Care UK Community Partnerships Ltd

Milner House

Inspection report

Ermyn Way
Leatherhead
Surrey
KT22 8TX

Website: www.careuk.com/care-homes/milner-house-leatherhead

Date of inspection visit:
08 February 2016
09 February 2016

Date of publication:
13 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Milner House is a care home that is registered to provide nursing and residential care people for a maximum of 76 people. The registered manager told us that the service no longer uses its capacity for double rooms and as such they would only accommodate a maximum of 46 people. There were 40 people living at the home at the time of inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility
for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified multiple concerns with regard to the way services were being provided at Milner House. The registered manager did not have sufficient oversight over the running of the home. Her management style was reactive and people often experienced care that did not meet their needs or expectations.

Staffing levels were insufficient and did not match people's high levels of dependency. We found that some people had to wait too long for their care which left them feeling vulnerable and scared. Staff morale was low because some staff were frustrated that their repeated requests for additional care support was not actioned. People did not receive person centred care and felt that some staff were unkind to them as they provided support in a hurried and rushed manner.

The registered manager had not recognised that some of the concerns that people raised amounted to allegations of emotional abuse and neglect. We therefore had to direct the registered manager towards taking appropriate action to safeguard people.

People had been placed at risk because the controls in place to reduce exposure to Legionella had not been managed effectively. The registered manager had not taken appropriate steps to ensure that immediate risks were minimised and a long term solution sought to prevent reoccurrence.

Whilst most people had a choice about their food, the serving of meals was task orientated and not personalised to people's individual routines. Specialist dietary needs and preferences were not always met

because staff did not fully understand the needs of the people they supported.

The service had a programme of staff training, but closer supervision of staff was needed to ensure that learning was reflected in practice. Whilst staff knew the need to gain consent from people they lacked a good understanding about what to do if a person lacked the capacity to make a decision for themselves. Staff were also unaware of the people for whom the registered manager had assessed as potentially being deprived of their liberty which meant their care may not have been provided in the least restrictive way.

Some staff showed a lack of respect for people and their home. For example we saw that some staff did not respect people's privacy by knocking on their bedroom doors before entering. We saw some genuine acts of compassion from staff, but not all staff had positive relationships with the people they supported.

People were not adequately supported to participate in activities that were meaningful to them. As such, most people spent the majority of their day either asleep or sat in wheelchairs. Staff were not always skilled at engaging with people, especially those living with dementia, effectively.

Formal complaints were investigated and resolved. There were limited opportunities however for people who felt nervous or were unable to raise concerns independently to express the things they felt unhappy about. These people did not feel listened to and valued.

Recent improvements to care planning meant that people's physical needs were better assessed and monitored. Assessments however had not always been effectively transferred into robust guidelines for staff. Some staff were unfamiliar with recorded information and as such did not deliver care in the way people preferred.

The service reacted well to people's identified health care needs and referred people to external professionals when required. There were no systems in place however to ensure people accessed preventative treatment, for example through attending routine dental checks-ups in order to maintain good oral health.

There were systems in place to manage medicines safely and ensure people received the right medicines at the right time.

Appropriate checks were undertaken when new staff commenced employment and nursing staff were supported by the provider to retain their registered professional status.

The provider had systems in place to monitor the service and had identified their own shortfalls in the quality of service at Milner House. The provider responded immediately to inspection feedback by producing an initial action plan to demonstrate how the necessary improvements would be made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Staffing levels were not sufficient to meet people's needs and as such people had to wait too long for their support.

Not all risks to people were managed appropriately to keep them safe.

People were not always adequately safeguarded from the risk of abuse.

Appropriate checks were undertaken when new staff were employed.

There were systems in place to ensure that medicines were managed safely and known risks to people's health were controlled.

Is the service effective?

Requires Improvement

The service was not always effective.

The provision of meals in the home was task orientated and did not reflect people's individual dietary needs and preferences.

The service could not be assured that people's legal rights were fully protected, because not all staff had a good understanding about people's mental capacity.

There was a programme of training in place for all staff and nursing staff were supported to keep their specialist skills up to date. Closer supervision of care staff was needed to ensure learning was reflected in their practice.

The service reacted well to people's health care needs, but was not always proactive in ensuring everyone had sufficient access to preventative treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff were clearly dedicated to their work and kind towards the people they supported, others were not.

Care was provided in a task focussed way that did not always respect people as individuals, which left some people feeling vulnerable and their emotional needs unmet.

Staff did not always take adequate steps to protect people's privacy and dignity and some showed a lack of respect towards people and their home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not adequately supported to engage in activities that were meaningful to them.

Recent improvements to care planning meant that people's needs were better assessed and monitored, but these assessments had not been transferred into personalised care.

Where people or their relatives had made formal complaints, these had been investigated and resolved. Some people however felt nervous or were unable to raise concerns independently and there was no system in place for these individuals to feel listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service lacked the visibility of strong leadership and oversight on a day to day basis. The registered manager was reactive to individual issues rather than proactively managing of the service as a whole.

The culture of the service was not always positive. Staff were focussed on completing tasks rather than on individuals and people did not feel valued and included in their care.

The provider was responsive to concerns raised and demonstrated a commitment to improving quality and to resolving the highlighted issues.

Milner House

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 was 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 over two days on 8 and 9 February 2016. The first inspection date was unannounced and consisted of three inspectors and a specialist nursing advisor. On the second day, the lead inspector was accompanied by an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure that we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. 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. This was because our inspection was brought forward in response to concerns raised with us by relatives, a whistle-blower and the local authority.

As part of our inspection we spoke with 17 people who lived at the service, six visitors, ten staff, the registered manager and the operational support manager for the service. We also reviewed a variety of documents which included the care plans for 16 people, five staff files, medicines records and other documentation relevant to the management of the home.

The service was last inspected in January 2015 where we found no concerns.

Inadequate

Our findings

The majority of people we spoke raised concerns about there being insufficient staff on duty to support them effectively. Several people told us that the length of time they had to wait for care had left them feeling, "Frightened "and "Scared." People said that staffing levels were, "Worse at weekends." People gave us many examples of times when the lack of staff support had a negative impact on their wellbeing. For example one person told us, "Well sometimes if I press the bell, no one comes and I get really frightened during the night." When we asked what they did if no one came the person said, "In the end I call out "help" or find something to bang (to make a noise)", the person then added, "I have sat in the toilet for half an hour ……I get so low if no one comes." Another person told us that they had waited so long for assistance with the toilet recently that they had become incontinent. They told us, "I felt so traumatised by it all." People commented that the service did use agency staff, but highlighted, "The trouble is they don't know you."

Prior to the inspection we were contacted by a relative who wanted to share their concerns about the lack of staff on duty at Milner House. During our inspection, visitors told us that they thought people were safe at the home, but also highlighted their worries about staffing levels. One relative told us, "There are times when they are under pressure" and another said, "There are staff around, but they are not necessarily in the lounge with people." Another visitor highlighted, "People sit in wheelchairs all day which is not good for them." We also observed this to be the case during the two days of our inspection.

Staff talked with us about their views of the staffing levels in the home. Staff were visibly upset about the situation and told us, "There are just not enough care staff to provide quality care." Both nursing and care staff repeatedly told us, "Care staff are under too much pressure. They have no time to spend with people." We asked staff what impact they felt this had on people and they told us, "Some people are left on the toilet for too long" and "The care here is institutionalised, because we have no time to support people as individuals."

In addition to concerns about the number of allocated care staff to support people, the registered manager also told us that the service currently had five vacancies for nursing staff and as such relied heavily on agency nurses to fill this void. The permanent nurses we spoke with said that this increased the pressure on them because most shifts they were working with another nurse who did not always know people's needs. They also highlighted that there was often no daily management oversight of shifts because the deputy manager who was supposed to provide additional support was frequently working as the second nurse to make up the numbers. One nurse told us, "We are so short on nurses that there is no contingency plan if one of us is sick." They also went on to describe how the lack of permanent nursing staff and the insufficient

allocation of care staff meant that basic things such as supporting people to clean and cut their nails was too often missed.

We observed that people's care needs were not met in a personalised way across the two inspection days. People were supported to get up in the morning when staff were available to assist them, rather than when they chose. Care staff were constantly rushing from one task to the next without having the time to spend with people. At mealtimes some people waited too long for support and as such lost interest in the food provided.

The registered manager told us that minimum staffing levels provided were two nurses and eight care staff each day with herself and the deputy manager being additional to this. A review of rotas for the previous four weeks identified 12 day shifts where there had been seven care staff on duty and two night shifts where there had been one nurse working. This meant that even without the concerns about current staffing levels not being sufficient, there had been multiple recent occasions when the home's own minimum levels had not been maintained.

We read in the falls audit that there had been 61 falls in the previous 12 months period. The audit identified that many of the falls had occurred when staff were at their busiest.

The failure to provide sufficient staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The day after the inspection the provider sent us an action plan which identified that they had taken immediate steps to review staffing levels in the home. The use of agency staff had been agreed by the provider to ensure minimum staffing levels were always maintained. In addition the Operations Support Manager had commenced an observational study of care staff working in the service to assess whether they were being deployed appropriately. We will continue to monitor the service to ensure staffing levels are sufficient to meet people's needs.

People had been placed at risk because the controls in place to reduce exposure to Legionella had been poorly managed. During the inspection we identified that most of the shower heads throughout the home had been removed. The registered manager informed us that this was because in November 2015, the home had tested positive for Legionella during routine water testing. The external company employed for testing had recommended the removal of all shower heads and to use only Legionella safe shower heads until all traces of Legionella had been removed. Whilst the registered manager had purchased a number of these recommended showerheads for use around the home, she had failed to appropriately risk assess the issue and ensure adequate steps were being taken to reduce the immediate risks and resolve the problem in the long-term. For example, they had failed to take adequate steps to ensure all that staff were aware of the risks and how these were being managed.

Failure to assess and where possible, mitigate risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Immediately following the inspection the provider contacted us to advise that they had taken urgent remedial steps to safeguard people from the risk of Legionella. They also told us that they had made arrangements for the affected water tank to be removed and for all water supplied to the home to be transferred to the mains system. At the time of writing of this report, the provider had confirmed that all necessary works had since been completed and all water outlets throughout the home had been re-tested and found to be free from Legionella.

Individual risks to people were identified and managed. For example where people were at risk of pressure wounds they had been appropriately assessed and measures taken to prevent tissue damage. Whilst there were no concerns about the management of pressure wounds within the home, some nurses' knowledge of this area was basic and there was no dedicated wound champion within the service. A wound champion is a member of staff who takes the lead in ensuring that the management of pressure care reflects current best practice.
People told us that whilst staff had never physically harmed them, they did not always feel that they were treated well by some staff. People said that some staff used their position against them. For example one person told us "They have subtle ways of punishing you" and another said "Some staff are not good and have the power." When we asked people what they meant by these comments they said that they felt some staff did not provide personal care in a timely way which made them feel devalued. We raised these concerns with the registered manager and whilst they immediately responded, they did not recognise these issues were allegations of emotional abuse and neglect. As such we had to direct the registered manager to make a safeguarding referral.

Failure to protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoken with had a good understanding about their safeguarding responsibilities and were confident about their role in keeping people safe and demonstrated that they knew what to do if they thought someone as risk of abuse. They confirmed that they had never witnessed and abusive practises. Policies and procedures were in place for staff to follow if they suspected harm and all staff were clear about how to correctly report abuse to the outside agencies if necessary.

People received their medicines when they needed them. Only registered nurses were authorised to administer medicines and there were appropriate systems in place to ensure their training was kept up to date.

We observed medicine being given to people. The nurses went to each person individually and gave the required medicines as prescribed.

There were policies and procedures in place to make sure that people received their medicines safely and on time. Medicines were administered from a trolley in which they were stored securely. When not in use the trolley was stored securely in a locked room. The stock cupboards and medicines trolleys were clean and tidy, and were not overfilled. Some items needed storage in a medicines fridge. Temperatures were checked daily to ensure medicines were stored at the correct temperatures.

Administration records showed that medicines were given as instructed by the person's doctor. There was a written guidance for each person who may need medicines only 'when required' for consistency.

There were systems in place to review any incidents and medicine errors that happened at the service. These were analysed and improvements were made if any trends or patterns were identified. Medicine use was also regularly audited. We saw that the home's monitoring systems had identified that medicines had not always been signed for immediately following administration. Corrective action had been taken to address this and we found no gaps in the records we checked.

Appropriate checks were undertaken before staff began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There

were also copies of other relevant documentation, including employment history and character references, job descriptions, evidence of up to date registration with the Nursing and Midwifery Council and Home Office Indefinite Leave to Remain forms in staff files to show that staff were suitable to work in the service.

The provider had a contingency plan in place to ensure the continuation of the service in the event of an emergency such as fire or power outage. People had individual risk assessments to demonstrate their safe evacuation from the service if necessary.

Requires Improvement

Our findings

People provided mixed accounts about the meals at Milner House. Everyone told us that they usually had a choice about the food they were given. Comments included, "Most days there are two items on the menu" and "I don't often like the supper so I have an omelette or a sandwich instead." However, people who were on soft diets did not always get the same level of choice as those who were not. For example, on the first day of the inspection, there was a Chinese themed menu to mark the Chinese New Year. We observed that those people who required a pureed meal were given meat, potato and vegetables automatically instead. When we asked staff about this they told us that they had not been given a choice that day because, "They would not be able to eat it."

Most people did not have any concerns about the quality of meals. For example, one person told us, "I am never hungry, the food is not at all bad" and another commented that, "The food is nice now, much better than it used to be." Relatives and visitors we spoke with thought the food at the home was generally good. One relative told us, "I think the food is quite good here" and another said, "The food always looks lovely." However, those people with specialist dietary needs told us that these were not always met. For example, one person listed some food that they could not eat and yet told us that these were still sometimes put on their plate. Another person said that they did not eat certain food groups for religious reasons, but that they frequently had to remind staff about that. Similarly, a relative commented that staff did not always understand the dietary needs of their family member. Whilst care records contained information about these specialist needs and preferences, the staff we spoke with were not always aware of them.

People told us that they usually received the help they needed with their meals, but that they often had to wait. For example, one person told us that whilst the food was good, "It is usually cold by the time I am helped to eat it." We observed people waiting a long time to be supported with their lunchtime meal. Tables were arranged in small groups, but meals were served at the same time which meant those waiting for assistance were sat looking at their food for up to 20 minutes before being helped to eat it.

We read in one person's care plan that they were being monitored with meals due to recent weight loss. We saw that when the person was offered their choice of meal at lunchtime, they requested a small portion. They subsequently received a large plate of food of which they only ate a small amount. After lunch we spoke with this person who told us that they, "Get put off" by the size of meals given to them. They also said that they had only finished breakfast at 10am and as such were not ready for their lunch at midday. Care records identified a number of people had lost weight and whilst referrals to other healthcare professionals had been made, there was a lack of guidance to staff about the steps they could take to encourage people

to eat better.

We observed the lack of flexibility around meal timings meant that most people were expected to eat at the same time regardless of when they had had their previous meal. Some people commented that the timings of meals did not work for them and that as a result they often ate their own supply of biscuits in the evening because they were hungry. With supper being served at 5pm, people had to wait a long time for their next meal which was breakfast the following morning. We also noticed that when people were asleep during the morning tea and biscuit round that they missed this opportunity because they were not offered it again when they awoke.

The failure to provide sufficient food to meet people's nutritional needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received adequate hydration. We saw that people were regularly offered drinks and for those that remained in their bedrooms, there were jugs of juice or water in their room that were regularly replenished. For those people at risk of dehydration, the nurses maintained an oversight of fluid monitoring charts to ensure they drank sufficiently.

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

We checked whether the service was working within the principles of the MCA and we found that this was not always the case. For example, the registered manager had made applications to the local authority, as the Supervisory Body for 14 people to be deprived of their liberty. Staff however, were not aware of these applications and as such could not demonstrate that the care for these people was being continually reviewed to ensure it was being provided in the least restrictive way.

Training records showed that staff had completed training in MCA and DoLS, but there had been no steps to ensure that this learning had been appropriately competency checked and applied in practice. As such, whilst staff demonstrated an understanding of the importance of gaining consent from people, they did not always understand the principles of the MCA and in particular the assumption of capacity. For example, the care plans for people who used bedrails contained a DoLS assessment in respect of their use, regardless of whether the person had the capacity to make this decision for themselves.

When we asked people if they thought staff were suitably qualified to deliver their roles effectively one person replied, "Up to a point." Another person commented that, "They speak a certain amount of English, but it is difficult to understand what some staff are saying." The service had a programme of training in place and staff told us that they regularly updated their learning and had completed courses such as moving and handling, health and safety, safeguarding and fire safety. Staff told us that most of the training they completed was online and nursing staff said that they wished they had more time to oversee care staff to ensure that their learning was reflected in their practices.

The service had a schedule for the supervision of staff and staff said that they usually received these one to one sessions on a six-monthly basis. Staff said the registered manager was approachable, but they felt that

the main barrier to them doing their job well was staffing levels and that this had not been addressed. The registered manager informed us that following some manual handling concerns that had been raised within the service, they had been undertaking on the spot checks of staff as they supported people to mobilise. It was our view that such competency checks needed to be extended to other areas of staff practices.

The failure to provide staff with appropriate support and supervision to carry out their roles effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to provide clinical supervision to nursing staff. The provider also offered all Registered Nurses the opportunity to access the Nursing Times learning to support them with revalidation. This demonstrated the provider's commitment to ensuring their registered nurses were updated in their practice and supported them in remaining on the professional nurse register.

The service reacted well to people's health care needs, but was not always proactive in ensuring everyone had access to preventative treatment. People told us that where they had identified healthcare issues that these were addressed quickly. Care records showed that appropriate referrals had been made to other professionals such as doctors, opticians, dietician or speech and language therapists in cases when problems had been identified. One person told us however, "The dentist has never visited here" and when we looked at the care records we saw there was no system in place for ensuring that people were offered routine check-up appointments with professionals such as dentists. Immediately following the inspection the service informed us that they had introduced these checks as part of the care planning process.

Requires Improvement

Our findings

We received a variety of feedback from people about their relationships with staff and it was evident that whilst some staff were clearly dedicated to their work and kind towards the people they supported, others were not. As such, one person told us, "Staff are incredibly kind and patient" whilst another told us, "They get very cross, they say you are not the only one here and we are very busy." Most people told us that there was a noticeable difference in the care provided by the different staff. One person told us, "It's all about the staff, 60% are good, 40% are not" and another said, "Some are kinder than others." One person highlighted that, "Some staff are much more caring than others and it really is luck who comes when you press your bell."

Some staff were more caring than others. For example, we watched one member of staff approach one person with a hot drink and start giving it to them without any interaction with them. Similarly, another staff member moved the wheelchair a person was sitting in without warning. Other staff did show people respect and compassion. For example, we saw one staff member comforting a person who was upset by sitting with them and rubbing their arm. They went on to offer the person a cup of tea and tried to encourage them to join in a game. Likewise, we noticed that when a person started coughing when they were drinking, a member of staff immediately went to them and said, "Mr x, are you alright? Don't worry, take your time."

Care was provided in a task focussed way that did not respect people as individuals, which left them feeling vulnerable and their emotional needs unmet. Due to the pressures on staff time, people were supported in a way that put the task required ahead of their individual needs. For example, people told us that they did not have a choice of when they were supported by staff in the morning. Frequent comments in respect of this included, "Staff tell me when to get up. Yesterday I had to wait a long time to get dressed because there weren't many staff on." Another person told us, "I try to wait for staff to help me in the morning, but you never know when they are going to come and so sometimes I have to get myself to the toilet." A further person commented, "It's so task orientated, it's not the staff's fault, they just don't have the time."

Staff also told us that they felt frustrated that they did not have the time to support people in the way they should. Staff repeatedly told us how they tried to give people a choice about their care, but that in reality everything, "Is such a rush." We observed that staff spent limited time talking with people. They completed a task and moved onto the next. For example, we saw that one person was being a cup of tea so quickly by a member of staff that it poured down their chin and onto their jumper.

Staff did not always take adequate steps to protect people's privacy and dignity and some showed a lack of

respect towards people and their home. Staff did not always knock on people's doors before entering their rooms. For example, we were talking with one person in their room and on three separate occasions staff entered the room without knocking. When they noticed our presence they addressed us and not the person. We also saw another staff member sitting in a communal lounge with their feet up on an armchair. When they noticed us they quickly stood up, but did not apologise to the person sitting opposite them.

The failure to ensure that people were always treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Our findings

People said that there were some in-house activities available for them to join in with, but that these were not always based on their likes or interests. For example, one person told us, "This afternoon it's bingo, I go to meet the other ladies." They went on to tell us that they did not particularly like the bingo, but that they enjoyed the social opportunity. Similarly another person said, "People come in to entertain you but I can't stand it". A third person commented, "A pianist came and played, that was nice, but I don't think I have ever been asked what activities I like".

One staff member told us that they had recently arranged group outings for people to visit the coast and the London Christmas lights. Those people that participated in these trips spoke highly of them and staff informed us that they had been a real success.

People were not always adequately supported to engage in activities that were meaningful to them. We saw staff make several attempts to engage those people sitting in communal areas to join activities on the morning of the first day, such as badminton with balloons and quoits. These attempts however were short lived with games only lasting a few minutes before staff either stopped them or people became disinterested. One visitor told us that they thought these activities were for our benefit, saying, "There is nothing ever going on. I knew something was up as soon as I walked through the door. There were lots of smiley faces and activities going on." In the afternoon we saw one person enjoy having a manicure with a staff member, but other people were seen to be sitting alone or asleep. Those people who were in their bedrooms did not have access to any activities unless they had visitors. One person told us that they got, "Lonely" and another commented that the only time they saw staff was when they required support with a task.

Recent improvements to care planning meant that people's needs had been better assessed and monitored. We found that the operational support manager had invested a lot of time in updating care records and ensuring that people's identified needs were regularly monitored. For example, we read that risks associated with people's weights, food intake, pressure care and falls were reviewed and updated on a monthly basis. However, these assessments had not always been transferred into personalised plans of care detailing how the person should be supported. For example, we read in one person's care plan that the person had a form of artificial feeding which allowed food to pass directly into their stomach. In other parts of the same person's care plan, there was reference to providing the person with a fork mashable diet and fluids via a teaspoon. It was therefore not clear from the records how this person should be supported to be fed.

Similarly, where people had specific needs identified in respect of medical conditions, such as diverticulitis, Parkinson's or dementia, there were no corresponding guidelines for staff about how to meet these needs or how they may impact on the care provided.

Whilst it was clear that care plans contained information about people's life histories or preferences, these were not always known by staff who delivered their care. For example, one person talked to us about their former occupation, their religion and their fears and yet none of the staff supporting them at the time of the inspection, including their nominated keyworker, were aware of any of this information.

The failure to provide person-centred care that was appropriate to meet people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been assessed as to whether they were at risk of developing pressure wounds and staff demonstrated their understanding about the action they should take in relation to pressure wounds. We saw that staff were responsive to people's pressure needs. For example, during the inspection one person who was at risk of developing pressure wounds told us that they did not find their bed comfortable. We reported this to the registered manager who immediately checked that the mattress was set correctly for the person's weight and then contacted the nurse specialist for the mattress supplier's to come and re-assess the person.

Where people or their relatives had made formal complaints, these had been investigated and resolved. People told us that when they had raised concerns formally appropriate action had been taken to resolve the issues. For example, one person told us, "Whenever I have asked for something to be done - it has been dealt with." Similarly, another person commented, "I think I would be listened to because I can express myself." Relatives echoed the same feedback and the complaints log recorded that the registered manager had conducted investigations and responded appropriately to concerns that had been raised.

Some people however felt nervous or were unable to raise concerns and there was no system in place for these individuals to be listened to. People expressed a general reluctance to make complaints even though they were clearly unhappy with their care. For example, one person told us, "I have to be careful what I say" and another requested that we did not repeat what they had told us. One person who raised concerns with us said that they would have told the registered manager if she had asked them how they were. We found that the service required greater management and oversight in order for people to have confidence to share their concerns and views.

Requires Improvement

Our findings

The service lacked the visibility of strong leadership and oversight on a day to day basis. Whilst the registered manager was based at the service, they were not sufficiently visible especially to those people who spent most of the time in their bedrooms. For example, one person told us, "I don't remember when I last saw the manager" and another commented, "There should be a manager available at all times." Similarly, one visitor said that they visited every week but they still did not know who was in charge.

Both before and during the inspection we received feedback that people, their relatives and other professionals had concerns about the way the service was currently being managed. It was evident that the provider had already begun to respond to these concerns and as such an operational support manager was based at the service to support the registered manager and her deputy. The registered manager told us that she had also begun a daily walk around the home and was making welfare checks on people. However, more work was needed in order to build people's trust and encourage them to provide their feedback. For example, several people were reluctant to talk about their views. One person asked us, "Will this discussion make a difference" and another questioned, "Will you listen to me or just what the staff say about me?"

The current culture of the service was not always positive. Staff were focussed on completing tasks rather than individuals and people did not feel valued and included in their care. Staff told us that they found the registered manager approachable but were frustrated that their repeated concerns about staffing levels were not being listened to. Staffing shortages and morale were having a significant impact on the service that people received which were not being addressed by the registered manager.

The running of the home was reactive to individual issues rather than adopting a proactive management of the service as a whole. For example, the handling of the Legionella issue was poorly managed before this was referred to the provider at the time of the inspection. Likewise, we had to provide the registered manager with direction as to how to appropriately handle the concerns raised by one person during the inspection. Once directed, the registered manager responded immediately, but had failed to identify these issues for themselves.

During the inspection we identified that two statutory notifications had not been sent to us in respect of two incidents which were reportable under the Health and Social Care Act. The registered manager had not identified that these two issues were required to be reported. Once informed she submitted retrospective notifications without delay.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a number of systems in place for auditing and monitoring the service provided. Recent meetings had been held for both people and relatives to express their views of the service. The most recent meetings had focussed on people's views about the food within the home. One person confirmed this when they said, "We had a residents meeting with the chef a few weeks ago." From the minutes of these meetings it was clear that people's views were listened to, but these opportunities needed to be extended to those people who were unable or unwilling to attend group meetings.

Where internal audits had identified shortfalls, it was evident that appropriate action had been taken to secure improvements. For example, the medication audits had identified that MAR charts were not always being signed and additional daily checks had been introduced as a result. Similarly, prior to the inspection, concerns had been raised about the moving and handling techniques used by some staff. As a result staff had completed additional training and the registered manager was undertaking spot checks to ensure best practice was being followed.

We provided detailed feedback at the end of our inspection and the provider responded immediately by producing an initial action plan which demonstrated a commitment to improving quality. The provider has since been in contact to update us with regard to the actions that have been taken and the additional senior management support that has been provided to the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care was not provided in a way that met people's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Action was not always taken to fully protect people from the risk of abuse or improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always

met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate action had not been taken to assess, monitor and improve the quality of services and mitigate risks relating to health, safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent and experienced staff deployed to meet the needs of people living in the service. Staff did not always receive appropriate support and supervision to carry out their roles effectively.