Millreed Lodge Care Limited

Millreed Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
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?	**Inadequate**

Overall summary

We inspected Millreed Lodge Care Home on 18 August 2015 and the visit was unannounced.

Our last inspection took place on 14 October 2013 and, at that time, we found the regulations we looked at were being met.

Millreed Lodge Care Home provides nursing care and accommodation for up to 33 older people and people living with dementia. At the time of our visit there were 30 people in residence. The accommodation is arranged over two floors and there is a passenger lift. Some of the bedrooms have en-suite toilet facilities. The lounge and dining areas are on the ground floor.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

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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 found staff were being recruited safely, however, people told us there were not enough staff and this was confirmed in our observations. Staff training, formal supervisions and appraisals were not up to date. Staff told us they did feel supported as the registered manager had an 'open door' policy. People told us some staff were better trained than others.

People told us staff respected their privacy and dignity, however, we saw staff practices which showed a lack of respect for people.

People told us they were happy with the care and support they received most of the time, but said sometimes they had to wait longer than they would wish to for staff to assist them to the toilet. We found some people did not have a care plan and for others the care plan was out of date. Risk assessments had not always been completed or plans put in place to show what action had been taken to mitigate any risk to people. People's care and support was being delivered based on staff's knowledge of the individual. Without care plans and risk assessments there was a risk people's care needs would not be identified and responded to.

People told us their health care needs were being met and doctors or community matrons were called if they were unwell. We found the medication system was not well managed and there was no assurance people were receiving all of their medication as prescribed by their doctor.

We found there were areas of the home which were shabby, areas that were potentially unsafe and identified infection prevention issues.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). People were being prevented from leaving the home without the necessary authorisations being in place.

The cook had a good knowledge of people's dietary preferences and spoke with them directly about the meals on offer. People told us the meals were good and we saw plenty of drinks and fresh fruit were available.

Visitors told us they were always made to feel welcome and could have a meal with their relative if they wished.

People told us if they had any concerns they would tell a member of staff and felt action would be taken to resolve any issues.

There were very few activities on offer to keep people stimulated and contact with care staff was only made in response to requests from the individual or when staff were attending to people's personal care.

We found there was a lack of provider oversight and very few checks were being made on the overall operation and quality of the service. The registered manager had not kept up with the internal audits and records were not up to date. This meant there was no on-going improvement plan to develop the service. We also found people using the service and their relatives were being asked for their views about the service but no action had been taken in response. This meant people views were not valued or acted upon.

Overall, we found significant shortfalls in the care and service provided to people. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

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. The service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection

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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 in any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff on duty to meet people's needs in a timely way or to keep the home clean.

There were areas of the premises which were unsafe.

People's medicines were not always handled and managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training, supervisions and appraisals were not up to date, although staff told us they felt supported.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We saw people were offered a choice of meals and people told us the meals were good. People had regular access to healthcare professionals, such as GPs, community matrons and opticians.

Is the service caring?

Requires improvement

The service was not always caring.

Most of the people we spoke with described the staff as kind and caring, however, we observed practices which showed a lack of respect for people.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some people did not have care plans and for others the plans were out of day. Care delivery was dependent on the staff's knowledge of people's needs.

Few activities were on offer to keep people occupied and stimulated.

The complaints procedure was out of date and complaints were not being recorded.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection.

People's feedback was not consistently sought, valued or acted upon.

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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 18 August 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and an expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of our inspection we spoke with 10 people who lived at Millreed Lodge Care Home, seven relatives/visitors, one nurse, five care workers, two cooks, the handy person, the activities co-ordinator, the registered manager and the provider.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included seven people's care records, three staff recruitment records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us that at times they did not think that there was enough staff on duty to meet their needs. One person using the service said, "Night time can be a problem I have to wait for a long time sometimes. I need two people to help me to go the toilet. Sometimes certain staff get annoyed if I wet the bed. They say I should know when I need the toilet and not wet the bed, but due to my condition I don't always know when I need the toilet so I can be laying on wet sheets." Another person told us, "Waiting to go to the toilet through the day. If they had another member of staff it would be better we wouldn't have to wait so much. They don't like it if you press the buzzer more than once." The nurse told us, "The girls are run off their feet, I don't feel like I can do an excellent job."

Relatives we spoke with also thought that at times there were insufficient staff on duty to deal with people's needs. One visitor said, "No never enough staff on duty. There is enough staff to run the home somewhat effectively. Not enough staff to give the extra time needed to give quality personal care. People like my relative can't call for help or use their buzzer. I just trust that when I am not here the staff look in on them. Depending on time of day if I press the buzzer we can wait from between seconds to many minutes. They prioritise people, those people who are bedfast wait the longest." Another relative told us, "I come most days there are not always staff in the lounges. I can be here for a good twenty minutes and not see anyone." A third person said, "They need to recruit more staff, the right people well trained."

The staff rota showed that one qualified nurse and five care workers were on duty on the morning shift and one qualified nurse and four care assistants were on duty during the afternoon and evening. Night duty was covered by one qualified nurse and two care workers. We saw that in addition to the care workers the service employed a housekeeper seven hours a day Monday to Saturday, a laundry assistant seven days a week and a cook and kitchen assistant seven days a week. The service also employed a full time administrator and maintenance man.

The care workers we spoke with had differing views on the staffing levels in place. While some staff felt there sufficient staff on duty others felt that especially at peak periods of the day including mealtimes and at the weekend they struggled to meet people's needs.

We saw there was one nurse on duty during the morning with five care workers. There were 30 people using the service ,17 of them required two members of staff to meet their moving and handling needs. At handover in the morning staff were given a list of people to assist. Two pairs of staff were supporting people who required the assistance from two care workers and one care worker worked on their own. We saw staff were busy throughout the morning assisting people to get up. One person was brought into the dining room at 11:20am for their breakfast. We asked staff if this was the time they chose to get up and were told not necessarily as people got up as they worked their way through the list.

We saw care workers did not have time to spend with people unless they were providing direct care and support. There was no staff presence in the communal areas for long periods of time. This meant there were not enough care workers on duty to provide care, support and supervision in a timely way.

We also had concerns about the number of hours allocated for housekeeping. The schedule for the one housekeeper on duty included cleaning all the bedrooms, bathrooms, toilets and communal areas every day within their seven hour shift.

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

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored in a safe way. We looked at the medication policy and found it was not 'fit for purpose' and did not provide staff with adequate guidance, for example, it gave no guidance about booking in medicines.

We observed some of the morning medication round which started at 8:20am and finished at 11:30am. We spoke with the nurse who told us they felt two nurses should be on duty to make the medication rounds more efficient. We saw people being given their medication but with no explanation about what it was for. We also saw eye drops being administered at lunchtime at the dining table.

We looked at the medication administration records (MAR). We saw two people were taking medication which needed

to be taken 30-60 minutes before food in the mornings. We saw this was not being done and all of the breakfast time medicines were given at the same time. We spoke to the nurse about this, who was not aware about the instructions, even though it was clearly specified on the MAR.

On another MAR we saw the person had been prescribed a medicine to be taken twice a day, however, they had only been given this medicine once daily.

We saw people had been prescribed various creams and lotions. There were no details or body maps to show staff where these needed to be applied and staff were not completing the MAR to show these had been applied.

We saw some handwritten entries on the MAR charts where staff had booked in medicines. These had been made by one person. We spoke with the nurse who confirmed any handwritten entries should be signed by two members of staff to check the instructions have been written correctly.

We saw some people had been prescribed 'as required' medication but there were no protocols in place to inform staff in what circumstances these medicines should be administered. For example, one person had been prescribed an antihistamine, but there was no guidance for staff about when this may need to be given.

This meant there was no assurance people were receiving all of their medication as prescribed by their doctor.

This breached Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We completed a tour of the premises and inspected a number of bedrooms as well as bathrooms and communal living areas. We found in some areas the premises required refurbishment and old fixtures and fittings replacing. For example; the carpet on one top floor corridor was faded and worn and we noticed damp patches on the ceiling and walls. In a number of bedrooms we found the extractors fans in the en-suite toilet facilities did not work and the nurse call leads had been tied up out of the reach of people who used the service. This was discussed with the registered manager who told us in many instances people were unable to use the toilet facilities alone and therefore the nurse call leads were not used. However, we could find no documentary evidence to support this.

We saw the shower trays in two shower rooms were marked and required replacing. The registered manager told us they had already identified this work needed to be carried out and had spoken with the provider about upgrading the bathroom and toilet areas.

We saw in some bedrooms the lighting was poor with only one central light with a low energy bulb. This was more noticeable in the bedroom with little natural light.

We found the ground floor toilet, near the dining room, had no lock to the door. There was a clinical waste bin in this room into which staff had put soiled incontinence pads without double wrapping them. There was therefore a very strong smell of urine and faeces in this room.

We looked in the laundry room and found one sink which was used by staff for hand washing. However, it was unclear where the housekeeping staff filled and emptied the mop buckets they used to clean the toilet and bathroom floors. The registered manager said they poured dirty water down the communal toilets. However, the infection control lead for the service was unsure and thought they might use the sink in the laundry room.

The infection control lead told us they had only recently taken on this role and had not yet held a training session with the staff team although they had provided staff with information on infection control. We saw there was an infection control policy in place however the registered manager told us it required updating to ensure it was fit for purpose. Following our visit we asked the local authority infection prevention team to visit so they can make a thorough assessment.

We saw the bathroom on the ground floor had no window restrictor in place. We saw there was ceiling tracking and hoist in this room to assist people with mobility problems.

We saw little useful signage around the home to aid people's orientation although people's names and the names of their key worker and named nurse were on their bedroom doors.

We saw that some generic risk assessments were in place for the building and for the equipment being used. However, it was apparent when we looked around the building that more specific environmental risk assessments needed to be completed if it was to provide a safe environment for people living with dementia. For example; we looked at a corridor on the first floor of the building

Is the service safe?

which led on to a flight of stairs. We found that because there was a change in floor levels there was a ramp on entering the corridor. The radiator on the wall on the left side of the ramp was not guarded and none of the four rooms located off the corridor including a shower room, sluice room, store room and bathroom were locked. The bathroom was very cluttered and we found a large clinical waste bin without a lid in this room. The store room was again cluttered and would have posed a safety hazard should someone have entered the room. The sluice room did have a bolt on the door, however, on three occasions during the inspection we found the door open.

At one end of the corridor we found an electrical box which could have easily been opened and at the bottom of the flight of stairs we found the key to a large electrical box marked high voltage had been placed on top of the box within easy reach.

We looked at the safety certificates for the premises including the gas safety certificate and the electrical wiring certificate and found them to be up to date. We also looked at the maintenance records for the equipment used by people who used the service and staff and found the equipment had been serviced in line with the manufacturer's guidelines.

The registered manager told us they had no capital budget for refurbishing the home and there was no long term refurbishment plan in place. The registered manager told us rooms were usually decorated by the handyperson as and when required or when they became vacant.

We spoke with staff about the fire procedures and we were told a sprinkler system was fitted which activated in the event of a fire. We were told this exempted the home from having to carry out an evacuation of residents in the event of a fire. Instead, they were required to move people who were in the vicinity of the fire to another part of the home. This exemption was not documented by either the registered manager or anyone from the fire service. We saw fire alarm tests were carried out weekly from different locations by the handy person, however, when they were on holiday these tests did not take place. Following our visit we contacted the fire service and asked them to visit to ensure staff were following the correct procedure.

This breached Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw there was a recruitment and selection policy in place which the registered manager was in the process of reviewing at the time of inspection. The registered manager told us during recruitment they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people.

The registered manager told us all new staff were initially employed for a probationary period prior to being offered a permanent position.

We looked at three employment files and found all the appropriate checks had been made prior to employment. The staff we spoke with told us the recruitment process was thorough and done fairly. They said they were not allowed to work until all relevant checks on their suitability to work with vulnerable adults had been made. They also said they felt well supported by the registered manager and senior management team and enjoyed working at Millreed Lodge.

All the care workers we spoke with demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously.

We spoke to the nurse about their understanding of the safeguarding processes. They told us they had been involved in making a referral when an allegation of sexual abuse had been made. They said the incident was reported by someone who was using the service for a short time. There were no staff in the lounge at the time of the incident. We saw the communal areas were not supervised by staff all of the time and some people who used the service would not be able to tell staff if something untoward happened. This supported the view that there were not enough staff on duty to ensure people were supported to keep safe at all times.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found staff had a poor understanding of this legislation. During our visit two people using the service were asking to go out. One person wanted to go to Hebden Bridge and the other to Oldham. We spoke to the registered manager who told us one person had a DoLS authorisation in place when they were in hospital but they had not applied for one since the person had moved to Millreed Lodge. They told us the second person had the capacity to make their own decisions and if they wanted to go out they could. However, we saw staff would not allow this person to leave the building. One told them the buses were on strike and another went with them to get their coat and when they got to the front door told them they could not go out as they had not got their bus pass or any money. There were no capacity assessments in people's care plans and no plans in place about supporting people when they wanted to go out. This meant people's freedom to leave the home was being restricted without the necessary authorisations being in place.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us some staff were better trained and more competent than others when they were moving them.

The registered manager told us all new staff completed induction training on employment (care certificate) and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised.

The registered manager told us that in the past the majority of mandatory training had been done in-house by staff watching training videos and completing questionnaires. However, the registered manager said that they were currently looking at staff attending more external training courses especially the ones provided by the Local Authority.

We saw there was a training policy in place which stated that that an individual development plan would be devised for all staff which would be reviewed and updated every six months. However, the registered manager confirmed that this policy required updating and staff did not have a personal development plan in place.

The registered manager told us they did not have a training budget and did not have an annual training plan. However, the registered manager confirmed that all staff received a minimum of three paid training days per year.

We looked at the training matrix and found gaps in the training staff had received and we saw a number of staff had not updated their mandatory training as required. The registered manager confirmed that the matrix was not up to date and did not accurately reflect the training staff had completed. The provider was therefore unable to demonstrate to us that staff had received appropriate training or had the skills required to meet people's needs. We asked the registered manager to send us an updated training matrix, but they did not do this.

The registered manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings. However, they acknowledged that supervision meetings had not been held in line with the policy and procedure that was in place.

The registered manager told us they were in the process of introducing a new supervision pack which would include minutes of one to one supervisions meetings, questionnaires completed by staff on specific subjects and the results of any direct observations carried out on the individuals care practice.

The registered manager told us the supervision policy and procedure document would be updated to reflect the changes made to the process. They told us one to one supervisions would now take place four times a year and all staff would have an annual appraisal. However, they confirmed this system was not yet fully operational.

Staff meetings were not routinely held. The registered manager was unable to recollect when the last meeting had been held but thought it was over a year ago. The registered manager said they operated an open door policy and staff knew they could contact them at any time if they had a problem. They also said they attended the morning handover Monday to Friday so they were available if staff wanted to speak with them.

Requires improvement

Is the service effective?

However, the lack of formal supervision meetings and staff meetings made it difficult to establish if staff received the support they required to carry out their roles effectively and in people's best interest.

The care staff we spoke with had differing views on staff training and supervision. One member of staff told us they did not benefit from the training provided by watching a video and felt it was just a matter of ticking a box to prove they had received the training when in fact they had learnt or understood very little. Another staff member told us, "I have completed all my mandatory training but if you want additional training you usually have to wait until there is a place on an external training course which can take time."

We spoke to staff who told us that they felt the registered manager had an open door approach. We spoke to a member of staff who told us, "I know if I had a problem, I could see the manager." Another staff member told us they had daily meetings with the registered manager. Staff also commented on how well they felt the team worked well together. A staff member told us they had received additional support from the management team following an unexpected death of someone living in the home.

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

All the people using the service and relatives we spoke with told us that they enjoyed the food and could get drinks and snacks throughout the day if they asked. All the bedrooms we visited had a jug of water and a glass. Juice and fresh fruit was available in the lounges. People also told us that they could get a drink of their choice on waking and were offered a supper at night.

We saw the menu for the day was written on the white board in the dining room and was on display in the corridor in pictorial form, to help people make an informed choice. We saw some people ate their meals in the dining room, some in the lounge and some in their bedrooms. During the morning the cook served people who came to the dining room for breakfast. People were offered a choice of meal and drinks. Drinks and biscuits were served mid-morning and drinks and homemade scones were served in the afternoon. People were asked during the morning what they wanted for lunch.

We saw breakfast was still being served at 11:20am which meant some people only had an hour between their breakfast and lunch. We spoke with the cooks who had a detailed knowledge of people's likes and dislikes and of the different diets they were providing. At lunch times we saw tables were nicely set with tablecloths, serviettes and condiments. There was a choice of meals on offer we saw people enjoyed their meals. However, we did note staff did not tell them the meal was very hot. The cook also told us they asked people what they wanted and put their requests onto the menu.

People told us that they were supported with health care needs and visitors told us they were kept informed about their relatives well-being. They also told us doctors were called in if they became unwell and district nurses visited on a regular basis. In some of the care files we looked at we could see people had been seen by GPs, community matrons, opticians and speech and language therapists. This meant people's health care needs were being met. We saw surveys which had been completed by two visiting professionals and noted their comments, "Staff always provide a warm welcome and very good customer service." "Residents always appear happy," "They know their residents very well and provide a very homely environment."

Requires improvement

Is the service caring?

Our findings

People using the service told us, “The majority of the staff are nice. If I press my buzzer more than once at night they get a bit shirty.” “Most of the staff are lovely. Odd ones I tend to be careful about; they have a bit of attitude.”

We asked people if they felt involved in planning their care they told us that staff did not have the time to sit and chat to them about what was important to them or how they wished to be cared for.

When we looked at the care plans we found very little information about people’s life histories or personal preferences. We spoke to staff about two people who had moved in to Millreed Lodge Care Home recently and they agreed having this information would be helpful so they could generate conversation.

Although people we spoke with told us that their privacy and dignity was always respected we saw practices that showed a lack of respect for people. At lunchtime one person in the lounge needed full support to eat their lunch. The care worker assisting them hardly spoke to the person and did not ask them if they were enjoying their food. We saw one person having their lunch in the dining room. Because the person was very small and sat in a wheelchair they could not sit right up to the table. Consequently, they spilled food onto the table and on to their knees. They proceeded to scoop the food from the table and their knee into their mouth. At no point did any of the care workers serving lunch offer any assistance. We observed staff place their pudding down on the table and walk away without offering assistance. One person told us they sometimes got sugar in their tea and they didn’t take sugar.

We observed a care worker speaking in a less than caring way to a person who did not feel like eating their lunch. When the care worker asked them why they were not eating their lunch the person replied that they did not feel like it. After some fifteen minutes a care worker then asked them if they would like a sandwich, the person said they would try one, the care worker’s response was, “You’re not doing me a favour.”

We saw the television had been left on in the lounge and ‘The Simpsons’ was on. We asked people if they wanted to watch that programme and no one did. We saw a member of staff walk straight into a person’s bathroom without announcing themselves or asking for permission to enter. We also saw staff enter people’s bedrooms without knocking.

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

One relative said, “All the staff are very compassionate are caring. I come at different times throughout the day and have seen staff in her bedroom holding her hand and talking to her.” Another relative told us, “They try to talk to him they make him feel wanted.” Someone else said, “A lovely caring home.”

We saw people looked well cared for and relatives told us their loved ones always looked well turned out.

We saw one care worker escorting one person from their bedroom to the dining room. The person linked the care worker’s arm and moved at their own pace. The care worker chattered about the weather and told them there was singer coming to entertain them that afternoon.

Relatives told us that they were always made welcome at the home, all the staff knew who they were and called them by their first names. Refreshments were always offered; all the visitors we spoke with had been told they could take their meals with their relatives if the wished. Relatives thought that all the staff were very kind and very hard working.

Requires improvement

Is the service responsive?

Our findings

We found people were moving into Millreed Lodge without any clear plan of how staff were going to meet their needs. Care workers told us the nurses wrote the care plans and they did not read them and got information about people in their care through the handover meetings between shifts.

We saw a number of people using the service had specialist 'air mattresses' on their beds. These were in place to reduce the risk of people developing pressure damage. We looked at two people's weights to check if their mattress was on the right setting for their weight. We found both were not set for the current weight of those individuals. We saw another person of low body weight but there was no weight recorded in their care file. They had a dynamic mattress in place but without knowing their weight the mattress could not be set correctly. This meant the therapeutic value of the mattress would have been reduced and could cause damage rather than preventing it.

We saw from one person's daily records their care needs had changed significantly since 5 August 2015, however, the care plan had not been updated to reflect those changes. For example, they had been seen by the speech and language therapist and thickened fluids and a mashable diet had been advised. We saw they were receiving the correct diet, however, this was not reflected in their nutritional care plan. We saw from the daily records this person was getting daily bed baths, however, their personal hygiene care plan stated they just needed assistance and prompts to wash and dress. We saw this person in the conservatory asleep in a wheelchair and they looked very uncomfortable. Staff transferred them to an armchair using a moving and handling belt. There was no up to date moving and handling plan to inform staff about what equipment they needed to use. Their care plan had been formulated in April 2014 and there had not been any changes made.

We saw one person was of low body weight and heard the cook telling them they would put some cream in their porridge. We looked at their care plan to see how their nutrional needs were to be met. We saw they weighed 31.5kg, there was no nutrition care plan in place and no monitoring of their food and fluid intake. This person went to the hairdresser in the morning and then was left in a wheelchair in the conservatory. They told us they wanted to sit in a comfy chair so they could put their head back. We alerted staff to their request and then saw them use a moving and handling belt to transfer them. As the person's feet did not touch the floor when they were in the chair the moving and handling belt was used to 'lift' them out of the chair. This was unsafe for both the individual and staff.

The lack of risk assessments and care planning was leaving people at risk of not receiving the care and support they required.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a copy of the complaints policy was on display in each person's bedroom. It stated, 'talk to senior staff or write to the manager – findings will be reported within three days. If not satisfied with the outcome the senior on duty will pass the complaints to the 'care manager' who will rectify this within seven working days, but no more than 28 days'. None of the people we spoke with had made a complaint about their care, but they told us that if they had a problem they would speak to a care worker or the registered manager.

The activities co-ordinator left in February 2015; another person had taken this role on and we were told they provided activities on a Monday afternoon. A singer had been booked for the afternoon of our visit, which people enjoyed. We saw an A5 pamphlet entitled "Millreed News" this stated a new birdfeeder was to be purchased and an item inviting people and their families to write what dignity meant to them on a paper leaf and hang it on the "Dignity Tree." It also announced when visiting entertainers would be performing and when the church service would be taking place. Throughout our visit we observed many lost opportunities by the staff to engage with people using the service. We observed people sitting for long periods of time without being spoken to. We did not see any interaction with people by the staff that was not request or task led.

Inadequate

Is the service well-led?

Our findings

We found policies and procedures were out of date, there were no effective systems in place to monitor the service or to identify improvements which needed to be made. Records we asked for were not readily available or did not exist and the downstairs office was disorganised.

We looked for evidence of audits carried out by the registered manager which we were told should take place on a monthly basis. We found that earlier in the year some audits had taken place between March and May, but since that time none had been carried out. Where the audit showed action was needed, it was not recorded when a task had been completed. The pharmacy audit tool completed in March 2015 identified that a list of staff who administered drugs and sample signatures was needed. As there were no notes to show this had been carried out, we asked the registered manager who was not sure it had been completed. In April 2015 an infection control audit showed that a refurbishment of the sluice room was needed. We were told that the design of this room was still under discussion at the time of our visit. The registered manager told us that the infection control audit was over-complicated and that they were planning to introduce a more manageable tool.

We looked at an overview of accidents and incidents over the last 12 months. The provider was unable to demonstrate this information had been analysed and used to look for patterns which could prevent avoidable injuries in the future.

We found a copy of the complaints procedure was on display in each room, although the address for the Local Commissioner for Administration was not listed correctly. We checked the complaints file and found that no complaints had been recorded since our last inspection. We found that one person who filled in a satisfaction survey had indicated that they had complained regarding the service they received. We were concerned that expressions of dissatisfaction were not being recorded.

We asked the registered manager whether any staff members had gone through a disciplinary process and were told that the last time this happened was several years ago. During our visit we found that one staff member had been suspended within the last 12 months in response to an allegation of abuse which the registered manager had not reported to the CQC. We asked the registered manager whether any checks had been made to assess the quality of care provided by staff. We were told that a tool had only recently been introduced for this purpose.

We spoke with a member of staff who advised us that the last staff meeting took place in 2013. The registered manager confirmed that staff meetings had not been held since this date.

We looked for evidence of meetings with people using the service and their relatives, but were told that these meetings did not take place. The care provider sent out surveys for people who used the service and their relatives. We looked at 16 questionnaires that had been returned in the last year. They showed a fair degree of satisfaction with the service. We found a breakdown of their responses on display in the reception area. Some people had anonymously commented, “Would like my food hotter,” “More staff,” “Choose room décor?” and “Not enough buffets/seating for visitors.” We were unable to find any evidence of action taken in response to this feedback and how it was communicated to people who used the service. One visitor told us, “We would like to see chairs in resident’s bedrooms. We bought six stools the first year our relative was in here they have never been added to by the manager.” This meant people’s views were not being listened to or acted upon.

We asked the registered manager about the support they received from the provider. We were told that the Area Manager had not visited in several months. We also asked about the governance checks carried out by the provider and found there were no records of their visits. When we spoke to the provider they acknowledged this and told us that they would take steps to improve governance.

During the inspection we found issues in a number of areas such as the premises, infection prevention, medication, planning of care, staff training and staffing levels. If there were effective systems in place all of the issues should have been identified by the provider and measures put in place to ensure they were rectified.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not protected from being deprived of their liberty.** **Regulation 13(5)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not always treated with dignity and respect.** **Regulation 10 (1)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as risks to their health and safety were not being assessed or plans made to mitigate those risks. The management of medicines was not safe and proper; the risks in relation to the spread of infection were not assessed, prevented, detected or controlled and there were areas of the premises which were unsafe. Regulation 12 (2) (a) (b) (d) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. The provider did not act on the feedback they received from relevant persons.

This section is primarily information for the provider

Enforcement actions

Regulation 17 (1) (2) (a) (b) (c) (e).