Veecare Ltd

Sevington Mill

Inspection report

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Date of inspection visit:
01 November 2018
02 November 2018

Date of publication:
30 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 November 2018 and was unannounced. We re-inspected this service earlier than planned due to concerns that had been raised about people's safety and the support they were receiving.

Sevington Mill is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sevington Mill can accommodate 50 people. At the time of our inspection there were 36 people living at the service.

Accommodation is spread over 2 floors in a large detached property. There was a large communal lounge, dining area and conservatory where people could choose to spend their time.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed in June 2018, they had applied to CQC to become registered as the manager at the time of this inspection.

Sevington Mill was last inspected June 2018. At that inspection it was rated as 'Requires Improvement' overall. At that inspection we found some improvements had been made, however their remained ongoing breaches of the Health and Social Care Act Regulated Activities Regulations 2014 in relation to Regulation 11; need for consent, Regulation 12; safe care and treatment and Regulation 17; good governance. Following that inspection the service was removed from Special Measures. We asked the provider to send us a report to tell us what actions they would take to ensure the ongoing breaches of regulation were met.

At this inspection we found that the improvements we saw in June 2018 had not been embedded or sustained. We found that there were continued breaches of regulation, along with a number of new breaches.

People were not kept safe from abuse or avoidable harm. Not all staff had received safeguarding training. Staff were able to tell us how to recognise and report safeguarding concerns. However, in practice they had not consistently reported concerns to management. Incidents and accidents were not fully analysed or reviewed by the manager and risk assessments had not been updated. Staff did not reflect and learn from accidents and incidents and there was a lack of reporting to the local authority or the Care Quality Commission (CQC).

Risks to people were not properly assessed. Risk assessments were not in place for skin integrity, falls or supporting people when their behaviour challenged, despite risks being known.

There were not enough staff to meet people's needs and the provider had not used a recognised dependency tool to determine safe staffing levels. Staff were not recruited using safe and robust recruitment processes to assess the candidate's suitability for the job.

Medicines management was not consistently safe. Temperature checks were not completed. Creams and ointments were not consistently stored safely and medicines were not always disposed of in a safe manner, in line with best practice. People did not always receive their medicines when they needed them, and those who 'self-medicated' were not assessed to ensure their competence.

Other areas of medicines management had improved. Medicine records were completed accurately, contained photos and guidance for staff. Medicine audits were completed by senior staff; and had identified some of the shortfalls we found. Competency checks were completed for staff responsible for administering medicines. Checks on the environment and equipment were completed.

People had not received full assessments of their needs and care planning did not consistently refer to best practice or evidence-based guidance to ensure effective outcomes were achieved. Staff had not received effective training, supervision, or appraisal to carry out their roles. Training in key areas such as behaviour that could challenge, end-of-life care or dementia care was insufficient and staff had not been assessed to ensure they had the appropriate skills and competencies to support people.

The management of nutrition and hydration was not effective. Food and fluid monitoring was not accurate nor consistently completed for each person who needed it. The service worked with healthcare professionals to ensure people received appropriate medical input, however guidance implemented as a result of this was not followed by staff. People's healthcare needs were not always met. Staff did not always recognise or respond promptly when people were unwell.

People had not been supported to have maximum choice and control of their lives. The registered provider, manager and staff did not fully understand the principles the Mental Capacity Act 2005 and the policies and systems in the service did not support people to find the least restrictive options. Restrictions had been assessed incorrectly and DoLS applications had been submitted lawfully but the registered manager had made applications for each person without considering their individual needs appropriately.

Staff were busy and rushed, which often meant people's emotional needs were not met. Through our observations we saw that staff mostly treated people with kindness. They recognised most people's needs well and caring interactions were seen. However, staff were not able to spend quality, meaningful time with people because they were too busy. People's involvement in care decisions and planning was not clearly evidenced. There was little adaptation to the premises to make them suitable for those living with dementia.

The service was not meeting the accessible information standard (AIS) and some people's care plan documentation was not written in a way they could understand. Complaints were not responded to effectively and there was no information about how to make a complaint available in an accessible format to meet the needs of people living with dementia.

Activities were limited. People sat in chairs, either in their rooms or the communal areas, for most parts of the day with little stimulation. People were not appropriately supported at the end of their lives. End of life care plans were basic and not based around the person's wishes.

The manager and registered provider failed to ensure that staff shared a clear vision for providing high quality person-centred care. The culture of the service was not empowering for people, relatives, or staff.

The service was not well led. Governance systems were not effective and service audits were not analysed to give oversight of the service or followed up to ensure that improvements were made. Statutory notifications had not consistently been submitted to the CQC. Staff had not been supported or their skills and knowledge developed and little work had been done to encourage learning and best practice from working in partnership with other professionals and health care providers.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to our findings and will publish our actions when this has been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people had not been minimised. This included risks associated with medicines, falls, and accidents and incidents.

There were not sufficient staff appropriately deployed to meet people's needs.

There was a lack of learning from incidents.

Staff told us they understood safeguarding processes and how to operate them but we found safeguarding incidents had not been reported. There was insufficient management oversight and action to ensure staff knew their responsibilities in relation to keeping people safe.

Recruitment processes were not adequately robust to ensure suitable staff were employed.

Environmental and equipment checks had been completed

Is the service effective?

Inadequate

The service was not effective.

People's healthcare needs had not been recognised or escalated.

The management of nutrition and hydration was not effective. Food and fluid monitoring were not accurate and not consistently completed for each person.

Staff had not received the training, support and supervision to complete their roles.

People received input from healthcare professionals, however guidance implemented as a result of this was not followed by staff.

Adaptations had been made to the environment, although there were minimal adaptations to aid those living with dementia.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was not protected and considered.

People were not always treated with kindness, respect and compassion.

People were not supported to be involved in their care and treatment.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person centred care.

Care plans had not been updated to reflect people's changing needs.

Complaints had not been responded to and action taken to prevent the issue from reoccurring.

There was limited activities and stimulation to occupy people or prevent the risk of social isolation.

Care planning around the end of people's lives was insufficient to meet their needs.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post.

Audits had been completed but there had not been action to address the issues identified in our inspection.

The provider had not displayed their rating on their website.

The provider had not submitted statutory notifications.

People's opinions had been sought, but the provider had failed to action any improvements or give any feedback about quality assurance.

Sevington Mill

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 1 and 2 November 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience on the first day. The expert-by-experience had personal understanding of older people and those living with dementia. On the second day there were two adult social care inspectors.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We did not ask the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 14 people who lived at Sevington Mill and observed their care, including the lunchtime meal, medicine administration and activities. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people's relatives throughout both days. We inspected the environment, including communal areas, bathrooms and some people's bedrooms. We spoke with five care and senior care staff, the cook, the manager, the provider and a healthcare professional.

During the inspection we reviewed 10 people's care plans and associated records. We also looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures. At the end of the inspection we asked for some information to be sent to us, we were not sent all the information we

requested.

We displayed posters in the communal areas of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any further feedback.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2018 the service was not consistently safe and required improvements. We reported that some improvements had taken place but that the registered provider remained in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found that the improvements had not been sustained or embedded, and that the service was not safe.

Potential risks to people's health had not always been assessed and there was not always detailed guidance for staff to mitigate the risk. Some people displayed behaviours that challenged including inappropriate behaviour. There was no detailed risk assessment or behaviour care plan to give staff guidance about how to manage the behaviour and keep the person, and others around them, safe.

Accident and incidents had not been consistently documented and action had not been taken to minimise the risk of the incident reoccurring. One person told us of an incident where another person went into their room at night. The person could not reach the call bell to inform staff, and was calling out to staff for help. We reviewed the accidents and incidents documentation, and found no record of the incident. We asked the manager if the incident had been documented, and the manager informed us that no incidents had been reported to them during the month of October. We reviewed the person's daily notes and the incident had not been documented. On the second day of our inspection, the manager was able to provide us with a note where the incident had been documented, however this was not officially reported. We reviewed the person's file and no changes had been made on the person's sleep risk assessment. The person told us "I don't feel safe, I feel terrified, there are never enough staff around and I screamed and screamed … I was trapped and nobody came to me, when I finally managed to get hold of my buzzer it didn't work so I just cried and cried and cried and I still haven't got over the incident nor have my friends around me and we don't know what they have done to stop it happening again but it hasn't happened again."

Falls had been consistently documented, however did not detail the action taken to mitigate the risk of the fall reoccurring. Information from the incident was not then used to update people's care plans and risk assessments, and there was little oversight into, for example, any trends to the incidents such as the time of the incident and the number of staff on shift.

At our last inspection we found that medicines were not safely managed. At this inspection we had some ongoing concerns. We found that creams were not always stored safely or in line with best practice guidance. Medicines were not dated upon opening, for example, creams and ointments. This placed people were at risk of receiving medicines beyond their shelf life. Most medicines should be stored at or below 25c to ensure they remain effective. Although there was a thermometer near to the medicine trolleys, there was no evidence of temperatures being monitored on a daily basis. The temperature in the medicines room and medicines fridge were monitored, however, the majority of medicines were not stored in this room. Within one of the medicine trolleys, there was a pot containing a tablet, that a person had not taken earlier in the day. We asked staff to dispose of this correctly, to ensure that it was not given to the wrong person.

Most medicines prescribed daily were ordered and received by the service on a 28 day cycle. When

medicines are not prescribed regularly, a stock should be kept by the service. This stock should be counted and recorded to inform staff when further stock needs to be ordered and to be able to check that people are receiving the medicine as prescribed. The stock medicines had not been counted and recorded, there was a risk that further stock would not be ordered when needed.

Some people self-administered some medicines, for example, inhalers to help control symptoms of asthma. These were seen to be out in people's rooms, however, there had been no assessment of individuals ability to self-administer. Medicine audits had not identified any risk as they had been completed as 'N/A' in areas relating to self-administration of medicines.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person had failed to manage medicines safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of medicines management were safe. Medicine records were completed accurately and contained photos to help staff ensure the right person received their medicines. Some people had 'as and when required' (PRN) medicines; there were directions in place which helped ensure people were regularly offered pain relief or laxatives, with proper time gaps between doses. Charts were in place for people who required transdermal patches (medicine applied by an adhesive patch on the skin). They were clear and showed that patches were rotated in line with guidance. Medicine audits were completed by senior staff; we saw records of the checks that had taken place. Competency checks were completed for staff responsible for administering medicines.

People were not safeguarded from the risk of abuse. Staff described the signs they would look for if they had concerns about someone being at risk of abuse. However, we found when potential safeguarding incidents occurred, staff and management failed to report them or make appropriate referrals to the local authority safeguarding team. For example, a relative made a complaint about an incident they observed between people at the service. The manager's response detailed that they had referred the incident to the local authority safeguarding team, notified the Care Quality Commission (CQC), and had asked the person's GP to review them. When we spoke with the manager they were unable to evidence that the GP had assessed the person following the incident, or that a notification had been submitted to the CQC, and that the local authority safeguarding team had been notified of the incident. There had been no recorded safeguarding notifications since our last inspection. The manager old us they were aware that any safeguarding issues needed to be reported and investigated under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document provides guidance for staff and managers on how to protect and act on any allegations of abuse). However, they had not ensured that all concerns were correctly reported.

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

People and their relatives told us they felt there was not enough staff most of the time to meet needs. We were also told of concerns about the high turnover of staff. Relatives commented, "I just don't think that there are enough staff to provide continuity for the people living here as they are always changing" and "the girls are kind enough they are just rushed off their feet all the time." People told us, "Staff have left, and I don't even think they are replaced sometimes. They have so many leave recently only one needs to go off sick and they are stuck. The weekend is probably the hardest hit"; "I have an overriding horror of being left and not answered when I call, I can't ever reach my bell to call for help if I need to. There are a few staff

sometimes, but they never seem to have much time for me" and "I am lonely and frightened. I am always on my own and no one has time to stop and talk to me. I always feel frightened and when I am in my chair, I cannot move from it."

Every staff member we spoke with informed us there was not sufficient staff to meet people's needs and keep them safe. Staff told us that people's needs had increased, but staffing had not been amended to reflect the increased needs. During the inspection the manager or registered provider could not evidence they used a dependency tool to calculate the number of staff required based on people's need and the layout of the premises. We asked for this to be sent to us following the inspection. It was sent to us after we contacted the service but did not clearly demonstrate how staffing levels were calculated. The manager told us that staffing levels were determined by the provider. We reviewed staffing rotas for the two months prior to our inspection, they showed that there were occasions where staffing levels fell below those we were told about. These shifts were mostly, but not always covered by agency staff.

A number of staff had resigned in the lead up to our inspection, and the manager informed us the day prior to our inspection three staff members resigned with no notice. Agency staff were booked to support where permanent staff could not cover shifts. However, staff told us this often did not reduce their workload, one staff told us "Sometimes the agency is more strain on us. Some haven't worked in care before, some it's their first time." There were no staff deployed to support people to participate in activities of any kind. We were told that an activities coordinator had been recruited and was undergoing pre-employment checks, however, there had been a number of months with no planned social or wellbeing activities taking place.

During the two days of the inspection additional staff, who were not on the planned rota, were asked to work. Despite this, we observed staff to be rushing, and to have little time to spend with people having meaningful interactions. We observed some people's needs could not be properly met because staff lacked the time and knowledge to support them in the right way. The manager had recognised this, but failed to ensure referrals and assessments had been completed by other healthcare professionals leaving people at risk of receiving inappropriate care and treatment.

The failure to deploy enough trained and competent staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had not always been recruited safely. We reviewed three staff files, and found in two gaps in employment history had not been explored. Staff completed Disclosure and Baring Service (DBS) checks to ensure that they were suitable to work at the home. Two references had been obtained to check the character of the staff. However, start dates had not been recorded on two staff files and therefore the provider was unable to assure us that sufficient checks had been completed before staff commenced their employment.

The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Safety checks on the premises and servicing of equipment had been completed by appropriate contractors within the required timeframes. The fire alarm had been tested weekly and other fire safety equipment such as extinguishers and emergency lighting correctly maintained. Actions from the services fire risk assessment in March 2017 had been marked as complete, except for one action, which the provider told us had been arranged on the day of the inspection. The provider chose to postpone the planned work due to the inspection. Inspectors informed the provider that it was not necessary to postpone this work. The provider

also told us that an updated fire risk assessment had been booked to take place within the fortnight following this inspection.

People were protected from the risk of infection. We observed the service to be clean. Domestic staff worked in the service seven days a week and they told us that all areas of the home had cleaning schedules. Records were saw confirmed this. There were also deeper cleans carried out weekly. There was an appropriate supply of personal protective equipment throughout the service and we saw that staff used this as needed.

Inadequate

Is the service effective?

Our findings

When people moved to the service their support needs were assessed, although they did not consider the full range of people's diverse needs. Assessments did not fully describe the support people needed and adequate guidance was not in place to ensure people received care which was effective and safe.

People's healthcare needs were not suitably monitored or met: some people were living with diabetes. There were no care plans in place to describe how their diabetes impacted on their lives. There was no guidance for staff to enable them to recognise the potential triggers, or any guidance about what action to take should the person have any adverse symptoms. We brought this to the attention of the manager and on the second day of the inspection we were shown new care plans that contained clear, person centred guidance for staff.

Some people had skin wounds or pressure areas. The district nurse visited regularly to assess and dress people's wounds. However, there were no care plans in place for staff to follow to ensure they were providing effective and safe support between visits. Special equipment such as airflow mattresses and cushions were in place, these mattresses should be set to the weight of the person using them to achieve the intended pressure relief. We were told these were check on a daily basis and saw that there were charts in place for staff to indicate they had been checked. However, these charts were not consistently completed and did not inform staff what setting they should be set at. These were also not checked by senior or management staff. On the first day of our inspection an alarm was sounding, indicating the mattress or pump was faulty and at low pressure. The mattress appeared to be deflated and the person looked very uncomfortable, along with the top sheet barely covering the plastic mattress. Airflow mattresses used at the incorrect setting could cause more harm to the person's skin. We brought this to the attention of the manager who arranged for the pump to be changed.

The failure to assess and meet people's health needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection we reported that food and fluid monitoring records were not effective, at this inspection this remained the same. Monitoring charts were in place, however they continued to not be consistently completed accurately, to give a clear picture of a person's intake. Where they had been completed and it was clear that a person's intake was insufficient, there was no evidence of what action had been taken.

The service did not sufficiently monitor or manage the risks associated with poor hydration and nutrition. One person had recently been discharged from hospital after being admitted with constipation. Prior to being admitted to hospital, staff had identified this person required some input and had contacted the GP. There was no other reference to these concerns until five days later, when the person was noted to have been admitted to hospital. Following their return to Sevington Mill, there had been no review or update of their care plan. There was no evidence of their food intake or stools being monitored, despite their care plan stating that they required monitoring. Their fluid intake was monitored and was seen to be at low levels;

their care plan stated that their daily target intake was 1000mls. Their monitoring chart indicated that over a period of eight days they did not achieve this target, there was no record of any action being taken as a result.

This person's hospital discharge letter also indicated that the service should contact their GP to arrange for an important medicine to be re-started. This had not happened; we highlighted to the manager that the medicine had not been restarted on the first day of our inspection. On the second day we asked for an update and the manager said it was not needed and stopped by hospital. Again, we explained that was not what the discharge notification said. Later that day, the GP visited the person, and staff did not ask the GP about re starting the medicine. We then spoke with the senior who confirmed they would speak with the GP. Later, they confirmed that they had left a voicemail for the GP to call back.

The failure to mitigate risks to people in relation to hydration and nutrition is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received sufficient training to support people effectively or carry out their roles. Staff told us that they had not received practical training or assessment in safe moving and handling of people. We asked the registered provider and manager about this and they told us they would send completed checks to us following the inspection. We were sent a blank template of what a check would look like, but no evidence that these had been completed to assess staffs' competence. Staff also told us they felt they needed training to be able to properly support people with behaviours that challenged, this had not been provided. Agency staff did not receive an induction to the service, staff told us that at times it was not beneficial to have agency staff as showing them what to do could take up their time. The induction of agency staff is an area that requires improvement. We recommend the provider introduces a process of inducting agency staff to the service.

We reviewed the services' training matrix. There were many topics where a number of staff had not completed training or had not completed refresher training within the necessary timeframe. For example, only 11 of the staff team at Sevington Mill had completed safeguarding adult training within the past 12 months. Many staff had not completed training in person centred care or equality and diversity. A large number of the staff team had not completed training in supporting people with health conditions such as diabetes or skin integrity, and only seven staff had completed training in supporting people at the end of their life.

The manager told us they were beginning to introduce supervision, however at the time of our inspection staff were not receiving appropriate support through effective supervision (a one to one meeting where work issues are discussed, including identifying areas of development and training) and appraisal systems. Staff had not been assessed to ensure they had the necessary skills and competencies to carry out their roles.

Failure to provide appropriate support, training and professional development is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. New staff worked through the Care Certificate standards. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

At our last inspection we found a lack of understanding around the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Some applications had been authorised, others were waiting for authorisation. Of those that had been authorised, there were no conditions to be met.

At this inspection we found that there was still a lack of proper understanding of the requirements of the MCA, for example assessments had been made but for generic, rather than specific decisions, as the MCA requires. Best interest decisions had not always been made in consultation with professionals or documented the least-restrictive practice considered. Staff daily notes recorded when people's verbal consent had been given for particular care tasks.

The failure to put in to practice the requirements of the MCA is a continued breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Areas in the service were adapted for wheelchair access, for example there were ramps to access the garden. People living on the upper floors could access a lift to move between floors. There were adapted bathrooms and people had a choice between bathing or showering. This provided people with comfortable living accommodation. However, there were minimal adaptations to aid those living with dementia as the service had not adapted the premises to improve people's quality of life and promote their wellbeing. We recommend the provider seeks advice from a reputable source regarding current best practice.
Relatives told us they thought the food served was okay and that their loved ones enjoyed it. One relative commented, "Mum seems to enjoy the food here, she gets a choice of meals." One person told us, "The food's not too bad, if I don't like offering I can choose something else." During lunch and dinner, we observed the food to look and smell appetising and people were offered a choice of main meals or alternatives. We spoke with the cook who understood people's needs and told us they liked to offer a choice of 'home-cooked' foods. For example, during the inspection we saw that homemade sausage rolls were available, along with homemade treacle sponge.

Inadequate

Is the service caring?

Our findings

Although people told us staff were kind, and we observed some caring interactions, the service was not consistently caring. Staff were busy and rushed, which often meant people's emotional needs were not met. For example, one person was observed to be increasingly distressed on the second day of our inspection. The person called out numerous times to go to the toilet over a 30 minute period. After 30 minutes a staff member responded, and took the person to the toilet. Other people sitting in the living area, were becoming increasingly concerned and frustrated by the person's distress. One person said, "They need someone to talk to them, but they just sit there on their own all the time." Another person said they had a headache from the constant calling out of the person.

Some people living with dementia could display behaviours which others could find challenging. We observed staff did not have the time to spend with these people when they became distressed or anxious. Throughout the inspection we observed one person to be anxious often, and to shout. Often staff would walk past this person ignoring their calling out, which caused them to become more unsettled. When a staff member did have time to sit and talk to the person, holding their hand and engaging in conversation the person seemed relaxed. However, this occurred infrequently, and people told us they avoided sitting in the lounge so as not to become distressed by the behaviour. A relative told us of their loved one, "They need stimulation, someone sensible to talk to. They get bored. The television is often left on a channel that no one is watching. Staff do not always have enough time due to staff shortages."

During the first day of our inspection we heard a person call out to staff for support from their bedroom. The staff member did not engage well with the person, shouting "Shut up." We raised this with the manager who advised us they would follow up with the staff members on duty.

People were not treated with dignity and respect. On the first day of our inspection, we observed one person to have become incontinent in their room. Despite several staff members passing the person, when we checked on the person an hour later, they had not received any support from staff. We pointed this out to the senior, and they sent a staff member to support the person.

One person told us that they used to enjoy having a bath, however they were rarely offered the opportunity of a bath at the service. They told us that staff rush them, and the experience was not as enjoyable as they previously had. The person told us staff did not have the time to support them, and did not ensure they were sufficiently dry which made it an unpleasant experience.

The failure to adequately treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People and relative's we spoke with advised us they had not been involved in the planning or decisions of their care. Care plans provided little guidance to staff on what people were able to do for themselves, and we observed very little interaction between staff and people where they were encouraged to be more independent. One person told us they preferred to have their breakfast in their room due to the behaviours that could be displayed by others, but that staff had told them they had to have their meals in the dining area.

There were some dementia friendly signs around the service, to help people who may become disorientated to time and place. However, there was little else to support people living with dementia, such as 'rummage boxes' (The rummage box can be used as an activity, as a distraction technique and therapeutically as a reminiscence tool). We reviewed one person's care plan who was living with dementia, and found their care plan did not address their current mental health or how the dementia impacted their daily life. There was no information provided in the care plan on the different types of dementia. This included any signs and symptoms staff should be vigilant of in case of decline, or who staff should seek further advice or guidance from. This placed the person at risk of receiving inappropriate care and support.

The failure to ensure that care plans were in place for all aspects of people's needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive consistently responsive care designed to meet their individual needs. Care files contained information about people's lives before they moved to Sevington Mill and care plans were written in a person-centred way. However, there times throughout the inspection when the practice in the service differed to what had been written about people's needs and wishes.

Advice had been received for one person from the local mental health team. This included providing guidance about how to support the person with meaningful and purposeful activities, to fulfil their day and contained a detailed action plan for staff to follow. There was no evidence of this guidance having been transferred to the persons care plan and no evidence in their daily records that the action plan had been implemented.

Throughout both days of our inspection there were no organised activities for people. We were told this was because the activity coordinator role was in the process of being recruited to. We were told this had been vacant for some months. Staff offered to put movies on the TV for some people and music in the conservatory for others. There were posters on the noticeboard displaying what activities would be available but these were not offered. One poster displayed 'Dates for the calendar'; this contained a list of visiting entertainers covering the period from September to December. During this period people could expect six sessions of 'music for health', four visits from a guitarist and a Christmas party with a singer. These events provided limited opportunity for social interaction and wellbeing. People told us that the enjoyed the entertainment, when it happened, and felt that the frequency could be increased. Many people chose to spend time in their own rooms. Some people were sat in their rooms with TV's not being tuned into a channel, and nothing else to stimulate them. Others told us they preferred to spend time alone as the lounge could be unbearable with people shouting out. People were at increased risk of social isolation.

There was minimal information in people's care plans about how their end of life care would be managed. In some people's files end of life care plans were not completed and in others did not consistently take into account people's comfort, any pain assessment needed, choices and final wishes. Some people had a care plan completed by a visiting doctor, providing guidance about when they should and should not be considered for hospital admission. The manager told us that they were supporting two people who were thought to be reaching the end of their lives. Their care plans about end of life recorded that their next of kin should be informed if they passed away, the name of the funeral director and that a do not resuscitate order (DNAR) was in place. The plan made no mention of how the individual could be made comfortable; including how any pain or anxiety might be managed. There was no reference to any particular preferences they might have. One person had been prescribed anticipatory pain relief medicines to ensure they were comfortable. These had not been commenced nor had the district nurses been contacted to assess if the time was right to commence them.

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

Complaints and concerns had been documented, but there was not a robust system in place to ensure complaints were responded to in a timely manner. We looked at records of complaints; these showed that complaints had been received from family members since our last inspection. Some action had been recorded in response a complaint, however this was not consistent. For example, a relative had made a complaint regarding their loved one's room and items within it. A letter had been sent to the complainant to confirm an investigation would take place, and a response be provided two weeks later. The provider was unable to evidence this had happened, or that the complaint had been resolved to the complainant's satisfaction. There was a complaints policy which on display, which detailed how people could expect a complaint to be investigated and responded to, however this was not available in a format accessible for people living with dementia.

The lack of a robust complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Most people's bedrooms had been personalised in some way with photos or people's own possessions. Preferences for male or female care staff had been documented along with the times people liked to get up and go to bed and their preferences in relation to food and drinks. During the inspection people were regularly asked what they would like to drink and how they preferred to take it, along with choices of snacks.

Inadequate

Is the service well-led?

Our findings

There was no registered manager; a new manager had been employed shortly before our last inspection in June 2018. They had submitted an application to become registered. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. It is a requirement of the provider's registration that there is a registered manager in post.

People told us the manager had changed so often they did not get to know them well. However, staff and people told us they had faith in the new manager. People told us the manager was approachable and generally visible around the service. The manager spent time during the inspection on a one to one basis with one of the people who could become very anxious. We found that since our last inspection, neither the manager or registered provider had embedded or sustained the necessary changes to ensure that people received safe, person centred care.

At our last inspection there was a continued breach Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 because quality auditing systems needed to become embedded. We have found that in our last four inspections, governance systems have not been effective. At this inspection our concerns remained. Despite a number of audits being completed, they had failed to identify and rectify the shortfalls in the quality and safety of care and support people were receiving. For example, medicine audits had failed to identify shortfalls around the monitoring of temperatures, recording of opening dates and the lack of assessment for people self-administering. Care plan audits had identified some areas that were lacking in detail but had failed to identify the lack of care plans and risk assessments we have highlighted in this report.

The provider employed a consultant to complete quality checks. The most recent checks, from October 2018 had highlighted many shortfalls, for example, the lack of training staff had completed, the lack of induction records for new staff, shortfalls in staff receiving supervision and some audits not being completed. They had also highlighted a lack of community involvement and innovative practice. There was no evidence that action had been taken as a result.

Monthly action plans had been submitted to CQC by the provider, to demonstrate actions they were taking to improve. However, we found that these also had not been effective in improving the quality and safety of the service.

Quality assurance surveys had been sent to relatives to complete in August 2018. Feedback on the surveys included 'They could do with some stimulation. It is very difficult for the activity person as there are so many different needs of residents' and 'Home could do with a re decorate.' Another comment detailed; 'Now you take dementia patients staffing is not adequate. The staff are lovely but they do not have time to cover everything that needs to be done.' The results of the survey had not been shared with stakeholders, and

were not displayed in the service. The provider informed us it was their intention to call a meeting with relatives and people but as of our inspection no date had been set. The provider and manager could not evidence any improvements made as a result of the feedback from relatives.
On 1 August 2018 a relative responded to the survey, along with writing directly to the provider. In this letter they requested a response to a letter they had sent on 2 July 2018. The relative had raised some queries about the service and care provided. In their letter they had specifically asked for a response from the provider, whether written or through a meeting. There was no evidence that any of the communication had received a response. When we spoke with the provider, they confirmed they had not responded to the relative.

A survey for people living at Sevington Mill had been started by the activities staff, but had not been completed when the activities staff left the service. No further attempts had been made to gain feedback from people living at the service. The manager informed us this would be something they would look to implement when they recruited another activities coordinator. None of the residents we spoke with could recall being involved in giving any feedback about the service.

Staff quality assurance surveys had been completed in September 2018, with varying results. An overview had been provided of the survey, with actions listed. However, these actions had not been completed, for example appraisals, training and personal development for staff. An action plan was due to be completed to address some of the themes from the survey, and a newsletter to be sent to staff, however staff informed us none of this had occurred.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered provider had failed to inform the CQC of safeguarding incidents when they occurred. This meant that the CQC could not maintain an informed overview of events and incidents happening in the service.

The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the manager had displayed their rating in the entrance of the service, but had failed to display their rating on the provider's website.

The failure to display the service rating is a breach of Regulation 20A of the Health and Social Care Act 2008 (regulated Activities) 2014.

The registered provider stated their values as, 'we believe in treating everyone as individuals, listening to their feedback, and ensuring every day is thoroughly enjoyable as opposed to a clinical environment. Individuality is at the heart of everything we do.' And their principles as 'delivering top quality care to the people living in their homes, providing a nurturing and engaging environment for all involved.' They also stated that they valued staff as one of their greatest assets.

Throughout our inspection, we found that staff told us they did not feel valued. People, relatives and staff told us there was not a positive culture at the service. We observed staff to be stretched and engaging in little conversation between with people. Staff did not consistently treat people with kindness, respect and compassion. The provider was present for both days of our inspection, and we observed no interaction between them and people. People and staff told us there was a lack of engagement from the provider with people. One person told us "[the provider] ignored me, they are all moaning about that. I thought blow them." Staff told us the interactions they had with the provider were not positive and they were often told that care staff were 'ten a penny'.

Staff and the manager had been working closely with the local health teams including the GP and district nurse. The service had also received support from the local clinical nurse advisor and clinical commissioning group.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to assess and meet people's health needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The failure to ensure that care plans were in place for all aspects of people's needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The failure to provide person-centred care, designed to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to adequately treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to put in to practice the requirements of the MCA is a continued breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person had failed to manage medicines safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to mitigate risks to people in relation to hydration and nutrition is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014 Receiving

personal care	and acting on complaints The lack of a robust complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The failure to display the service rating is a breach of Regulation 20A of the Health and Social Care Act 2008 (regulated Activities) 2014.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to deploy enough trained and

competent staff is a breach of Regulation 18 of the Health and
Social Care Act 2008 (Regulated Activities) Regulations 2014.

Failure to provide appropriate support, training and professional development is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

TBC