Laudcare Limited

Millbrow Care Home

Inspection report

Millbrow
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Cheshire
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16 August 2017
18 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 2, 3 and 16 August and 18 September 2017.The previous inspection of Millbrow was a focused inspection and was carried out on 29 January 2016 when it was found to require improvement in the safe and well led domains.

Millbrow provides accommodation and personal care for up to 44 people. At the time of our inspection the service was accommodating 42 people.

There was a registered manager in place at Millbrow. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to: person centred care; dignity and respect; safe care and treatment; safeguarding service users from abuse and improper treatment; meeting nutritional and hydration needs, staffing and good governance. We also found a breach of the Care Quality Commission (Registration) Regulations 2009 as the registered person had not always notified the Commission of incidents or allegations of abuse.

Risk assessments and care plan did not always adequately identify and address people's health and personal care needs. Staff did not always follow actions stated as being required on people's care plans. People did not always receive safe and effective care.

Allegations of abuse were not always reported or acted on in accordance with local procedures. Medicine management systems were not effective. Medicines were not always stored safely and records were not complete.

Medicine management systems were not effective. Medicines were not always stored safely and records were not complete.

Standards of food hygiene and safety were poor and systems were not robust to prevent the spread of infection.

Agency staff were employed on a regular basis. The process for ensuring that these staff were adequately inducted when they first started working at the home needed improvement.

We saw that people were left without access to drinks for long periods of time and there was as long as a 17 hour gap between the evening meal and breakfast the following day for some people. People's dietary requirements were not always met and staff had not always supported people effectively with weight loss or

gain which presented a risk to their health and wellbeing.

The environment on the first floor, for people living with dementia was poor. There was a lack of visual and tactile stimuli and a lack of signage made it difficult for people to orientate themselves around the home.

People's personal hygiene was not always attended to in a timely manner. Monitoring charts were inaccurate, as they were not completed contemporaneously. We observed instances where staff recorded that they had attended to people when we could evidence that they had not.

The leadership and governance in the home was inadequate. Quality assurance systems were complicated but failed to identify serious failings in the care people were receiving.

People did tell us that they enjoyed the activities that were arranged at the home. The home employed an activities coordinator who was passionate and enthusiastic about her job.

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.

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.

Safeguarding systems and processes did not provide adequate protection to people using the service.

Infection control systems were not adequate to protect the spread of infection within the home.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional needs were not always met.

Although staff had received some training, there were gaps in refresher training and not all staff had taken part in fire drills.

We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's personal hygiene was not always attended to in a timely manner.

When staff engaged with people they were kind and patient, however a culture had been allowed to develop where staff spoke about people in an impersonal way.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not reflect all people's health and personal care needs. Staff did not always follow the care plans.

Reviews of care plans did not always identify changes to people's needs.

People enjoyed the activities on offer.

Systems for managing and responding to complaints were in need of review to ensure all complaints are recorded, investigated and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

Leadership and governance arrangements were not robust as systems and processes to safeguard people and assess, monitor and improve the quality and safety of the service provided were ineffective.

Millbrow Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 2, 3 and 16 August and 18 September 2017 and was unannounced.

During the first 2 days the inspection was undertaken by an inspection manager, one adult social care inspector and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services. On the third and fourth days of the inspection one inspection manager and two inspectors completed the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at all of the information which the Care Quality Commission already held on the provider. This included any information the provider had to notify us about. Furthermore, we invited the local authority to provide us with any information they held about Millbrow. We took any information they provided into account.

During our inspection we spoke with the regional manager, the resident experience lead, the registered manager; a visiting registered manager, clinical lead; one activity coordinator; a maintenance person and 14 staff. We also spoke with nine relatives. Although we met with 32 people who lived in the home we were only able to gain the views of 18 people. This was because some people were unable to communicate with us due to their various health issues.

However we also undertook a Short Observational Framework for Inspection (SOFI) observation during lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records including: six care plans; six staff files; staff training; minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and a range of audit documents.

Inadequate

Is the service safe?

Our findings

When we asked people living at Millbrow if they felt safe there were mixed views. Three people who lived in the home told us they felt safe. Comments included "Yes we are OK here", "They keep the doors locked so we are kept safe" and "We are fine here. I feel safe in my room, the staff are always around if I need them and they give me my medicines when I need them". However, other comments received about staffing levels included "Staff are very busy, I have to wait my turn", "When I buzz for the toilet staff say I'll be with you in a minute; it's no good when you need to go" and "I get fed up of buzzing now, it's a nuisance".

Relative's comments were mixed. Comments included "There aren't enough staff on duty. They are always busy." They said their relatives also had to wait for support/assistance. Examples of concerns were regarding waiting for toileting, drinks and immediate attention if people were feeling unwell.

At the time of our inspection there were 42 people living in the home who required different levels of care and support.

We asked the registered manager for information on how the dependency needs of the people using the service were calculated. The registered manager told us that the minimum staffing levels required for the service were five care staff and one nurse between the hours of 8.00am and 8.00pm on the downstairs unit and four to five care staff and one nurse between the hours of 8.00am and 8.00pm on the upstairs unit. Between 8.00pm and 8.00am there were 2 care staff and one nurse on each unit. She said that staffing levels would be amended if people's needs changed. However on the third day of our inspection we arrived at the home at 7.30am and noted that there was only one nurse on duty 8.00pm until 8.00am to over the two units. Later, another member of staff from within the organisation was brought in to support the agency nurse.

Staff told us they worked very hard but felt they had sufficient staff to provide safe care to the people who lived at Millbrow. They told us they worked well together as a team and supported each other. However, we observed on a number of occasions, that people were left for long periods without receiving required care interventions. For example, at 10.30am on the first morning of the inspection we also saw another person sitting in a lounge with congealed Weetabix in a bowl in front of them. The nurse in charge of the unit told us staff let this person try to eat independently first and would step in to help if she was unable to feed herself. However, the time period left allowing this person to try to feed herself was too long as her breakfast was inedible when we saw it. This person had lost 6kgs in weight since January 2017. We saw another person asking for her breakfast at 11.13 am and staff saying they would get it for her. However, we saw that by 11.39 am she had still not been served her breakfast. When we returned to the home on 18 September, we saw that people were still left waiting for long periods without being given a morning drink, breakfast or assistance with personal hygiene. We started our inspection at 8.30 am and found that many vulnerable people had not been offered sufficient fluids to sustain their health and well-being in the previous 12 to 16 hour period. Records showed that six people had not been offered anything to drink in the previous 12 hour period and a further 3 people had not been offered anything to drink in the previous 16 hour period.

These issues are a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 in that the registered person failed to ensure that people received care that met their needs.

A corporate safeguarding policy and procedure had been developed by the provider to offer guidance for staff on their duty of care to prevent the abuse of adults at risk of abuse, harm or neglect. A copy of the local authority's adult protection procedure was also available for the registered manager and staff to reference, together with a policy on whistleblowing.

We looked at the safeguarding records for the service and viewed the 'central log of concern and safeguarding' record. The Care Quality Commission had received only four statutory notifications for the abuse or allegations of abuse concerning a person(s) who uses the service in the past twelve months. During our inspection we discovered that there had been other allegations of abuse that had not been notified to the Commission or acted upon correctly by the registered persons. Examples were shared with the Regional manager and registered manager during our inspection.

Following our inspection on 16 August we referred two people to the adult safeguarding team at Halton Borough Council because we had concerns that staff were neglecting to meet their care needs. Following the fourth day of our inspection we referred a further 10 people to the safeguarding team based on our observations because none of these people had access to drinks other than when staff served drinks at set times and a number of them had lost significant weight.

At the time of our inspection, training records detailed that the majority of the staff team had completed safeguarding adults training. Systems were also in place to monitor staff that required safeguarding adult's refresher training. Although the majority of staff had completed this key training, we identified concerns in relation to safeguarding systems and processes and a failure to report, notify and / or act upon safeguarding incidents correctly in accordance with local multi-agency policies and procedures.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to establish and operate effective systems and processes to protect people using the service from abuse and improper treatment.

The service had a detailed policy with regard to the management of medicines. A matrix was provided which detailed that relevant staff had received medicines training via e-learning. We were told that assessments were carried out each year to ensure the competency of staff administering medicines. The manager was aware of the process to follow in the event of an error.

We reviewed stocks of medicines to ensure that they were being appropriately managed. We saw that the latest cycle had begun three days earlier and that certain recently prescribed medicines were ready for return to be destroyed. We saw that there were six large boxes plus other smaller boxes full of various medicines for example, nutritional supplements, Macrogol, Lorazepam, Diazepam and Nitrazepam. There was no clear audit trail as to the medicines waiting to be returned as they had not yet been entered in the record book and the amount to be destroyed had not been entered on the previous Medication Administration Record (MAR) as required.

We were concerned that these medicines were not being effectively controlled and that ordering processes were not being managed appropriately. For example one person was prescribed a medication to be taken twice daily and 56 were received for the new cycle, however a total of 82 in 3 different boxes were being returned and for a person prescribed nutritional supplements there were large quantities contained within two crates and a cardboard box ready to be returned. From the excess stock and records available, we

could not feel confident that all medicines had been administered as prescribed. The service did not have systems in place for the proper and safe management of medicines. We raised this concern with the manager, regional manager and clinical lead during the inspection and they confirmed that the matter would be addressed.

Some medicines needed to be refrigerated for storage. Temperatures were required to remain within an acceptable range to ensure that the medicines were not adversely affected. We saw from the records that there were several occasions when the temperatures were outside the acceptable range. On some occasions action had been taken to "reset" however there was no evidence that further checks were made on those days to determine whether the action had been effective. It was noted that the temperature was outside the acceptable range on 29th, 30th and 31st July, action was taken each day to reset but this had not addressed the temperature. There were also some gaps in recording, for example there were no records for the period 13th to 17th July 2017 inclusive.

We discussed medications with the clinical lead who was knowledgeable with regard to procedures and requirements. They were able to provide information about the way in which medicines were managed within the service. We looked at records relating to medicines which are prescribed "pro re nata" (PRN), to be taken when needed. We saw that records were not always maintained as required, for example some protocols were out of date, stating the person was prescribed tablets when the medication was now prescribed in liquid form. Also, separate administration records were retained detailing when the medicine was administered and the effects, for example whether pain had settled, however they were not in place for all PRN medications, so it was not possible to judge whether the medicines were effective.

We looked at the process in place for "homely remedies", medications which can be purchased without prescription and which a GP has authorised the use of, such as paracetamol, simple linctus etc. We were advised that the process for these medicines was being reviewed. We saw that stocks were not always managed appropriately as the date that a bottle of linctus had been opened was not recorded to ensure that it remained fit for use. Also, a label had been partially removed from a prescribed medication. Prescribed medications should only be administered to the person they have been prescribed for and the medicines policy states "Homely remedies must be purchased over the counter; they cannot be obtained on prescription".

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure the proper and safe management of medicines.

No concerns were expressed by staff with regard to people receiving their medicines in a timely manner and we were told that the medicines training provided to staff had been sufficient. Staff told us that in addition to nursing staff the service employs Care Home Assistant Practitioners (CHAPS) who undertake certain tasks which were previously allocated to nurses, including the administration of medicines following completion of a 3 month course.

Although environmental checks formed part of the organisation's quality assurance system we saw no evidence that all infection control issues were being acted upon. For example, the last quarterly report viewed identified that no issues of concern were recorded in the health and safety and infection control section. We were advised that the home was currently without a maintenance person and an infection control lead and this was why the records were not fully up to date.

Concerns were also highlighted around infection control by the local authority contract monitoring and

quality assurance team when they undertook an infection control review on 13 September 2017. Issues included the observation of heavily contaminated pressure cushions and other equipment and a strong malodour on the first floor. Staff were also seen to be walking along corridors with soiled laundry and neglecting to wear appropriate personal protective equipment such as gloves and aprons. One person had been admitted to hospital on 11 September but their en-suite toilet had still not been cleaned and was full of faeces. The fridge in the first floor dining room had food debris and out of date food stored in it.

Between days 3 and 4 of the inspection, we were advised that an Environmental Health inspection had taken place. This inspection identified that improvement made in standards of food hygiene and safety had not been maintained and the home had been given a Food Hygiene Rating of 1. The Food Hygiene Rating Scheme is a 6 point scheme where 0 is "urgent improvement necessary" and 5 is "very good". A score of 1 denotes "major improvement necessary". The home has been subject to a number of outbreaks of diarrhoea and vomiting.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that all premises and equipment were clean and properly maintained. It is also a further breach of regulation 12 in that the registered person had failed to ensure a robust system for preventing and controlling the spread of infections.

We looked at 14 care files for people who were living at Millbrow and noted that each person had a range of risk assessments and other supporting documentation. However, there were some significant gaps in information, which meant that people's needs were not fully identified and risks not mitigated. For example on day 1 of the inspection we found that one person who was identified in their pre-admission assessment in May 2016 as having type 2 diabetes, did not have this recorded on their care plan at all until July 2017. This person had gained a significant amount of weight over a seven month period but this was not addressed in their risk assessment. On 18 September 2017 when we carried out day 4 of the inspection we found that one person had been admitted to hospital on 16 September 2017 with severe dehydration and resulting cardiac arrhythmias. This person's care plan recorded them as being at low risk nutritionally and "able to take adequate fluids", even though they had lost 7.8kgs in weight since 2 August 2017.

This is a further breach of regulation 12 of the Health and Social Care Act 2208 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that the risks to the health and safety of service users were fully assessed and mitigated.

We looked at a sample of six staff personnel files. The information contained in the files demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. This enables the registered manager to assess their suitability for working with vulnerable adults. One staff member we spoke with confirmed they were unable to commence employment until all checks had been carried out. They told us they completed an application form and attended an interview. They could not start work until they had received clearance from the DBS. This confirmed there were safe procedures in place to recruit new members of staff.

The registered manager told us that agencies provided profiles for agency staff who worked at the service.

We asked to see these records and cross referenced them with details of agency staff that had completed shifts within the last three months. The profiles confirmed details of the worker with confirmation that safe recruitment had taken place and that they were trained and qualified to enable them to carry out their role. However, we found that for some staff a profile was not on file. Nurses are required to register with the Nursing and Midwifery Council (NMC) and are issued with a personal identification number (PIN) to confirm they are appropriately registered. We saw that some of the profiles on file contained information indicating that the person's PIN had expired. We brought this to the attention of the manager who could not confirm the process in place to ensure that profiles remained up to date or explain why some were missing. This meant that the manager could not always ensure that agency staff employed at the service were appropriately recruited, trained or qualified.

We recommend that the provider reviews their process for confirming the professional qualifications of agency workers.

A business continuity plan, fire risk assessment and personal emergency evacuation plans were in place to ensure an appropriate response in the event of a fire, breakdown of services or equipment and / or major incident. We noted that this information had recently been updated by the registered manager. This information helped staff to be aware of their specific responsibilities and the action to be taken in the event of an emergency.

Inadequate

Is the service effective?

Our findings

People told us that they felt staff were effective in their roles and that communication was good. Comments included "Staff are lovely and know my needs", "They (staff) are well trained and know what to do, especially if someone needs help quickly" and "They (staff) always understand what people are saying to them, even when people cannot really speak. They just seem to know what they want".

Some relatives told us that they felt the staff were effective. Comments included "The staff understand that the people who live here have memory and communication problems but they make sure that they are able to do the things they want to do" and "I don't know how they do it. All the staff seem to be able to speak with the people here and understand their needs". However we received some negative comments about the effectiveness of the service including "I am not sure if (name) is getting the treatment he needs. We don't get much feedback and I feel that the nursing staff are overstretched and agency staff don't have the time to get to know people's needs" and "It's more like a containment unit as most of the people have dementia. Staff just have to keep their eye on, them they cannot make them better".

The provider had a programme of staff training and development that was delivered to staff via a mix of face-to-face and e-learning. We received a copy of the training matrix and this identified that staff had undertaken training in subjects such as moving and handling, equality and diversity, first aid and mental capacity. We saw that whilst all mandatory training had been provided some, such as training in the Mental Capacity Act was in need of update. We saw that whilst all mandatory training had been provided some, such as training in the Mental Capacity Act was in need of update. We observed staff trying to assist one person who was becoming increasingly agitated and distressed and they were struggling to know how to respond. Staff told us that although they had asked for training in specific topics such as the care of people with dementia and managing challenging behaviour this had not been provided. Furthermore, fire drills had only taken place during the day, almost always at around 10.30am. This meant that they captured the same group of staff and some staff, particularly night staff had not received training in this area.

On the third day of the inspection an agency nurse was due to cover the day shift and was awaiting a handover from the night nurse. The agency nurse told us he had not had not yet had an induction so was not familiar with the layout of the building. The registered manager told us there was a process in place to ensure that agency staff received appropriate induction and this was recorded on a form entitled "Orientation of Agency or Bank Nurses". The orientation covered a wide range of topics for example the building, report of people using services, records and care plans, fire systems, medication trolley, cupboards including controlled drugs and the nurse call system. We saw that a form was not on file for all agency staff that had been used by the service. On the day of inspection the agency nurse had still not received induction by 11.00 a.m. although they had been tasked with administering medicines. The manager said that they "didn't want to disturb him" as the worker had started the medication round. However, records provided indicated that this person had also completed two shifts the previous week. This meant that agency staff did not always receive appropriate induction.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations

2014 in that the registered person had failed to ensure that all staff were suitably inducted prior to working in the home and some staff required refresher training in mandatory topics.

Staff spoken with confirmed they had attended team meetings periodically and received supervision sessions throughout each year. Examination of the supervision matrix highlighted that all staff had received at least one supervision in 2017 with most records showing that most staff had undertaken three supervision sessions with their line manager during 2017. Staff spoken with told us that they found these meetings to be useful as they were able to raise issues about working practices, training needs or any personal issues and know that they were listened to and any issues would be addressed. However staff said that they were not always told in advance when these meetings were to be held which gave them little time to prepare for them.

We looked at how people were supported to eat and drink and at the overall dining experience. We observed a lunch time meal being served. We saw that meals were transported from the main kitchen to both units using heated trolleys. Meals were served in the dining area on each unit although some people preferred to eat in the lounge areas or their bedrooms and this choice was respected.

Staff had protective aprons on for service. There were four staff supporting people to eat their lunch. We observed staff supporting a person to eat their lunch standing up (his choice) this worked for him and staff responded to it. We observed that people were provided with a choice of meal at lunch time and evening and that staff were mainly attentive to the needs of people using the service. For example, we saw one member of staff asking a person what they would like to eat and offering support to cut the meal up into smaller pieces. However, another person was dipping her sandwich into her soup bowl (there was no soup left in it). A staff member asked if she would like some more soup and she said yes but this was not then provided. Observation of the dining experience indicated that overall people found the service to be pleasurable. However, some elements could be improved, for example we saw that on the ground floor dining unit there were no tablecloths or condiments on the tables and no hand care was offered to clean people's hands before eating their lunch.

We observed one person coughing and spluttering whilst eating their lunch. This person was in a reclining position in an easy chair. We looked at this person's care plan in respect of their eating and drinking guidelines. We saw that they had been assessed by the speech and language therapist (SALT) and they had been identified as being at high risk of choking. We saw that a choking assessment completed by the home stated that the person needed to be 'sat upright for meals'. We noted that this was not occurring at the time of our visit as the person was lying back in an easy chair. On 18 September 2017, we again saw another person lying in a semi-recumbent position in bed with the meal left on a tray next to them. This person's care plan recorded that they were at high risk of choking and required pureed diet and thickened fluids. Failure to ensure people are properly positioned prior to eating presents a risk that they may choke.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that care was delivered in a safe way for service users.

In other care files we looked at records showed staff used the Malnutrition Universal Screening Tool (MUST) to identify whether people were at nutritional risk. There was some evidence that they monitored people's weights, to identify whether people were losing or gaining weight inappropriately. However, in the care plans that we looked at, this was not being consistently recorded or reviewed and it was not clearly recorded what action had been taken where a significant change had occurred with someone's weight. This indicated that people's weights were not consistently monitored and managed. We noted that fluid charts

had not been accurately completed as to when people had been provided with drinks. Many of the fluid and food charts that we looked at recorded that people's last meal of the day had been given at around 16.30 hours the previous day and their last drink at around 20.30 hours. We could not establish if staff had failed to maintain records accurately or if people had actually not been given food and drink within acceptable timeframes. There was no evidence however that people had been given drinks overnight or in the early morning on waking, because on the third day of the inspection we started walking round the home shortly after 8am. On the first floor the majority of people did not have access to drinks in their rooms and in some bedroom areas drinks had been left but were out of reach to the person living there.

On 18 September 2017, we started the day's inspection at 8.30am and again found that the majority of people had no access to drinks in their rooms and that fluid charts recorded the last drink the previous night as being given at around 21.30 hours; three people had not been given drinks since 17.30 hours the previous day.

On 18 September we found that 10 service users on the first floor had lost weight including two people who had lost 8kgs in weight since March 2017, one person who had lost 15.5 kgs since March 2017 and one person who had lost 21kgs since March 2017. Some people were prescribed supplements and/or fortified diets. However, the fluid intake charts did not accurately record if people had received these. We spoke with three care staff and two did not know which people they were caring for were on fortified diets. The chef told us that they sent fortified milk up to the dining rooms for breakfast but it was often returned unused to the kitchen.

We looked at the care file for one person and saw that in their pre-admission assessment they were known to have type 2 diabetes. However, this information had not been transferred on to this person's care plan, which stated they liked "toast and jam" and 2 sugars in their tea. There was no evidence that this person had been provided with a suitable diet up until July 2017.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that the nutritional and hydration needs of service users were met.

We spoke with the chef on duty and looked at the kitchen. We noted that information on the dietary needs of people using the service was recorded in the kitchen to enable all staff to be aware of people's nutritional requirements.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We discussed the requirements of the MCA 2005 and the associated DoLS with the registered manager.

We noted that a policy on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been developed by the provider to offer guidance for staff on the core principles of the Act, assessing lack of capacity, best interest decision making and deprivation of liberty safeguards.

We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Applications were submitted to the local social services department who were responsible for arranging any best interests meetings or agreeing to any DoLS imposed and for ensuring they were kept under review. The registered manager maintained a record of people with authorised DoLS in place and the expiry dates. Information on applications awaiting authorisation and people with a Lasting Power of Attorney (LPA) had also been recorded. A LPA is a way of giving someone you trust, the legal authority to make decisions on your behalf if you lose mental capacity at some point in the future, or if you no longer want to make decisions for yourself.

Although training records viewed highlighted that a number of staff had not completed training in the MCA and DoLS, staff spoken with confirmed they had received training in the MCA and DoLS and demonstrated an awareness of their duty of care in respect of this protective legislation.

During our visit we saw that staff took time to ensure that they were fully engaged with each person and checked that they had understood before carrying out tasks with them. Each time we saw that staff explained what they needed or intended to do and asked if it was alright rather than assuming consent. They allowed people the time to respond and respected that it may take some people longer to respond. We observed a number of different staff using hoists to re-position people at various points throughout our inspection. This was carried out in a dignified and respectful way. Each time, we saw that the staff members took their time, did not rush the person, reassured them throughout if they were becoming anxious and spoke to them throughout the entire time that they were using the hoist.

The nurse in charge each morning received a verbal and written handover from the night staff. However, communication in general was poor in that care staff did not know the full details about the care they needed to deliver (such as dietary needs). Furthermore advice from other health care professionals was not always recorded on people's care plans and charts or used to inform risk assessments.

The providers information return detailed that people using the service were registered with a local GP, dentist and optician and that annual health checks were routinely carried out. The home worked alongside health and social care professionals to ensure people's health needs were met. Examination of health care records confirmed that people using the service had access to a range of social and health care professionals subject to individual needs. We were informed that daily handover meetings took place and noted that handover records and checklists' were completed to record and exchange information. We noted that the nurse in charge of each shift facilitated the handover and verbally cascaded need to know information to all members of the staff team.

We undertook a tour of the home and noted that where possible, people's rooms had been personalised with memorabilia and personal possessions and were homely and comfortable. We noted that some areas of the home were in need of cleaning and redecoration. On the first day of the inspection we saw that the corridor on the upper floor which accommodated people who were living with dementia had recently been redecorated. We saw that the walls were bare and signage was not in place to identify people's rooms. The area did not appear to be dementia friendly. We raised this with the registered manager who said that pictures and other items to create a homely environment were waiting to be put on the walls following the redecoration. However, by the third day of our inspection two weeks later, no further action had been taken to address this. The ground floor accommodation was adequately adapted to meet people's needs. There was directional signage in place to support those living with dementia and it had recently benefited from some redecoration.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff very much and felt they really cared about them. Comments included "It's a hard job looking after some of the people who live here but the staff are marvellous. They keep calm, are very friendly and are kind and caring no matter what", "They (staff) are wonderful people. They know all about me and make sure I am well looked after" and "Could not do without them. They care for me and about me. They deserve a medal for the way they do their jobs. Great bunch".

Care plans had been reviewed and signed by the person (if they were able to) themselves or their relative, if legally allowed to do so, and people told us they had been involved in their care plan. Family members said they had been involved with care planning and felt that independence was encouraged as much as possible. Everyone we spoke with agreed that there was a good understanding of peoples' likes and dislikes. All relatives spoken with told us that the staff were excellent, kind, and caring in their approach.

We observed kind and familiar interactions between staff and people who lived at the home which confirmed that staff knew people very well. We observed staff helping people to the toilet, talking discreetly to them, and encouraging them to move at their own pace, so they did not feel rushed.

We also observed one staff member helping a person to sit in their armchair; they said things like, "The chair is right behind your legs, just sit when you are ready." This helped the person to feel secure and they sat without any hesitation.

We observed a staff member supporting a person who was displaying challenging behaviour. The staff member was able to calm this person well. She was able to talk with the person and reminisce with them about things that were important to them. The person quickly settled and was at ease.

Staff explained why they would knock on people's doors before entering as well as supporting people with their independence. Staff said things like, "I treat people how I would want to be treated." Also "I don't just assume residents want my help, I always ask if they need me to help them."

We observed that staff were attentive to the needs of the people living at Millbrow and that people were supported to follow their preferred routines. For example, we saw staff standing in corridors outside people's rooms, not being intrusive but ensuring people were able to do what they wished to do whilst remaining safe and dignified.

However, despite the good practice we observed, we had concerns that this was not always consistent. We observed that a number of people looked unkempt, with dirty finger nails or unbrushed hair. We saw one person who required immediate assistance with their personal hygiene. Their monitoring chart indicated that staff were to check on them every15 minutes but even though entries had been recorded indicating this had taken place, it was clear from the person's physical appearance that staff had not checked on them for some time. This left the person in an undignified and distressing state. We brought this to the attention of the registered manager who told us they would investigate the matter.

On the first floor we saw that most people did not have their name on their bedroom door, but just a number (one person had neither name nor number). This presented an impersonal feel and a lack of respect for people living at the home.

On some occasions we heard staff talking in an impersonal way about people living at the service, for example, saying "He needs the toilet, you come and help me. I'll take her (resident) in there. I'll do her then we can start the other (resident)." These conversations were within earshot of visitors and people using the service.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that all service users were treated with dignity and respect.

Information about people who lived at Millbrow was kept securely to ensure privacy and confidentiality. The provider had produced an easy read information brochure on the service which was available in reception for people to view.

Inadequate

Is the service responsive?

Our findings

Comments from people who lived in the home included, "I am happy enough. The activities that go on here quite interest me"; "Linda the activity coordinator is absolutely fabulous. She arranges all sorts of stuff, she's great" and "Staff understand my needs and help me to get up and go to bed when I want. I don't like activities as I like TV and the staff know this".

Comments from family members included, "The staff know how my mum likes to be cared for and she loves them all", "They do take on board when you suggest things such as taking (name) downstairs to sit with a friend" and could not wish for more. (Name) is happy and well cared for. I think the staff have lots to do but they always do it with a smile".

Although people were satisfied that the care and support they received generally met their needs, they said sometimes they had to wait for assistance. One person said "Sometimes when I want to go to the toilet there are no staff around to help me" and another person said "Carers are wonderful but sometimes we have to wait our turn to be assisted".

We observed on a number of occasions, that people were left for long periods without receiving required care interventions. For example, on the first morning of the inspection we observed someone lying in bed who required immediate assistance with their personal hygiene. We heard this person shouting for help and the registered manager told us that this person was "often distressed". No staff were seen to go and assist this person. We checked the daily monitoring charts for this person and they indicated that the person should observed and checked on every 15 minutes. The chart had been completed exactly every 15 minutes all morning, up to and including the time that we were with the person, even though no staff had entered the room. It was clear that this person had not been checked at the times stated on the chart because their toilet requirements had obviously not been attended to for much longer than 15 minutes.

This is a further breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person failed to ensure that people received care that met their needs.

We saw that one person required safety checks to be made by staff every thirty minutes as they were unable to use their call bell. When we reviewed the chart at 09.15hrs, the last checks had been recorded at 07.30hrs. It was not possible to be certain that records made about the times staff checked people living at the home, or delivered care interventions were accurate, as we saw that records were sometimes made retrospectively. On one occasion we saw that entries had been made in advance of the time, stating that a person had been checked at 10.45 when inspectors were actually with the person between 10.30 and 10.45 and the staff member had not been in attendance.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person failed to ensure that records were accurate, complete and contemporaneous.

On 16 August 2017 we saw that one person required safety checks to be made by staff every thirty minutes as they were unable to use their call bell. When we reviewed the chart at 09.15hrs, the last checks had been recorded at 07.30hrs. It was not possible to be certain that records made about the times staff checked people living at the home, or delivered care interventions were accurate, as we saw that records were sometimes made retrospectively. On one occasion we saw that entries had been made in advance of the time, stating that a person had been checked at 10.45 when inspectors were actually with the person between 10.30 and 10.45 and the staff member had not been in attendance. On 18 September 2017 we observed one care staff scribbling out an entry they had made on someone's charts. When we looked at the chart we saw that the carer had recorded at 8.30 hours an entry that they had given the person a drink at 09.00hours in advance of that actual time.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person failed to ensure that records were accurate, complete and contemporaneous.

We looked at the pre-admission paperwork that had been completed for people currently living at the home and could see that assessments had been completed. We noted that they were not always dated.

We saw that care plans did not always address all people's health needs. For example, the nutritional care plan for one person did not specify that they had type 2 diabetes so they were at risk of receiving inappropriate care and treatment. Care plans also lacked sufficient detail for staff to be guided as to the care they needed to deliver. For example, the conditions that medications were prescribed for, possible side effects and signs/symptoms for staff to be observant for were not always noted. A care plan for another person who was at high risk of pressure ulcers only stated "to be assisted several times a day to give pressure relief"

The plans for other people that we looked at were not being reviewed consistently and were not being updated following a change or a visit from another professional. For example, it had been noted that there was a significant decrease in someone's weight and it was recommended that the person see the GP. There was no record on file of a GP visit and the care plan had not been updated since the weight had been taken. Another person had gained a considerable amount of weight to an extent that this may have been detrimental to their health. This risk had not been identified on their care plan and their nutritional risk assessment had failed to identify this as a cause for concern. This meant the person did not receive appropriate advice and guidance to make an informed decision about their diet and other aspects of their care.

This was a further breach of regulations 9 and a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to provide appropriate care that met people's needs and had failed to assess the risks to the health and safety of service users or do everything that was reasonable practicable to mitigate any risk.

The home had a complaints policy. We saw this displayed in the reception area of the home. We asked people whether or not they had ever made a complaint and if so how this was acted upon. People told us "If I don't like anything I will say so" and "I take no messing I can speak up". One relative stated they had raised a concern and said, "I was happy with the way it was dealt with as I was able to tell the manager what I felt". However, another person told us that they had made a complaint but it had never been acknowledged. We asked relatives what they would do if they felt that they did want to make a complaint. People told us they had raised concerns in the past and felt that not all these had been acted upon. We viewed the complaints file and noted that a full record of each complaint, how it was investigated and what the outcome was, was

not available.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that the registered person had failed to ensure that all complaints were investigated and acted upon appropriately.

People told us that they decided when to get up or go to bed, decided where they wanted to be and whether they wanted to join in with things going on within the home or out and about.

We asked staff members about several people's choices, likes and dislikes and the staff we spoke to were very knowledgeable about the people that they were caring for and the care that they needed. The staff knowledge was not always reflected fully within the care plans. We saw that in some care files, some areas of the plans were personalised and reflected the needs of the individual including their wishes for end of life. However we found that the care plans were not very well organised and it was often difficult to find information. This would not enable any member of staff reading them to have a good idea of what help and assistance someone needed at a particular time.

Activities were organised by the activity coordinator at the home, and consisted of armchair exercises and other requested activities such as games, puzzles, cards, movement and music and ball activity. We saw that the home kept a log of the activities and who chose to participate.

We saw records of weekly meetings held with the people who lived in the home to arrange the activity programme for the week. This was to ensure everyone was getting an opportunity to engage in something that they enjoyed. One person told us, "I just love these activities. We do something every day and always have fun". Other comments included "We have a great time. We all sit together and have quizzes and we all remember the past and have a laugh. We were talking about the war years today and how many changes have taken place. Good memories" and "They take me out to a social club and I thoroughly enjoy it. The staff are good here; it's just one big happy family. We all have different needs and capacity but Linda (activity coordinator) ensures that everyone joins in".

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We observed activity sessions on the three days of our visit and noted how relaxed and content people were during these sessions. Staff understood each person's capacity to join in and provided discreet assistance and support where required to enable them to be a part of the group.

People's relatives were high in praise of the activity coordinator and her passion to provide stimulation and fun within the home. Comment's included "Wonderful lady, loves all the people here and makes their life better by just being around", "What a smashing person she is (activity coordinator). She lights up this place. She fund raises so the people here can have more outings. She is a breath of fresh air" and "Always smiling and providing stimulation. She goes to the people who cannot take part in group activity and sits with them. She reads to them, paints their nails and has general conversation, she's a gem".

Inadequate

Is the service well-led?

Our findings

People told us that they thought the home was well managed and that the registered manager was fine. Comment's included "She is nice and talks to me. I had a problem and told the staff and the manager came to see me to tell me it had been sorted", "Yes she seems alright, nice enough and this place is well managed, it's good here" and "I think she is a good manager."

We had mixed opinions from people's relatives about the home management. Comments included "I think it's been hard for her to establish herself. This home has had so many managers and changes of staff over the past few years it must be difficult for her. I have had no problem, she has listened to my concerns and has addressed them", "Nice enough woman but a very hard job. Staff seem to come and go which does not help any manager"," I think she is getting there but still has some way to go", "She is never around, her door is always shut and we cannot speak with her" and "I think the overall leadership is poor. There are no proper maintenance people, staff are run off their feet, it's a hard job but I don't think the home is well managed at the moment."

We spoke with the registered manager who advised that she had identified a number of issues which she had started to address. She told us that whilst some issues had also been picked up by the provider's quality assurance processes not all had fully been identified. She said that there had been a number of changes of personnel in the past year which could explain the shortfall.

Millbrow adhered to the provider's own internal quality assurance system. This included audits on areas such as care files, accidents and incidents, safeguarding and infection control. The registered manager was also required to report each month to the regional manager employed by the provider. They met monthly and went through previous action plans, current issues and areas to be addressed in the future. We were able to speak with the regional manager and look through samples of the monthly meeting notes. We could see that the registered manager was carrying out regular audits, however, we had concerns about the effectiveness of them.

The audit system appeared to be complicated and based on a "tick box" format. As part of the governance system the registered manager was required to ensure that the care file for one person living at the home was audited each week, either by herself or a senior member of staff. The regional manager was then, in his monthly audit required to check that a care file each week had been audited and then re-audit one of those care files himself to ensure that the original audit had been robust and accurate. We asked the regional manager if he audited the care files and he told us that he would select a care file at random to audit. When we asked if that care file was one of the ones audited that month by the registered manager he replied "No, what would be the point of that?" We pointed out that the purpose of his audit would be to check that the people responsible for doing the majority of the audits in the home were doing them in a thorough and robust manner and that by checking a completely different care file he was not able to assess this.

We checked the audits for the care file related to one person whose nutritional care plan was inadequate because it had not identified that they had type 2 diabetes and had not addressed their significant weight

increase. This person's care file had been audited four times since admission to the home but each time the auditor had ticked to indicate that their nutritional care plan met their needs. This meant there was a significant failure in the quality assurance process.

Despite a range of auditing and monitoring systems being in place, it was evident that findings were not always effectively acted upon. For example, during our inspection we identified concerns relating to: person centred care; safe care and treatment; failure to adequately safeguard service users from abuse and improper treatment; meeting nutritional and hydration needs, failure to notify the Commission of incidents of abuse or allegations of abuse: staffing; poor record keeping and poor leadership and ineffective governance. The above highlights that effective systems and processes had not been established or operated effectively to assess, monitor and improve the quality and safety of the service provided.

During the first three days of the inspection we spoke with the registered manager who advised that she had identified a number of issues which she had started to address. She told us that whilst some issues had also been picked up by the provider's quality assurance processes not all had fully been identified. She said that there had been a number of changes of personnel in the past year which could explain the shortfall. When we returned to the home to complete the fourth day of the inspection the registered manager had resigned and was no longer working at the service. Two managers from other parts of the organisation were managing the home between them and the regional manager was maintaining an oversight on progress. However, we had concerns that four weeks after we had last been in the home, no discernible improvements had been made and the standards of care provided to people had deteriorated further.

This is a further breach of Regulation 17(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to establish and operate effective systems and processes to assess, monitor and improve the quality and safety of the service provided. Furthermore, the registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who may be at risk from the carrying on of the regulated activity.

We asked the registered manager whether she undertook spot checks and observations in order to ensure she was visible on the units and provide leadership and direction to team leaders and support workers. The registered manager told us that she had undertaken regular 'walk arounds' however no records of these checks or the findings had been maintained.

We also asked whether service users had been asked to provide feedback on the quality of their experience of the care provided. The regional manager told us this was undertaken by way of questionnaires being sent to people who used the service and their representatives. However we were unable to review this at the time of our inspection as no questionnaires had been returned.

Periodic monitoring of the standard of care provided to residents funded via the local authority was also undertaken by Halton's Quality Assurance Team. This is an external monitoring process to ensure the service meets its contractual obligations. Millbrow had last received a contract monitoring visit during July 2017. Following the visit, Haltons Quality Assurance Team issued an action plan in response to concerns regarding: infection control; recruitment practice; staff supervision; gaps in recording of care plans and risk assessments. Despite the action plan having been issued, we found similar issues during our inspection.

We looked at maintenance records relating to essential services and general upkeep of the premises. We saw that records were not up to date and the registered manager told us that the home was currently without a maintenance person and therefore the records had not been completed.

The registered manager is required to notify the CQC of certain significant events that may occur in Millbrow. We noted that the registered manager had not always notified the Commission of safeguarding concerns. This meant that the registered manager had not complied with the legal obligations attached to her role.

This is a breach of Regulation 18 (1) (e) of the Care Quality Commission (Registration) Regulations 2009 in that, the registered person had failed to notify the Commission without delay of any incidents of abuse or allegations of abuse in relation to a service user.