was taking to make improvements.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection visit, we carried out inspections in October 2015 and April 2016 at Milverton Gate Care Home. At our October 2015 inspection we found there were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs and the provider was using high numbers of agency staff. At our last inspection in April 2016 we found the provider had made improvements, had reduced the use of agency staff and recruited more nurses and care staff. However, at this latest inspection we again found the use of agency staff had increased because several permanent staff members had left their employment at the home.

Some people and relatives told us they felt the use of agency staff meant people did not always receive care from staff that knew them well and, at times, there were insufficient numbers of staff available to support them.

When we asked people if there were enough staff one person told us, "Enough staff? Definitely not." A relative we spoke with commented, "No not always, I completed a questionnaire survey and said the problem is too many agency staff. These [people] are seeing strangers all the time. My [relation] is 80 percent blind and likes consistency and permanent staff who know him."

A healthcare professional we spoke with commented, "The main concerns we have are the rapid change in staff, the nursing staff. They [provider] rely a lot on agency who don't know much about the [people]. It has changed a bit…. It is difficult for us, we get used to somebody. It is rapid the way nurses come and go and everyone prefers continuity."

At 10.30am we saw an agency nurse arrive at the home. The deputy manager had been delayed in administering medicines to people because they were supporting the new nurse and they had requested the agency send another nurse to support them. The administration of medicines was expected to start at 8am and the delay could have impacted on people's health and well-being.

Some people told us they had to wait for long periods of time before they received support from staff, one told us, "Well it varies when the staff come to wash and dress me, but there isn't enough staff on."

One relative commented to us, "Not all the time is there enough staff, we have pressed the call bell in the past and no one has come. [Relation] has even managed to press it himself and has said some times are longer than others." Prior to our inspection a relative had contacted us to express their concerns regarding the low numbers of staff available and the high use of agency staff. One person told us the use of agency staff meant at times they were receiving care from staff who they did not know and said, "Half the [staff] at night don't even know your name."

Staff we spoke with also told us there were insufficient numbers of staff available to people. One told us, "They need more staff, they have not got enough, they are trying to get more, we do have agency and they are employing people." On the day of our visit, we saw the activities co-ordinator was also involved in other

tasks around the home, they told us, "I also do the dinners and some care…They need more staff, they have not got enough, they are trying to get more, we do have agency and they are employing people."

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

The provider's management team acknowledged the recruitment and retention of permanent nursing staff had been their biggest challenge and this had meant agency staff had to be used to ensure there were enough staff to meet people's needs. To ensure continuity of care, they told us they tried to request staff who were familiar with the home and the people who lived there. The provider had recruited more permanent care workers and the manager informed us two nurses were due to start work in the upcoming weeks once checks on their suitability were completed.

Following our inspection visit the provider sent us an action plan which stated that staffing levels were being reviewed by the regional manager and had been increased until people's needs had been reassessed using the provider's staffing dependency tool. This was to ensure the tool had been used correctly to determine there were sufficient numbers of staff available and deployed appropriately to support people.

Some people and their relatives told us they felt that there had been improvements in the reduction of agency staff and were encouraged by the new manager and actions they had taken to improve staffing. One told us, "I think they have chosen a half decent manager this time and previous concerns I have had regarding agency staff seems to be improving."

During our visit, most call bells were responded to quickly and most people had access to them. However one person we spoke with told us they felt sick but they did not have their call bell within reach and we pressed it for them. We found it took 11 minutes for staff to respond. Another person told us, "When I call them [staff] they do not come, I have to wait a long time." We asked this person how long and they told us sometimes they had to wait beyond 10 minutes before staff attended.

However other people told us, "Yes, when I press my call button they come when they can, but they are pretty good." And, "There is always somebody there if you need a hand."

The action plan provided to us after our visit stated risk assessments would be completed for every person in relation to the use of call bells and these risk assessments would be reflected in people's care plans. In addition wireless call bells would be ordered for any person deemed at risk. We were informed following our inspection visit that quotes for the purchase of these had been requested.

The provider used risk assessment tools to identify risks to people and their safety. Risk management plans were in place to minimise those risks and maintain people's health and wellbeing. For example we found people at risk of skin damage if they were not relieved of the pressure on their skin, were being repositioned regularly to reduce this risk. There were risk assessments for moving and handling, falls and nutrition and we saw that most people had risk assessments completed and these were reviewed.

However we saw risk assessments for one person, who was new to the home, had not been fully completed until seven days after their admission. Records showed their mobility had not been assessed despite their medical condition reducing their ability to walk and move safely. Another person who had recently been admitted to the home had no risk assessments in place. This meant that people may have been placed at risk of harm as staff would not have relevant information on how to reduce risks and maintain their health and wellbeing.

Another person had a risk assessment in place stating they were at risk of placing their call bell wire around their neck if they had one available. We saw this person had their call bell in bed with them and a notice was on display which advised staff the call bell should be available to the person at all times. This meant the person was potentially at risk of harm.

We discussed this with the management team who told us they would address this immediately with staff. They removed the person's call bell and their risk assessment was updated accordingly. We asked how staff would know this person required assistance and we were informed they were able to call out for assistance and were on hourly checks by staff. However the provider acknowledged this could mean the person may have to wait for staff to support them in between checks.

The manager told us nurses were responsible for assessing people's risks and carrying out pre admission assessments. They went on to say a combination of the use of agency nurses and having until recently, no deputy manager to oversee risk assessments in the home, meant there were some gaps in people's risk assessments. The RET staff member told us, "We need to tighten up our pre admission process and our ability to manage new residents."

The manager told us the assessment process would improve now a deputy manager, who would be the clinical lead, was working at the home, and new permanent nurses had been recruited. This meant people's risks would be correctly assessed and plans put in place to reduce risk to their health and well-being. When we spoke with staff, most were knowledgeable about risks to individual people and what steps to take to reduce the risk of harm.

During our inspection visit we looked to see if people received safe care and treatment to maintain their health and wellbeing. Some people received their food via a Percutaneous Endogastric Tube (PEG). This is a special tube that is inserted directly into a person's stomach when they are unable to have their food by mouth. We looked at the records in relation to the care of the PEG site which indicated staff should ensure the site was cleaned at least once a day. This is important to prevent infection around the area. One person's records showed this had not been completed on six days and another person had no record of when the site had been cleaned. We saw one person had experienced an infection around their site.

We discussed this with the manager during our inspection visit and they assured us the deputy manager would address this immediately. Following our inspection visit the provider informed us people's care plans had been updated and guidance added to inform staff of the correct procedures to follow in caring for the PEG site.

Prior to our inspection visit we received information that staff had not followed the correct procedure when they had witnessed a safeguarding incident. We spoke to the interim manager at the time of the incident and they advised us they would be speaking with all staff in one to one supervision meetings to remind them of their responsibilities and the correct actions to take. We also found two incidents had not been correctly reported to the local safeguarding team, one involving a medication error and another when one person had not been regularly turned during the night. The manager had carried out investigations and informed the local GP but records did not show they had made safeguarding referrals. Following our inspection visit the provider sent us an action plan which stated all incidents and accidents within the home were being reviewed to ensure the local safeguarding authority would be notified where relevant.

The managing director also informed us during our visit all staff would be receiving safeguarding training again regardless of when they last completed the training. This was being carried out to ensure all staff were

fully up to date with safeguarding policies and procedures.
Staff we spoke with understood their responsibilities to safeguard people, in order to protect people from the risk of harm or abuse. One staff member told us, "It is about keeping people safe so they are not abused by other people. If people need help with walking, they might need to be assisted by two. It could be punching, sexual abuse, not giving someone meals or drinks, neglecting them, it is not allowed."

We asked people if they felt safe at Milverton Gate Care Home. One person said, "Yes I feel safe here but I have not been here long. I can't grumble too much this is the best place I have been in."

We looked to see if people received their medicines as prescribed. We found most medicines were administered, stored and disposed of correctly and most people told us they received their medicines on time. However we identified some gaps in people's medication administration records (MARS). For example, a record showed that on one day there were three missing staff signatures to confirm when medicines were administered. This could have meant the person had not received their medicines three times that day. However; the manager had already seen the gaps in the records during a medication check and had carried out an investigation. We also saw the provider had checked medicines and had also seen missing signatures on other occasions and carried out investigations and spoken to the nurses responsible.

We looked at the medicine record of a person who lived with diabetes. We saw regular medical advice had been sought in relation to the person's blood sugar levels but there was no guidance in the person's records to indicate what staff should do if the person's blood sugar levels became too high or too low and made them unwell. The provider informed us following our visit that the person's care plan would be reviewed and updated with guidance for staff to follow.

Some people required their medicines 'as required' (or PRN) and most had 'as required' medicine plans in place which gave staff a clear understanding of why people needed these medicines. However we saw protocols were not always available in people's medicine plans for staff to understand why and when people might want these.

Five people were prescribed PRN medicines for pain relief but their care records did not evidence how their pain levels were formally being monitored or assessed. This is important for some people who cannot tell staff they are experiencing pain, for example a person living with dementia. We also saw one person's regular medicine for pain relief was out of stock for three days. This meant the person may have experienced pain or discomfort and would not have had their medicine available to them.

The provider informed us following our inspection visit their Pharmacy Technician had visited the home to conduct a full medication audit and additional training was planned for staff to ensure stock levels were correct and medicines were administered safely and on time. Pain assessment care plans and PRN protocols were all being updated to ensure people's pain was being effectively managed. In addition an extra nurse was now on duty in the morning to ensure people received their medicines on time.

The provider's recruitment policy and procedures minimised risks to people's safety and ensured only suitable staff were employed. Prior to staff working at the service, the provider checked prospective staff member's suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to start working at the service until checks had been received from the DBS and reference requests had been returned.

We checked the premises were being maintained and health and safety checks were in place. The provider's records clearly documented the checks carried out and any actions required. We saw people had emergency evacuation plans, however the file containing up to date information which the emergency services would require was inaccurate. This is important in order for emergency workers to know how many people were in the building and their individual needs. This was rectified immediately following our inspection visit.

Requires Improvement

Is the service effective?

Our findings

In October 2015 we found the home required improvement at being effective, this improved in April 2016 however we found at this inspection visit this had not been maintained and required improvement again.

People mostly received the food and drink which was suitable for their needs. People told us they were happy with the meals, but some felt they did not have enough drinks throughout the day. A person told us about the food, "The food is good, excellent, always get a choice. I don't know if you can have something different if you don't like what is on offer; eating is a problem because of my 'shakes' but staff ask do I need help." People said about their drinks, "Some days I don't have enough to drink as I need help." And, "Food (good) yes but not enough to drink, I could do with a drink now."

Where people had been identified at risk of malnutrition or required special diets to maintain their health and wellbeing we saw appropriate referrals had been made. We looked at peoples' care records and saw where people had been assessed as at risk of malnutrition they had been weighed regularly and received specialist support from dieticians or speech and language therapists where extra support and advice was needed.

We noted one person had been recommended to have a soft diet as they were at risk of choking. We saw, the care staff who supported the person had given them sausages but the person did not like gravy which staff had offered to soften their diet. As a result the person ate their meal without the gravy, placing them at potential risk of choking. The cook was unaware of this person disliking gravy when we asked them. They informed us the sausages had the skin removed but gravy needed to be added to make the meal easier for the person to swallow. They went on to say they would discuss this with the person to find a suitable alternative and would ensure all staff were made aware of the person's preference.

The cook told us they were informed by the care staff about people's specific dietary needs and acknowledged that communication needed to be improved; they had discussed with the manager and requested nursing staff complete diet sheets with relevant information about people and their needs. They told us this used to take place but since there had been changes in the management of the home this had stopped.

We discussed this with the management team during the inspection and they informed us the nursing staff would now complete diet notifications for the kitchen staff. After the inspection the provider informed us training had also been organised for staff to increase their knowledge about supporting people with swallowing difficulties.

We saw staff supported people to eat and drink and did so at a pace appropriate for the individual. When we observed lunch we saw staff assisting people with their meals but noted some did not engage much with the person.

We observed one person being assisted with their meal in their room. The member of staff assisted the

person into an appropriate position to take their meal and sat next to them. They described the food for the person and checked it was the correct temperature and that the person was enjoying their meal.

We saw drinks were in reach of most people, and charts recording how much people had to eat and drink were up to date. Most staff we spoke to were knowledgeable about people's dietary needs and their likes and dislikes. During our visit we heard staff asking people if they would like a drink. We saw the person had a drink in front of them but they had poor eyesight and were unable to see it. We placed their drink in their hand and they were able to drink independently.

People and their relatives told us they felt staff were well trained and had the correct skills and knowledge to provide their care. One told us, "Yes they do know how to look after me."

Staff were seen using appropriate moving and handling equipment and techniques. Being moved in a hoist can cause people anxiety and we saw staff reassured people throughout their move that they were safe, and explained to the person what was going to happen to them next, this reduced their anxiety. For example we heard them say, "The hoist is going to raise you up now, are you ready." People who had some difficulty standing and moving were appropriately supported and encouraged by staff who also waited and enabled them to proceed at their own pace. We spoke with one staff member who told us, "I've done safeguarding (training) and MCA. Infection control was quite interesting. I did moving and handling. . . I know what it is like to be hoisted." They went on to they had also experienced how it felt to be assisted to eat and drink by another person.

We asked staff if they would be able to identify if a person's skin was at risk of becoming damaged. They were able to tell us what signs they needed to look for which indicated skin damage, and how to reduce the risk by reposition the person regularly. They told us they would also report concerns to the nurse in charge. This demonstrated that staff put their learning into practice.

Staff told us they received training suitable to support people with their health and social care needs and they felt confident and suitably trained to effectively support people. Staff new to the home completed an induction programme and 'shadowed' (worked alongside) an experienced member of staff before they supported people independently.

However the manager was open and transparent regarding staff training and told us that some staff had not completed all of the training expected of them. They commented, "This has been part of my biggest challenge, getting all the staff training up to date." They went on to tell us that staff had been having difficulty accessing the E Learning (computerised) training programme

Following our inspection visit the provider's action plan informed us all staff employed at the home would be supported to complete all of their training and the manager would ensure the training record system would be up to date and accurate. Individual staff had been written to and given dates by which they must have completed all of their required training.

The provider had enrolled new staff on the Care Certificate Course. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people. Nursing staff do not complete the Care Certificate however the RET manager told us, "We now have a new corporate induction for new nurses, we want to train and develop our nurses."

A healthcare professional visiting on the day of our inspection told us they visited the home regularly and offered training to staff about skin damage and continence care. They told us due to the high turnover of

staff they had been concerned about staff knowledge and practice regarding the management of people at risk of sore skin and continence issues. They told us the use of agency staff and inconsistent on site management had led to poor practice but felt things had improved in recent weeks. They commented, "It is a bit calmer, it looks much improved, the [treatment] I recommended, this has been done. With the staff they are very short but trying to get things done… I think it is really good, much calmer… [People] are all clean, their skin is intact. The regular staff here are lovely."

Staff told us they had not consistently felt supported by management and had not had many one to one meetings [known as supervision], due to the constant changes in management at the home. The provider acknowledged this and the new manager showed us their plan with dates for all staff to receive supervisions. The new manager told us they had already started meeting with staff and this would be a priority, some staff we spoke with confirmed this was taking place.

Staff we spoke had a basic understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what it meant for people. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Staff told us they understood the MCA was about how people made decisions and their ability to make them. One told us, "It's about decisions, I ask people first before I do anything, and it's all about their choice." Another told us they actively encouraged people to be independent and people were given choice as to when and how they liked to receive their care, they told us, "We always give choices to people." During our inspection visit we heard staff ask people for their permission before carrying out tasks. One person we spoke with told us, "Most staff do ask, can they carry out a task before they do it." We heard and saw staff sought consent before they supported people with personal care, asking, "Can I help you with that?" and, " Can I put your feet up?"

Where people lacked capacity they were assessed in accordance with the MCA, however one assessment for a person new to the home lacked detail and had not been completed. This meant staff did not have sufficient information about decisions the person was able to make about how they liked to receive their care and make choices.

The regional manager told us this would be reviewed immediately and the provider's action plan outlined that staff would receive face to face training about the MCA and the completion of best interest decision assessments. Staff would also be asked to complete reflections following the training to demonstrate they had understood.

We checked whether the provider was working within the principles of the MCA, and whether conditions of authorisation to deprive a person of their liberty were being met We found relevant applications, where necessary, had been submitted the local authority. However we found one authorisation had expired which meant that the person may have had their liberty deprived without the necessary authorisation in place. The manager told us this would be looked at immediately and during our visit an investigation was taking place and the application was being submitted. The provider advised us after our inspection visit that expiry dates of all DoLS in place would be recorded by the manager to ensure applications were submitted before they expired.

People had access to healthcare services when they needed them. During our visit we saw the local GP attended one person who was unwell, and one person was supported by a care worker when they attended a hospital visit.. We saw in people's records that relevant referrals had been made to various healthcare professionals such as the GP, Tissue Viability Service (wound care), speech and language therapists, dieticians, chiropodists and opticians.

Requires Improvement

Is the service caring?

Our findings

In October 2015 we found the home required improvement at being caring. This improved in April 2016, however we found at this inspection visit improvements were once again needed.
Most people and relatives we spoke with during our visit spoke positively about the care they received, but told us that staff did not have time to sit and talk with them outside of delivering personal care. Comments made by people were, "Staff are very good and kind," and, "Staff don't have time to have a chat or cup of tea with you."

One relative commented, "90 percent [staff] are kind and treat [person] respectfully but its all task orientated, staff don't have time to sit and have a chat with the [people]. The new nurse here today seems really nice and caring; she showed concerns about [person's] poor appetite."

The PIR acknowledged that staff did not have enough time to engage with people and stated, "Sometimes care assistants have other tasks that they need to do and so cannot spend the time with [people] that they would like." The staff we spoke with all confirmed they did not have opportunities to spend time talking with people, one told us, "We try and have a laugh and joke with people." The new manager was looking to recruit volunteers from the local community who would be able to spend time speaking with people and supporting them with activities of their choice.

Staff did not always take opportunities to engage with people. For example, we saw that two people ate their lunch in silence with staff present only asking them if they had finished their meals or would like some more.
We also heard one staff member ask another who was assisting a person to eat their lunch, "Is she eating it?" without addressing the person directly. This was not respectful to the person.

We saw another member of staff, assisting a person with their meal whilst standing over them as opposed to sitting with them. After 10 minutes a more senior member of staff saw this and invited them to sit with the person whilst helping them with their meal. The manager spoke to the member of staff after the lunch was over. The provider's action plan sent after our visit told us staff would be supported and trained by the provider's dementia specialist to understand how to make mealtimes more pleasurable and dignified.

Whilst we saw some areas of poor practice, we also saw other staff who were attentive and spoke with the people they were supporting. We found the home had a calm atmosphere and we heard laughter between staff and people. We saw staff touch people on the hand and arm and people responded positively to this. We observed staff checking people were okay and attentive to them and also heard friendly banter between staff and people.

A healthcare professional told us they had just spoken with a person who lived at the home and their visiting relative. They told us both the person and their relative were happy with the home.

Staff were seen and heard being discreet when people needed assistance. They reassured people who were

anxious and responded calmly and sensitively. For example, we were told one person became anxious after lunch. We saw staff sat with the person until they fell asleep.

All staff told us they were committed to providing good care and looking after people well. The deputy manager told us, "I believe they [staff] are caring people. No one is ignorant, they would help people. I think they have a good bedside manner and respect the [people]." A member of staff told us, "It's a lovely home, I just love it."

Staff respected people's privacy. For example, when doors were closed, staff knocked on the door and identified themselves before entering the room after gaining permission, where possible, from the person. A member of staff told us, "I knock on the door but also I make sure no-one is listening to a private conversation I may have with a person." We observed doors were shut and staff spoke in hushed tones when discussing people's intimate personal needs in communal areas. Interactions between staff and people were mostly warm and compassionate.

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. A relative we spoke with told us, "Yes we are made welcome when we visit, the staff are friendly."

People told us their dignity and privacy was respected by staff. We saw this was the case; staff greeted people by their preferred names and personal care was provided in private. However we saw that one person, after they had received their morning wash, were supported to wear a shirt which was too small, exposing their stomach and back. The manager told us they would ask staff to assist the person to wear more suitable clothing.

Some people and relatives confirmed they were involved in making decisions about the person's care. One person commented, "Most staff do ask can they carry out a task before they do it and they help me to maintain my independence."

Relatives we spoke with told us they were able to sit and discuss their family member's care with staff, however one told us their involvement in their relation's care plan had declined in the last few months but added, "Having said that I do think they are doing their best."

Requires Improvement

Is the service responsive?

Our findings

In October 2015 people told us they were not always supported to pursue their hobbies and interests. In April 2016 we found improvements were made but these had not been sustained and at this inspection visit concerns remained.

We asked people if they were supported to pursue their hobbies and interests. In response to this, people told us, "I get fed up some days lying here all day," and, "I do nothing all day, I get bored." A relative we spoke with told us, "Due to [person's] impaired sight he can't see the T.V. or read; he loves the singers when they visit and the man whom does physical exercises with [people]. But yes he does get bored. The activity co-ordinator is really good but she gets put upon and ends up delivering care."

Another commented, "I visit a couple of times a week. I am not overly impressed. I've been here up to an hour before and not seen any staff; they seem to be a bit busier today because you're here." We observed one staff member was playing a game with a person, and the relative told us, "I have never seen that before." One staff member we spoke with commented, "I would like to see more activities for people, some just sit and go to sleep."

There were two activity co-ordinators at Milverton Gates Care Home; however one was on an extended leave of absence and the second worked part time.

The management team acknowledged that opportunities for activities needed to be increased within the home. The manager told us by introducing volunteers into the home from the local community this would benefit people to have more access to hobbies and interests. This was particularly important for those who were unable to get out of bed and into the communal areas. The activity coordinator had been tasked with making contact with local schools, churches and existing volunteer projects. The manager told us the volunteers would work alongside the activities co-ordinator and would be supervised by staff. All would have DBS clearance before being allowed to support people in the home.

Following our inspection visit the provider told us they would be providing training to staff to assist them to identify opportunities for positive engagement with people and an activity co-ordinator from one of the provider's nearby homes would be asked to support the activity programme and introduce specific activities for people who lived with dementia.

During our visit we saw the activities coordinator carry out some individualised activities with people in the communal lounges. They told us, "Activities are planned but can change, it depends what people feel like." We saw them joking and laughing with a person they were supporting to make an Easter chicken.

We looked at people's care plans and found they contained relevant basic information about people but were not always centred on the person and their individual needs. At our last inspection all care plans had been reorganised and information was easier to find. However the RET staff member was open and honest that care plans needed to be updated and reorganised again and told us the lack of permanent nurses had

impacted on them being reviewed and updated.
They commented, "The deputy manager has been carrying out some care planning reviews. We have some work to do to move care plans forward. Some have been written and updated." They went on to tell us that they had produced a full care planning 'manual' which they showed to us. This gave nurses guidance on how the care plan should be completed and what essential information should be contained about peoples care and treatment.

One agency nurse we spoke with told us they found information in care plans was not always easy to find. They told us this had caused a problem when one person needed to go to hospital and they were unable to find information relating to their medical condition. This information would be important for hospital staff in order for them to correctly assess and care for the person.

The RET staff member told us to improve care plans they were organising a training day 'workshop' for the nursing staff. The manager told us each day a 'Resident of the day' would be identified. This meant one day each month one person and/or their representative would be spoken with, to see if they were receiving care in the way they wanted. Housekeeping, maintenance, kitchen, nursing and care staff would all be involved in the process to ensure the persons full needs were being correctly assessed and met. Care records would be changed to reflect any required or requested changes but would also be updated if there were any changes to a person's needs or condition in between the monthly review.

We asked staff if they had time to read the care plans and they told us they did not. We looked at some care plans and then asked staff about people's needs. We found they were mostly well informed about people and the support they required. For example one staff member we spoke with was able to tell us in detail about a person's specific dietary needs and their life history. They also went on to tell us the person required special cutlery and cups to help them eat and drink.

Some people told us they did not always receive their personal care at their preferred. One person commented that they would like to have their wash earlier in the morning but had to wait until staff were available. They told us, "I haven't had a wash today… It's not the staff fault they are always on the move." We checked later and the person had received their personal care however since recently coming into the home they told us they had not received a shower. We discussed this with the manager during our inspection visit and they told us they would look into this.

We noted from team meeting minutes that the new manager had addressed the frequency of showers people were receiving and reminded staff of their responsibilities to ensure people received their personal care according to their preferences. Staff had requested a new shower chair to assist them in meeting people's needs and this had been ordered.

We saw in peoples' care plans that their individual personal care preferences were recorded, for example one person had requested they shower in the evening. During our inspection visit we saw people were well presented and their bed linen was clean.

We looked at how the provider managed complaints. We asked people if they knew how to make a complaint about the service. People told us they would speak to staff and as part of the provider's regular audits the regional manager told us people were asked for their views on the care they were receiving.

Relatives told us they would approach the manager or staff if they had concerns. One relative said, "I have spoken to the manager when I have had any concerns but there have been four or five managers lately there is no consistency." However another told us they had asked to speak to a manager when a member of staff

had been rude to them. They told us following their complaint the member of staff no longer worked within the home. Another relative we spoke with told us they had complained to staff on occasions about their relative's nails being dirty.

We saw there was a 'tablet computer' in the reception area which was available for anyone who visited the home to use. This could be used to request an appointment to speak to the manager and raise concerns and complaints. Relatives we spoke with confirmed they had used the IPad to provide feedback on the service. During our visit, we saw the provider's complaints procedure was on display on the notice board in the entrance of the home.

The manager told us learning from complaints would be shared with staff in staff meetings and individual supervision sessions.

Inadequate

Is the service well-led?

Our findings

The provider has a history of non-compliance with the regulations of the Health and Social Care Act 2008 at this service. At our inspection visit in October 2015 we found the home was not well led and the provider was in breach of the regulations; as a result the home was placed into special measures.

At our last inspection in April 2016 we found the home continued to require improvements but the provider had made significant improvement. They had recruited a new registered manager and deputy manager along with a new regional area manager. All had worked for the provider before moving to Milverton Gates Care Home. As a result of the improvements the home was removed from special measures.

At this inspection we found not all of the improvements made had not been sustained and the provider was again in breach of the regulations. We found the home was not well led and the provider failed to consistently provide, and ensure, good governance.

Since our last inspection there was inconsistent leadership at the home. The registered manager moved to another of the provider's homes and the deputy manager had left. As a result three separate interim managers had been overseeing the service in the last year. There had also been two new regional area managers. The new manager started working at the service in January 2017 and advised us they would be applying to register with us. The RET manager told us, "We have not had consistent management or permanent nurses at the home."

Staff we spoke with told us, "We have had so many different managers; sometimes we wonder who we will get next. Another told us, "With the management changes it is not good, you feel like leaving yourself." The deputy manager told us, "I feel quite frustrated, it is a beautiful home, the surroundings, the staff are all good, but they have not had a lot of guidance."

All the staff we spoke with told us the constant changes in managers had led to the service being disorganised and communication amongst staff was poor. We found evidence of this on the day of our inspection, the new manager had been on a week's leave and the RET staff had been covering the home in the manager's absence. We found both were not always able to answer our questions about the people living at the home and their needs. This is important as the manager would need to oversee people's care and be able to share important information with healthcare professionals or emergency workers.

The provider conducted staff satisfaction surveys and we saw replies reflected what staff told us. For example one question asked if, 'I trust my manager to do the best for me and the home' only 58 percent indicated they agreed in March 2017, and 56 percent said they would recommend the home to a friend or colleague. However we saw improvement in all scores for April 2017 with overall scores rising from 69 percent in March to 89 percent in April 2017.

We looked at the provider's audits that were undertaken to check the quality and safety of service people received. This included checks on the management of medicines, care records, health and safety issues,

staff training and the safety and cleanliness of the premises.
Information provided to us showed between January 2017 to April 2017 an overall result of only 69% compliance was achieved by the home and incompletion of care plans was consistently recorded as poor. In particular we saw consistent low scoring relating to recording of people's risk assessments, management of pain, and incomplete admission documentation. We also saw that audits were not consistently completed for some of the auditing time periods.

We looked at incident and accident investigations and saw that where issues had been highlighted some had not been thoroughly investigated. Actions were not consistently taken in response to any shortfalls identified to ensure people received a good quality service and actions taken by the manager were not always clearly recorded. For example we saw the manager had identified in March 2017 that there were 'many missed signatures' on peoples' MAR charts. They had informed the GP however when we requested information regarding how many people were involved and what additional actions the manager had taken, this information was not available.. One of the management team acknowledged to us during our inspection visit, "The systems and processes need improving; it hasn't been kept up to date."

This was a breach of Regulation 17 (HSCA 2008 (Regulated Activities) Regulations 2014.

The new manager told us they understood their responsibilities and requirements to submit the relevant statutory notifications to us in relation to potential abuse so that we were able to monitor the service people received. However when we looked at the provider's audits systems two incidents stated we had been informed about medication errors, but we could find no record of these, although safeguarding had been informed. The provider confirmed to us after the inspection we had not been notified and three other incidents where notifications should have been submitted were not. They informed us they would ensure these were completed; however we still had not received them following our inspection.

This is a breach of Regulation 18 (2) Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

After our inspection visit, the provider sent us an updated action plan advising they had reviewed all the incidents and accidents and the new manager was receiving support from the resident experience team to ensure all actions were completed and the relevant notifications submitted.

In response to the staff survey findings, staff were being spoken with individually to discuss their views and individual meetings were being arranged with human resources to provide an opportunity for staff to freely discuss how they were feeling. In addition the manager was praising staff to boost morale and make them feel valued. The managing director told us they wanted to hear how staff were feeling and their views and opinions would be listened to and acted on by the senior management team.

People had opportunities to share their views about the service they received. We saw where people had been asked if they felt safe in the home, involved in decisions about their care and offered choice their scores had improved from 50% satisfaction level in January and February to 100% in March 2017. However when asked if they felt staff were respectful this fell from 100% to only 50% in March. Relative feedback indicated an overall satisfaction for the home of 94%, however we saw for the question 'does your relative get help to eat and drink when needed' only 73% were satisfied.
Whilst we had serious concerns about the continuing change of leadership at the home, we found people, their relatives and staff felt that the new manager was approachable and was beginning to make positive changes in the home. Staff felt morale was slowly starting to improve in the home and saw the new manager and deputy manager as open and supportive.

We asked people and their relatives for their views on the service, comments made were, "It isn't too bad here, they do their whack. It's a nice home clean and everything," and, "Yes, I have completed questionnaires both in writing and using the 'IPad'..."The manager is always around and for me she is doing what she says she would." Another person commented to us, "It's a wonderful place you can't expect perfection. It's clean and tidy."

Staff were all positive about the new manager and the impact they had made on the service. One told us, "I have got a positive vibe from [manager] that she can make changes. The regional managers are quite supportive.... There is an out of hours' number. I think [manager] is approachable she listens." Others commented, "[Manager] is very supportive, she has put more staff on… the new deputy is very good and updates us all on new people." Another told us, "The manager is lovely. They come and go though, we feel insecure."

Staff who had worked at the home at the time of our last visit told us they felt more cared for by the provider in recent months and were more positive about coming to work. Two commented, "We have been getting lots of support from the provider." And, "It's hard work, but we muck in and work as part of a team." Staff told us team meetings were now being held so they could discuss the service and share information.

In order to improve communication amongst staff the provider was introducing a '10 at 10' meeting. This would be held daily with the manager and staff would be given the opportunity to discuss any concerns, innovations, ideas and feedback about the service.

The managing director and management team were open and transparent regarding the challenges the home faced. They told us they were committed to making and sustaining improvements needed and that the new manager and staff would receive support from the RET and regional management team. The managing director acknowledged that the home had experienced a difficult year due to the numerous managerial changes but they were confident things would improve. They told us the lack of consistent regional manager support for the managers and staff had impacted on the service provided and staff morale. As a result an experienced regional manager had been brought in to oversee the running of the home and to support the new manager and staff.

The regional manager told us, "There will be a supportive development plan for the new manager and staff and I am having a big managers meeting tomorrow [for all local provider homes] where I will be explaining what our expectations are for services." They went on to say this was also an opportunity to share learning points and also good practice.

The new manager told us they were keen to move the service forward and that building a permanent team was the key to ensure continuity of care for people living at the home. They told us they had felt well supported by the provider since starting at the service. The provider acknowledged that ensuring senior managerial oversight and a consistent staff team was essential to the success of the home. They assured us robust plans would be in place to support the manager and to make sure improvements were imbedded. Action plans submitted to us following our inspection visit showed the provider was taking positive steps to address the concerns we found.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents 18(2) The registered person failed to notify the commission of incidents specified in paragraph (2) which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) The provider did not continually assess, monitor and improve the quality and safety of the service. 17(2)(a)The provider had failed to monitor the quality and safety of the service provided,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1) There were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's care and treatment needs.