

Bupa Care Homes Limited

Mill View Care Home

Inspection report

Bridgeman Street
Bolton
Lancashire
BL3 6SA

Tel: 01204391211

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21 September 2017

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 20 and 21 September 2017 and was unannounced.

Mill View is a care home providing nursing and personal care for up to 180 mainly older people within six houses. It is situated in Great Lever about half a mile from Bolton town centre. The home is situated in its own grounds with garden areas and car parking available at the front of the home.

There was an interim registered manager in place, who had been tasked with managing the home for six months and inducting a new manager within that six month period. 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 identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to medicines and maintaining records. You can see what action we told the provider to take at the back of the full version of the report.

People who used the service that we spoke with told us they felt safe. The recruitment procedure was robust and there were sufficient staff on each of the houses to meet the needs of the people who used the service.

There were appropriate safeguarding and whistle blowing policies in evidence. Safeguarding issues were addressed appropriately and staff undertook regular training in safeguarding.

General and individual risk assessments were in place and were up to date. Health and safety records were complete and up to date. Medicines systems were in place but we found there was some missing medication, gaps in topical medicines administration and unsafe storage of thickener powder.

There was a comprehensive induction programme and training was on-going for all staff. We saw evidence of staff supervision sessions which were undertaken on a regular basis.

The food and drinks were plentiful and nutritious. The environment was clean, bright, pleasant, tidy and clutter free. There were dementia friendly signs to help orientate people living with dementia around the home.

There were appropriate care plans and risk assessments included in the care files. However some recordings were not up to date and monthly evaluations of care plans had not always been completed as required.

Appropriate referrals were made to other agencies and we saw evidence that the home worked well in partnership with other agencies.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People we spoke with told us they were cared for with kindness and compassion and staff were respectful to them. We observed care on the different houses over the two days of the inspection. We saw good, friendly interactions between staff and people who used the service.

There was a service user guide which included information about the services offered. We saw evidence within the care plans of involvement of people who used the service and their families in care planning and review.

People were supported to be comfortable and as pain free as possible when nearing the end of their lives.

There was evidence of activities occurring within the home. Activities included gardening club, musical bingo, manicures, arts and crafts, shopping at Bolton market, table top games, knit and natter, hymn singing and film club. We saw photographs of old Bolton, and old music and film stars to aid reminiscence.

Care plan files examined were easy to navigate through and contained clear, detailed care plans. There was a good level of person-centred information within the plans. However, several of the care plan monthly reviews were not up to date as per the home's procedure.

Residents' and relatives' meetings were undertaken regularly. Customer feedback was also encouraged in each house and we saw the service had responded to some suggestions made. There was an appropriate complaints policy and procedure in place.

Regular meetings were taking place between the home and the CCG regarding issues previously identified on the nursing houses. There was an improvement plan in place and progress had been made with regard to all the concerns.

A number of audits and checks were undertaken on a regular basis. These were followed by action and improvement plans to address any issues identified.

We saw evidence of staff support via one to one meetings, group supervisions and regular staff meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People that we spoke with told us they felt safe. The recruitment procedure was robust and there were sufficient staff on each of the houses to meet the needs of the people who used the service.

Safeguarding issues were addressed appropriately and staff undertook regular training in safeguarding. General and individual risk assessments were in place and up to date. Health and safety records were complete and up to date.

Medicines systems were in place but we found there was some missing medication, gaps in topical medicines administration and unsafe storage of thickener powder.

Requires Improvement ●

Is the service effective?

The service was effective.

There was a comprehensive induction programme and training was on-going for all staff. We saw evidence of staff supervision sessions which were undertaken on a regular basis.

There were appropriate care plans and risk assessments included in the care files.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Good ●

Is the service caring?

The service was caring

People we spoke with told us they were cared for with kindness and compassion and staff were respectful to them. We observed care and saw good, friendly interactions between staff and people who used the service.

There was a service user guide which included information about

Good ●

the services offered. We saw evidence of involvement of people who used the service and their families in care planning and review.

People were supported to be comfortable and as pain free as possible when nearing the end of their lives.

Is the service responsive?

The service was not always responsive.

There was evidence of activities occurring within the home. There was a good level of person-centred information within the care plans. Several care plans had not been re-evaluated monthly as per the home's procedure.

Residents' and relatives' meetings were undertaken regularly. Customer feedback was encouraged in each house and the service had responded to some suggestions made.

There was an appropriate complaints policy and procedure in place. Complaints were addressed appropriately.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Regular meetings were taking place between the home and the CCG regarding issues previously identified. There was an improvement plan in place and progress had been made with regard to all the concerns.

A number of audits and checks were undertaken on a regular basis. These were followed by action and improvement plans to address any issues identified. However, they had not picked up all issues found.

Staff were supported with regular one to one supervision sessions. We saw evidence of regular staff meetings.

Requires Improvement ●

Mill View 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 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.

The inspection was brought forward due to concerns raised by the local authority commissioning team and the Clinical Commissioning Group (CCG) regarding some poor nursing practices within the home.

The inspection took place on 20 and 21 September 2017 and was unannounced. The inspection team comprised of an adult social care inspector, a medicines inspector, two specialist advisors who had professional experience in the areas of nursing and mental health and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This person had experience of older people who used residential services

Prior to the inspection we looked at the information we held about the service in the form of notifications, safeguarding concerns, whistle blowing and complaints. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

During the inspection we spoke with the registered manager, the quality manager, 13 staff, including nurses, care assistants and an activities coordinator and three visiting health professionals. We spoke with 15 people who used the service and six relatives. We looked at six staff files, 21 care files, meeting minutes, training records, health and safety records and audits held by the service. We observed three meal times on different houses to help us understand the experience of people who were unable to speak with us. We also attended a residents' and relatives' meeting.

Is the service safe?

Our findings

People who used the service that we spoke with told us they felt safe and relatives agreed. Comments included; "I feel safe in here"; "I'm sure my [relative] is safe in here"; "No worries at all, yes I do feel safe". We saw that all houses had signing in and out books, key pad locks and fingertip recognition panels to help with security.

During the inspection we looked at six staff files. We saw that the recruitment procedure was robust and each file included an application form, interview questions, job description, terms and conditions of employment, medical questionnaire, two references and proof of identity. Each potential employee was required to supply two references, one from their current employer if possible. Checks had been carried out with the Disclosure and Barring Service (DBS) or the Criminal Records Bureau (CRB). These checks identify people who are barred from working with children and vulnerable adults and inform the provider of any criminal convictions noted against the applicant.

On the days of the inspection there were sufficient staff on each of the houses to meet the needs of the people who used the service. We looked at staff rotas, which evidenced good numbers of staff on each house. A dependency tool was used to help ensure staffing levels were appropriate and we saw that staffing had increased recently on one of the nursing houses to meet people's needs.

We asked people who used the service and their relatives if there were enough staff. Comments included; "Most of the time there are sufficient staff on duty"; "There's enough staff on but we could always do with a bit more"; "There's enough staff, they are always there for you, ready for you when you call for them"; "Sometimes they could do with another person"; "They haven't enough staff"; "There are sufficient staff most of the time".

Prior to our inspection we contacted the local clinical commissioning group (CCG). They told us there had been a significant number of agency nurses employed on the nursing houses which had contributed to the issues with regard to some poor nursing care practices. The home was addressing this in a number of ways, one of which was to recruit more permanent nursing staff and a day and a night nurse were due to start at the home in the next month. They had also put a comprehensive induction programme in place for agency nurses to help them be better equipped to care for people who used the service. The home were also endeavouring to block book agency staff to try to ensure consistency of nurses on the houses. A comprehensive handover was done on each shift change which also helped ensure consistency of care. The registered manager told us the agency was to be contacted following the inspection to discuss collaborative working practices and improvements to practice needed.

There was an appropriate safeguarding policy and procedure and safeguarding issues were addressed and logged. Staff we spoke with were able to explain what safeguarding was and how they would report any issues. The training matrix evidenced that staff had undertaken training in safeguarding. There was a whistle blowing policy in place which outlined how staff could report any poor practice they may witness. 'Speak Up' posters were displayed throughout the home with contact numbers for staff to use in confidence if

required. Staff we spoke with told us they had not witnessed any bullying or victimisation within the home.

We saw that disciplinary procedures were followed correctly. The interim registered manager was currently addressing sickness records. Letters were being sent to people with a high incidence of sickness and absence and the manager was conducting interviews to look at how staff could be supported to have a better attendance record.

A CQC medicines inspector looked at how medicines were managed in the home. We looked at how medicines were stored and checked on four of the six houses at the home. We saw that charts were completed properly, including identification, allergy status, patch application and good management of covert administration.

Each house had a dedicated medicines storage room that was locked and tidy. Temperature sensitive medicines were stored in locked fridges that were monitored in accordance with national guidance. On one house, we saw that waste medication was not stored safely in accordance with The National Institute for Health and Care Excellence (NICE) guidance.

We observed staff giving the morning medicines on one house. One person was given their medicines straight into their stomach via a percutaneous endoscopic gastrostomy (PEG) tube. The person's door was left open whilst the medicine was given via the PEG, which did not maintain the individual's privacy.

On the same house, we found that thickener was not stored safely. Supplies were left unattended in the lounge where people who used the service were sitting whilst the medicines round was taking place. There is a risk of choking if this powder is inadvertently swallowed and it should be kept out of reach of vulnerable people. Thickener powder was stored safely on the other houses we visited. Following the inspection the issues raised regarding safety of thickeners were discussed at the head of departments meeting. Training was also arranged for staff on the safe use of thickeners.

We looked in detail at the medicine administration records (MAR) for fifteen people in the home and six other people who used the service who were prescribed topical preparations applied to the skin. Two individuals had notes in their record that their medicine was not available. One person had not received their regularly prescribed paracetamol for seven days. The second had not had their cream applied, which was later found in the medicines trolley. Following the inspection the registered manager had ensured additional homely remedies had been purchased so that all houses had a stock in case of need.

Some people who used the service were prescribed medicines to be given "when required". Additional information to help staff give the medicine safely was not always available in the MAR chart seen. Some people were prescribed pain-relieving medicines to be taken when needed. Staff did not always record the times when medicines containing paracetamol were given. This is important as it ensures a safe time interval between doses.

We examined the records for medicines applied to the skin (TMAR). Carers were responsible for applying creams and ointments and completing the TMAR chart. All six of the charts we examined had gaps when applications had not been signed as completed. This meant that some individuals did not receive their topical medicines as prescribed. The home responded by ensuring recording of topical medicines was discussed at the next head of department meeting and training booklets were circulated with a memo giving guidelines for completion dates.

Regular audits (checks) were performed by staff to ensure that medicines were managed properly. We saw

evidence of daily, weekly and monthly audits being done across the home. Action plans had been produced for houses that had not reached set targets. However, these audits had failed to address the issues we found during the inspection.

Our findings of missing medication, gaps in topical administration and unsafe storage of thickener powder demonstrated a breach of Regulation 12 (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

General and individual risk assessments were in place and were up to date. We looked at health and safety records and found these to be complete and up to date. We saw a monthly maintenance plan, portable appliance testing (PAT), regular equipment checks and maintenance and regular testing and maintenance of all fire and emergency equipment. Fire records were kept up to date. Water temperatures were regularly checked and there was a current legionella certificate in place. We saw a current gas safety certificate.

Personal emergency evacuation plans (PEEPS) were in a 'grab' file near the entrance of the home. These gave details of the level of assistance each person would need in the event of an emergency and were updated regularly to ensure information remained current.

Is the service effective?

Our findings

We spoke with people who used the service about how effective it was. Comments included; "It's very clean and the food's alright, the staff are very good, they're very nice with you. The staff are very helpful, you can ask them anything. They all work very hard"; "There's not a lot I would change in here, we have nice food and clean beds"; "I couldn't be in a better place, nothing I would complain about"; "They're very good with me".

One relative we spoke with said, "Sometimes the housekeeping could be a bit better". When asked to elaborate they said, "Sometimes the beds are not made and the floors are not clean, but on the whole I'm very satisfied, at the end of the day it's the care. They always contact me if my [relative] has fallen or she's ill".

Staff were required to undertake a comprehensive induction programme and we saw evidence of this within the staff files we looked at. The induction included the completion of all mandatory training, orientation to the home and their role within it, reading of relevant policies and procedures and signing as read. All training and knowledge was evaluated and rated. There were new starter observations which were completed on all aspects of their roles and whilst this was happening these staff were supernumerary. There was a three month probation period to be completed and this could be extended if necessary to help ensure staff were fully equipped for their role. One new staff member told us, "I love my job. I am feeling OK and have settled in now. There is plenty of training".

Training was on-going for all staff and refresher courses for mandatory training were undertaken regularly. Each house had a system to identify when training was due for renewal and this was communicated with the registered manager. Clinical training was available for clinical staff. The training matrix evidenced that mandatory training was up to date, with some refresher courses booked for the near future. We spoke with staff about training and all felt training was readily available to them. However, although staff we spoke knew people they cared for well and were knowledgeable about their individual needs, they demonstrated a very basic understanding of dementia and some were not aware of the different kinds of dementia that could be in evidence or different presentations of the disease in different individuals.

We saw evidence of staff supervision sessions which were undertaken on a regular basis, approximately three monthly. These were individual meetings where progress, personal development, training needs and any issues could be discussed. We also saw evidence of group supervisions where general issues, such as sickness, rota planning, training, care plan audits and dependency assessments could be discussed and information disseminated to staff.

The service had obtained a food hygiene rating of 5, which is the highest rating. We observed different mealtimes on several of the houses. On some of the houses people's special requirements and nutritional needs were listed, but on other houses regular staff were just aware of these requirements. This could be an issue if agency or new staff were serving the meals and a consistent system on each of the houses would have been helpful.

We observed breakfast on one house was observed. People who used the service were offered breakfast when they arrived into the dining room area. People were offered choices of hot and cold drinks and cereals. There was a pictorial and printed menu board in the dining area. There was a calm and relaxed atmosphere in the dining room and people were not hurried to make choices or to eat and drink. Assistance to eat was offered and prompts were made to certain individuals who were repeatedly getting up from the table. Staff were wearing personal protective equipment (PPE), plastic aprons and gloves, when necessary and people who used the service were offered clothes protectors. Most people were sitting in easy chairs around the lounge area rather than sitting at the dining tables. Drinks were seen to be refilled or individuals were given fresh drinks if theirs had gone cold. Staff knew the people well and also knew their likes and dislikes. There were some warm and affectionate interactions observed between staff and people who used the service. Adaptive crockery was available.

We observed lunchtime meals on two of the houses. The menu included a choice of cauliflower soup, vegetable lasagne, sandwiches, salad, yoghurt, ice cream, fresh fruit, tea, coffee, squash and water. The food looked and smelt appetising, and was served nicely on the plates. Adaptive cutlery and crockery was available for the people who required it. We observed the hostess offering food choices to one individual by showing him two different plates of food and explaining what was on which plate. She then gave him sufficient time to make his choice. The atmosphere was calm and relaxed and there were plenty of staff on hand, including the house manager, helping to serve meals and assisting people. Staff were patient, friendly and helpful. Some people were assisted to eat by their loved ones. Some people had to be encouraged to sit at the table, which required patience and professionalism. Drinks were served prior to the meal. The people who used the service were given clean clothing protectors and the staff were wearing PPE. The tables were covered by clean table cloths, with the cutlery set out nicely. Lunch was served from a hot trolley by the hostess. One person who used the service said, "There's a new menu every day and you place your order for the following day. You get fresh fruit as well". Another said, "If there's something you don't want they will bring you something else". A relative commented, "My [relative's] food is pureed, it always smells good, it's the right temperature and is served on time".

The environment was clean, bright, pleasant, tidy and clutter free. There were dementia friendly signs to help orientate people living with dementia around the home. Some bedrooms had name plaques to help people find their own room. There were appropriate pictures around the home and posters with clear information about events and activities. There was a café area which was open on Saturday afternoons and was reportedly well-used by people who used the service and their relatives. One house was found to be malodorous and this was reported to the registered manager who agreed to address the issue immediately. On the same house there had been a leak through the ceiling in the kitchen above the food preparation area. The registered manager addressed this immediately and the ceiling tiles were replaced promptly. Some plastic drinking mugs were seen to be stained and these were replaced.

Appropriate referrals were made to other agencies and we saw evidence that the home worked well in partnership with other agencies. The home worked closely with the advanced nurse practitioner, the tissue viability nurse, the Greater Manchester NHS Mental Health Trust Intensive Support Team (IST) and other professionals. One health professional we spoke with told us, "I have been involved with multi-agency meetings around the recent issues. Things are improving, there are some agency staff but there is improved morale". Another said they visited the home at all hours of the day and found the same good standard of care. They said, "They [staff] always do what we ask of them". We saw detailed evidence within care files of specialist support provided by podiatrists, dietitians and GPs.

The service was involved in the 'Red Bag' initiative. This was designed to meet the requirements of NICE guidelines around transition between inpatient hospital setting and community or care homes. The idea is

that a red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital episode and is returned home with person. The standardised paperwork will ensure that everyone involved in the care for the person will have necessary information about the individual's general health, e.g. baseline information, current concern, social information and any medications. On discharge the care home will receive a discharge summary with the medications in the red bag. The pathway enables a significant reduction in the amount of time taken for ambulance transfer times and for A & E assessment times and reduces avoidable hospital admissions. This could have a significant impact on people who used the service as their experience of moving between services would be less stressful.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw within care files that consent for care had been signed by the person who used the service or their representative. Capacity assessments had been completed and there was evidence of people's abilities with regard to decision making. There were 105 DoLS in place at the service. These were reviewed on a monthly basis by the clinical service manager who flagged up when renewals were due. A new electronic system was to be implemented to ensure all DoLS applications and authorisations were kept up to date.

Is the service caring?

Our findings

We spoke with 15 people who used the service and six relatives. Comments about care included; "Definitely we are treated with respect, they're kind and compassionate."; "Staff are very understanding, they explain what's going on"; "Staff are kind and compassionate, they take a lot of stick off us"; "I'm being well looked after"; "The staff are great with me, they are absolutely wonderful"; "They look after us well"; "They help me get dressed and undressed, they are really good"; "We are well looked after here"; "Staff are always cheerful and make time to talk, they don't rush you"; "I can't fault the place, I have no concerns or worries about [relative] or the care they receive".

Relatives told us their loved ones were clean and well-presented any time they visited. One person said, "My [relative] is always clean shaven which is how he prefers to be. I would recommend this house to others". There were no restrictions on visiting times and a relative said, "I am made welcome any time. The staff are very caring and they respect [relative's] dignity by the way they look after him".

We spoke with 13 staff who all told us they loved the job and felt they were making a difference to people. One person said, "I love the job. The girls and boys on the floor do a cracking job". Staff we spoke with were knowledgeable about people they cared for and spoke of them with respect and warmth.

We observed care on the different houses over the two days of the inspection. We saw good interactions between staff and people who used the service. Staff were friendly, calm and respectful when caring for people and we saw a lot of laughter and friendly banter between staff and people who used the service. Personal care was offered discreetly and dignity preserved when care interventions were given.

We saw evidence within the care plans that people who used the service and their families had a say in how their care was delivered and reviewed. People we spoke with felt they had a good level of involvement in all aspects of their or their loved one's care. We also saw evidence of completion of documentation about people's wishes for the end of their lives. People were supported to be comfortable and as pain free as possible when nearing the end of their lives.

People's bedrooms were personalised and they had their own possessions around them. People we spoke with were happy and comfortable in their rooms.

There was a service user guide for potential new users of the service and their families. This included information about the services offered, activities, safeguarding, sample menu and the complaints procedure.

Is the service responsive?

Our findings

We asked if the staff were responsive to people's needs. One relative said "The staff are very good, they are very patient. Some staff are better than others in recognising people's needs ". One relative had been in to the home to compliment them on their response to their relative's recent period of illness and how this was handled. One person, who was nearing the end of their life, had reported they had experienced their, "Best day ever" whilst undertaking an activity at the home.

Other comments included, "You can talk to staff as if they were your own relatives. If you have got problems they try to help you"; "You are encouraged to make your views known"; "They are responsive, especially if you are unwell, they will get you a doctor"; "Staff always have time to listen to you, they are always there for you".

We asked people about activities within the home. They told us, "They bring me papers every day, I love my papers, once a month they bring communion"; "The garden here is fantastic ,the way it is set out, I'm looking forward to seeing it grow"; "If it's nice or sunny I can take [relative] outside in the garden"; "Plenty going on if you want to join in or if you don't you can just sit back"; "There are different activities in each unit and all residents can use these. They'll get a taxi for you to go to Bolton market. Also there's a hairdresser comes round".

There was evidence of activities occurring within the home, though we did not witness many activities during the inspection. In all houses there was a display of weekly activities, which included gardening club, musical bingo, manicures, arts and crafts, shopping at Bolton market, table top games, knit and natter, hymn singing and film club. We saw photographs of old Bolton, and old music and film stars to aid reminiscence. There had been a summer fayre which some of the people who used the service and relatives had assisted with. This event had raised money for the home which would be used to purchase individual Christmas presents for each person who used the service. All the indoor activities took place on different houses to help facilitate people moving around the building and having a change of scene.

There were six activities coordinators and we spoke with one of them. They had recently undertaken Focused Intervention Training and Support for Dementia (FITS) with two other staff members. The FITS training project promotes person centred activities and social intervention with people with dementia. This provides a framework for understanding and effectively caring for people living with dementia. At the time of the inspection the home were undertaking a 'European Express' to six different countries. This involved tasting the food and looking at the culture of other countries through quizzes and discussions around the language.

We looked at a total of 21 care files on different houses around the home. There were appropriate care plans and risk assessments included in the care files, such as senses and communication, lifestyle, healthier happier life, safety, moving around, skin care, washing and dressing, going to the toilet, eating and drinking, breathing and circulation, mental health and well-being, future decisions. Specific plans were in place where required relating to issues such as pressure care, catheter care and medicines. Risk assessments for issues

such as falls, behaviour and equipment were in place. We saw evidence of falls diaries where required and information about equipment, such as expected mattress settings clearly stated within moving around care plans. Waterlow scores regarding skin integrity were logged and issues such as weights, nutrition and behaviour monitored as required.

All care plan files examined were easy to navigate through and contained clear, detailed care plans. All files examined contained completed 'My day, My life, My story' information. There was a good level of person-centred information within the plans. However although some recordings were clear and complete, some were not up to date and monthly evaluations of care plans had not always been completed as required. We spoke with the registered manager about this and she agreed to address the issues immediately.

We saw residents' and relatives' meetings were undertaken regularly. A residents' and relatives' meeting had been arranged on the second day of the inspection, so we attended this meeting to look at what was discussed. We observed a frank and open discussion about recent problems with change of management and staffing and discussions about the way forward.

Customer feedback was also encouraged in each house and we saw the service had responded to some suggestions made. This had entailed improving the outside lighting, having more entertainers and more trips out.

There was an appropriate complaints policy and procedure in place. We had recently been contacted on two separate occasions by people who felt their complaints had not been addressed as they would wish. This had been when there had been a change of management and some of the complaints had been missed. They had since been addressed to the satisfaction of the complainants. We looked at the complaints log and saw that complaints were now being addressed as per the policy.

Comments from people who used the service and relatives included; "I felt comfortable in raising concerns, and they were handled satisfactory manner"; "If you have any problems or issues they go out of their way to get the answer"; "I am comfortable in raising concerns"; "Yes, I would feel comfortable in raising concerns or complaints".

Is the service well-led?

Our findings

There was an interim registered manager in place, who had been tasked with managing the home for six months and inducting a new manager within that six month period. 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.

Regular meetings were taking place between the home and the CCG regarding the issues identified on the nursing houses. These included wound care, skin integrity, medicines management, infection prevention and control, recruitment and retention. There was an improvement plan in place and we could see from this that progress had been made with regard to all the concerns. The meetings had been undertaken on a weekly basis but had now been reduced to monthly as the progress indicated less involvement from CCG was required. A voluntary suspension had been put in place on new placements on Victoria House to help ensure the issues identified were addressed appropriately before resuming placements.

The service operated a 'resident of the day' process, where each person who used the service had a day when their requirements were assessed to help ensure their needs were being met.

We saw evidence that the new manager and the clinical services manager had undertaken some night visits and some early morning visits at the home. They had recorded any issues they identified and had discussed these at the heads of department meeting to look at improving practice. They reported that on the second night visit, issues identified at the first visit had been addressed.

We saw that a personal care plan audit had been undertaken on one person's file on 11 July 2017. This had scored 57% and was RAG rated as 'RED'. This had identified gaps in the care plan re-evaluation, however not all actions had been completed in line with the recorded timescales. In another file the senses and communication care plan had not been evaluated since 22 July 2017. The bed rails assessment, choices and decisions over care, lifestyle, falls risk assessments (despite scoring high) care plan evaluations had not been updated since 22 July 2017. A third file evidenced that the individual had not had a weight recorded on the weight chart in their file since 08 September 2017, despite the care notes stating that they had lost 10.6 kg whilst in hospital.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported with regular one to one supervision sessions. There were also group supervisions where staff issues could be discussed. We saw evidence of staff meetings, including daily heads of department meetings, where discussions took place around good practice, concerns and issues. There were also regular hostess, kitchen staff, housekeeping and general staff meetings on each house. From the minutes we saw that attendance at meetings was good and discussions included infection control, privacy and dignity, safety, training, weight loss, staff cooperation, activities, uniforms, table settings, special diets,

care plans and documentation.

We asked staff if they felt supported by management. Some had been unsettled by recent management changes but felt improvements were now taking place. One person told us, "There is good management on each house". Another said, "We are well supported and all the staff are good and show me everything". A third staff member commented, "I love working here. I am well supported by [name of house manager]".

There was evidence of the service quantifying and analysing falls on a monthly basis. This were looked at in relation to time of day, location, injury, underlying condition, whether a GP was called or the person taken to hospital, how many staff were on duty and whether agency staff were part of that group. This helped identify trends and patterns and hopefully reduce the number of falls occurring. If a person had suffered two or more falls in a month this was looked at in relation to what could be done for that person as well as the wider analysis.

There were quarterly health and safety and nutrition audits undertaken and action plans produced. We saw actions such as referrals to a GP or dietician from these plans. Clinical metrics were completed weekly, these measures provided insight into operational performance and drove improvements, for example, we saw that an anti-psychotic medicine had been reviewed and ceased because of this. Other audits included the use of bed rails, wounds and nutritional support, and infection control. All were followed by an action/improvement plan. However, the systems in place to monitor and oversee the daily management of the service had not identified the concerns we noticed in regard to medicine management.

There was a daily walk round by the clinical services manager who looked at incidents, staffing and people who were unwell. There was a weekly risk review on each house. A recent review of dependency levels had been carried out and this had resulted in an increase in staffing levels.

The provider undertook a monthly audit and produced an action plan to be worked through. We looked at the action plan for August where some of the actions had been completed and others were in progress.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider was failing to ensure that there were sufficient quantities of medicines to ensure the safety of service users and to meet their needs and were failing to manage medicines safely
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider was failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided