Anchor Carehomes Limited

Mill View

Inspection report

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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

We inspected Mill View on 8 and 15 March 2016 and the visits were unannounced. Our last inspection took place on 14 April 2015 and 21 May 2015 and, at that time, we found there were three regulations which were not being met. These related to the safe management of medicines, safe staffing levels and management of complaints. On this visit we found very limited improvements had been made.

Since our last visit the overall management of the service has been taken over by Anchor Trust.

Mill View is registered to provide accommodation and personal care and support to up to 50 older people and people living with dementia. The living accommodation is arranged over two floors and all of the bedrooms are single with en-suite toilet and shower facilities. It is located a short distance from Bradford city centre and is accessible by public transport.

At the time of this inspection there were 46 people using the service.

There was no registered manager in place. 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.

There were not enough staff, with the right skills and experience, on duty to care for people safely or to make sure their needs were met in a timely way. There were not enough housekeeping staff to make sure the home was kept clean and odour free.

People told us they liked the staff and found them kind and caring. We witnessed some staff practices which demonstrated a lack of respect for people

People told us they felt safe in the home. However, we found staff did not have a good understanding of how to control risks to people's health, safety and welfare.

People told us meals at the home were good and the cook understood people's dietary needs. However, the mealtime experience for people varied depending on which floor they were on or which staff were assisting them.

We found people had access to healthcare services. Safe systems were not in place to manage medicines and people did not always receive their medicines at the correct times.

We found the service was meeting the legal requirements relating to the Deprivation of Liberty Safeguards (DoLS).

Visitors told us they were made to feel welcome and if they had any concerns they would speak to the manager or another member of staff.

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. People using the service and their relatives were not being asked for their views and so were not able to influence the way the service was being managed.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

Staff were recruited safely but there were not always enough staff on duty to meet people's needs in a timely way or to keep the home clean.

Staff did not understand how identify and manage risks to people's health and safety.

Medicines were not always managed safely and given at the correct times.

Is the service effective?

Inadequate

The service was not effective.

Staff were inducted, trained and supported but did not always have the skills and knowledge to meet people's needs.

The quality and variety of meals was good but people were not always being given a real choice of meals or supported to have enough to eat and drink.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met. People were supported to access health care services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind but did not always treat people with respect

Visitors were made to feel welcome and said staff were friendly.

Is the service responsive?

Inadequate

The service was not responsive.

People's care records were not up to date and did not inform people's care and support.

There were very few activities on offer to keep people occupied.

People knew how to raise any concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager and a lack of other senior staff to provide leadership and direction to the staff team.

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

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

Mill View

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 15 March 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience on the first day and two inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. On this occasion we did not ask the provider to a complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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

Over the two days of our inspection we spoke with fifteen people who lived at Mill View, five relatives, five care workers, three night care workers, housekeeper, handyperson , cook, the deputy manager, the manager, support manager and three district nurses.

Inadequate

Is the service safe?

Our findings

When we inspected the service in April & May 2015 we found there were not enough staff to care for people safely. Again on this visit we were concerned there were not enough staff on duty. However, we could see staff had been recruited and once their induction training was completed they would be available to work at the home.

We asked people using the service if they thought there were enough staff on duty to care for them. One person told us, "There were not many on duty when I had my accident, so not a speedy response." A relative told us, "There are not enough staff and the lounge (ground floor) is not always supervised."

We spoke with one of the senior night care workers who told us there should be five members of staff on duty at night. They went on to explain the night staff team should consist of a night care manager, a senior care worker and two care workers. However, they told us on the night shift they had just completed there had only been four staff on duty, as one staff member had telephoned in sick at short notice and they had been unable to cover the shift.

The night of 7 March 2016 had been worked by one senior care worker, a care worker and two agency care workers. This meant there was only the senior care worker to administer medicines across both floors. This meant whilst they were completing this task one of the floors would only have had one member of staff available to respond to people's needs.

One of the people using the service became unwell and needed to go to hospital. The senior care worker sent one of the agency staff with them, which reduced the staffing levels to three. The senior care worker contacted the night care manager who came in to cover the rest of the shift, from around midnight.

The night care manager, prior to being called into cover the night shift, had agreed to cover the day shift. We saw they worked right through until the early afternoon.

The manager told us the service had recently experienced staffing problems and they were reliant on agency staff on both day and night duty to maintain staffing levels. The manager said when agency staff were used they always tried to use the same members of staff so that people received continuity of care. The service only used staff from one agency. The manager said agency staff always worked alongside staff employed by the service and ensured the skill mix and experience of staff on both units was in line with the needs of people who used the service. However, when we looked at the duty rotas we saw night shifts when three out of the five staff were from an agency and one night when four of the five staff who worked were from an agency.

We looked at the duty rota which showed the deputy manager had worked a 24 hour shift one Saturday. We spoke with the deputy manager who told us in the absence of any other staff to give medicines, they had worked from 8am on that day until they had completed the night medicine rounds, then had been available 'on call' in the building should anyone require medicines during the night. We saw from the duty rotas that

week the deputy manager had worked in excess of 72 hours. We concluded this was not safe practice.

We saw the service employed two laundry assistants who covered seven days a week (five hour shifts). This meant that when there was no laundry assistant on duty the care staff took over this role.

In addition, staff told us they were responsible for washing up after meals with the exception of lunchtime when they just had had to rinse the plates off before sending them to the main kitchen to be washed. The care staff told us although they had a dish washer on the unit it was still time consuming and took them away from their main role of providing care and support. On the second day of the inspection the dishes from breakfast and the lunchtime meal were being sent to the kitchen to be washed up but the care staff were still washing up after the tea time meal.

Relatives we spoke with told us the lounge areas were not always supervised as care staff on their allocated floor could be assisting people in their bedrooms or to the toilet.

Staff also told us on a number of occasions on the first floor unit there had only been two staff on duty. This meant if both staff were required to assist one person with their personal care needs there was no one available in the main lounge/dining area to care and support other people. The staff confirmed two people on the first floor unit required the assistance of two members of staff to meet their personal care needs.

At breakfast time we saw one man walking around the corridor in a state of undress, we watched them enter a bedroom, where the female who occupied the room was still in bed. The housekeeper, who was passing the bedroom, supported the man to return to his own bedroom. If the housekeeper had not been in the vicinity there were no care staff offering the man any support or supervision.

On 8 March 2016 we saw an agency care staff member was working on the ground floor. We saw from the rota they had worked at the home before, however, they needed constant direction from one of the other staff and did not interact with the people using the service. We concluded there were not enough staff with the right skills to care for people or to ensure their safety.

The manager told us the service only employed two cleaners to cover seven days which meant there was only one cleaner on duty each day covering a nine hour shift. The manager acknowledged there were not sufficient cleaning hours. We spoke with the cleaner on duty who told us they made sure the bedrooms and toilet areas were kept clean but did rely on the care staff to assist them in keeping the home clean and tidy. We concluded this was not sufficient time to keep a 50 bed home clean.

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

On the first day of the inspection we noted there was an underlying odour of stale urine on the ground floor. One relative said, "It's always smelly and it's been like that for a while." When we returned on the second day the carpets were being professionally cleaned and the offensive odour had been reduced.

Another visitor showed us stains on the skirting board in their relative's bedroom, which had been made from a spilt drink. They said the stains had been there for over two weeks. Both relatives told us the housekeeper was very good but did not have enough time to do everything.

A third visitor told us they rarely brought younger members of the family to visit because they had frequently found faeces in the relative's bedroom.

We saw staff wearing rings with stones in and other jewellery. The manager told us this was against the company policy. We also saw soiled incontinence pads had been disposed of in the clinical waste bins, without being put into a disposal bag first. This meant staff had carried soiled pads from people's bedrooms or toilets to the sluice room, without putting them in a bag first. It also meant the smell coming from these bins was offensive. This was discussed with the manager who told us all staff were aware of the procedure to be followed but had failed to follow it. They told us this would be addressed through supervision and training.

Risks to people's health and safety were not understood and appropriately controlled by the service. Prior to our visit we had received concerns about the management of people's skin integrity from the district nurses.

We looked at one care plan and saw in October 2015 a pressure ulcer risk assessment had identified this person was at high risk of developing a pressure ulcer. No further assessments had been completed until January 2016 when staff had calculated the score incorrectly and identified the risk as still being high. However, if the calculation had been done correctly the assessment showed this person was at very high risk. The care plan had not been updated to show what additional action staff were going to take in order to mitigate the increased risk. We saw in the records this person had subsequently developed a pressure ulcer.

In another care plan the person was receiving treatment from the district nurses for a pressure ulcer. The records showed the district nurses had requested this person's position was changed every hour. We saw from the records this was not always happening and sometimes they were being left in the same position for up to one hour and 50 minutes. This meant staff were not mitigating the risk of further deterioration or tissue damage.

One visitor told us when they had looked at their relative's care plan this showed a weight loss of 7.3kgs over a period of a week. They told us this was clearly a mistake in the recorded weights but said it was very worrying staff had not picked this up and checked the weight.

We saw from the care plans some people had been assessed as being nutritionally at risk and had experienced weight loss. We saw staff were recording what people were eating and drinking but no one was checking these records to make an assessment as to the adequacy of their food and fluid intake. We also saw the portion sizes for people who were assisted with their diet were very small. We saw some people had been prescribed food supplements by their GP. We found two sachets of Complan in the ground floor kitchen cabinet. There were initials on one sachet but nothing to identify who should have received the other sachet. This meant supplements were not being given as prescribed. We concluded there was a lack of planned action to mitigate the risks to people who were nutritionally at risk.

We saw from the complaints file a relative had raised concerns about falls management at the service. They had asked for a sensor mat to be used on their relative's chair, so staff would be alerted by the alarm if their relative got up and could offer appropriate support to reduce the risk of falling. This was agreed by previous management but not provided. They also reported the sensor beam in the bedroom, which sounds the alarm to alert staff their relative was moving was also broken. Following discharge from hospital no falls mat or sensor was in place and their relative sustained two further falls, one of which required emergency hospital treatment. This showed us appropriate action had not been taken to reduce the risks of this person falling and injuring themselves.

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

When we inspected the service in April and May 2015 we found medicines were not always being managed safely and asked the provider to make improvements. On this visit we found ongoing issues with the safe management of medicines.

We saw staff administering medicines with patience and sensitivity, giving people plenty of time to take their medicines.

We found some medicines had been prescribed to be given 30 to 60 minutes before food but saw these were given after people had eaten their breakfast.

We saw eye drops had been prescribed to be instilled for seven days. Our observations showed the eye drops had been instilled until the supply was exhausted amounting to eleven days. Likewise, an ointment had been prescribed to be applied for five days and the skin to be cleaned with a specific scrub for five days. Both preparations were administered for eleven days.

The provider had an 'as necessary' (PRN) protocol in place which gave clear instruction as to when these medicines should be administered. However, we found the policy was not always being followed, for example, one person was prescribed one medicine with the MAR sheet recording 'one to be taken daily – for occasional use'. There was no indication as to why or under what circumstances the medicine could be administered and whilst the care worker said they administered the medicine for nausea they had no knowledge of the alternative potential uses of the medicine. The care worker told us they would urgently address the issue.

We also found one person had been prescribed four different analgesics, two at fixed times and two on an as required (PRN) basis without any instructions as to when any one of the preparations should be used and in what order. The care worker told us the person had the ability to tell care staff what they needed. However subsequent scrutiny of the person's care plan showed they lacked capacity to make decisions and authorisation had been sought regarding Deprivation of Liberty Safeguards (DoLS). Whilst a (PRN) protocol existed for each individual medicine, there was no indication available to direct staff as to which PRN analgesic to try first and at what point another medicine should be tried.

Whilst auditing the controlled medicines we also saw a further discrepancy with this person's medicines. The GP had changed the doses of the medicine they were receiving at night. We found in the two days following the change the medicine had not been administered as instructed. On the evening of the 7th March the person had been administered 10mgs instead of 20mgs. The following morning 20mgs had been administered instead of 10mgs and again at night 10mgs was administered instead of 20mgs. Immediate discussion with the deputy manager confirmed our observations to be correct.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted an audit to account for medicines dispensed in named boxes. We randomly chose five medicines and on three occasions we found discrepancies where the numbers of tablets taken and the number of tablets in stock did not tally.

We saw the recording of Warfarin was substandard which did not allow for the accurate accounting of which dose of the medicine had been administered. For example, the MAR sheet showed warfarin in three doses of 3mgs, 1mg and 500mcg had been dispensed yet care staff did not record which preparation had been used. Staff recorded on the reverse of the MAR the date, time and dose of warfarin administered. However, when a dose such as 4mgs was administered we did not know whether four 1mg tablets had been given or one 3mgs and one 1mg tablet. This made reconciliation of stock levels difficult. We concluded medicines were

not being safely managed and not always administered in line with the prescriber's instructions.

We found one person's prescribed cream in one of the kitchen cupboards. It was for use on the individual's buttocks and had been left in a cupboard with plates and dishes. We asked one of the care workers why it was in that cupboard and they said, "Don't know why that's in there really." We gave the tube of cream to a senior member of staff and told them where we had found it. They told us it was the night staff that had put it in the cupboard and it should not be there. This meant this cream was not being stored appropriately.

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

When we looked at the care files we saw there were personal evacuation plans in place for people should an emergency arise. However, some of the information was out of date. For example one person was described as being mobile with a walking frame, but they were being cared for in bed. We looked at the emergency evacuation file and found it contained 50 individual fire evacuation plans, many of which had been completed in March 2015 and were out of date. At the time of our inspection there were only 46 people who used the service. This meant should a fire break out there was not accurate information about the number of people using the service or their needs in an emergency situation.

We saw service and inspection records for the lift and hoists, water quality and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested or were currently in the process of being tested. We saw fire-fighting equipment was available and emergency lighting was in place. However, the manager was unable to find the gas certificate or electrical wiring certificate for the home. This meant we could not assure ourselves of the gas and electrical safety in the home.

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

We saw the food standards agency had inspected the kitchen in 2015 and had awarded them 5* for hygiene. This is the highest award that can be made. This meant food was being prepared and stored safely.

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

We saw there was a recruitment and selection policy in place which showed all applicants were required to complete a job application form and attend a formal interview as part of the recruitment process. The manager told us during recruitment they obtained at least two written references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people.

We saw there was a disciplinary procedure in place and the manager told us if they found a member of staff was no longer suitable to work in a health or social care setting they would make a referral to the appropriate agency, for example, the Disclosure and Barring Service. This meant action was taken if staff were not performing to the required standards.

We looked at four staff employment files and found all the appropriate checks had been made prior to employment. However, the files were disorganised and in one instance the service had accepted a reference from an organisation not shown in the work history section of the applicant's application form. The manager was unable to explain why this not been picked up and challenged at interview.

The staff we spoke with told us the recruitment process was thorough and done fairly. They said they were not allowed to work until all relevant checks on their suitability to work with vulnerable adults had been made.

Inadequate

Is the service effective?

Our findings

The manager told us all new staff completed induction training on employment and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. This was confirmed by the staff we spoke with.

We saw four new staff members who were completing their induction training and spoke with two recently employed staff who told us the induction training was very good, was completed over a two week period and included written assessments and competency tests. The manager confirmed that following induction training all new staff completed a programme of mandatory training which covered topics such as moving and handling, dementia awareness, infection control, food hygiene, health and safety and safeguarding.

The training matrix showed the majority of staff were up to date with their mandatory training. There were systems in place which triggered when individual staff needed to update their training.

The manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings with their line manager and their annual appraisal. The supervision and appraisal record showed 37 staff were employed by the service and 10 had recently been employed and were training or shadowing permanent members of staff. Of the remaining 25 staff 18 had received formal one to one supervision and 12 had received an annual appraisal. This meant not all staff had received formal supervision to discuss their performance and personal development.

We asked relatives and the district nurses if they felt staff had the skills and experience to provide people with appropriate care. One visitor gave us the names of two members of day staff who they felt understood their relative and provided appropriate care and support. They felt other members of staff needed more training.

One of the district nurses told us they had seen staff squirting pro-shield into a bowl of water. This is a cleansing product which needs to applied directly onto the skin to be effective. They had raised this with the deputy manager whose response had been, "I have always done it like that." Another district nurse told us training had been delivered to all staff about prevention of pressure ulcers. This was done to help staff to understand the importance of good pressure area care. However, both district nurses reported this had made little difference and they were still finding people using the wrong pressure relieving cushions or not sitting on one at all.

During the two days of inspection we identified issues with infection control procedures, pressure sore prevention, catheter care, health care, nutrition, care planning, risk management, dignity and respect all of which led us to conclude staff required more training and support to ensure they had the skills to fulfil their role.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

After considerable searching for relevant information we established an agreed position with regard to one person who was subject to DoLS and who had an authorisation pending with the supervisory body. One person was subject to an authorised DoLS. We saw the supervisory body had attached one condition to the authorisation which had been enacted.

We saw documents indicating a further 20 applications had been made dating back to 11th June 2014. These 20 applications had not been progressed to either a conclusion of authorisation or rejection. The provider had recorded correspondence with the supervisory body. Records showed the provider had discussed the backlog of application on 8th December 2014. The records indicated the supervisory body viewed the applications to be valid but of a low priority. However the record also showed the supervisory body had said they should be made aware if any people's conditions changed and if necessary an urgent application made. We saw one person to whom the supervisory body referred on the 8th December 2014 had experienced a decline in their mental health and had recently been reviewed by the mental health team. We also saw the person constantly wanted to leave the home and on occasions shouted, "Let me out." Care records also recorded the person saying they felt to be imprisoned. Despite records showing a decline in the person's mental health the supervisory body had not been made aware of this. We saw another person who spent large parts of their day asking to leave the home and banging on doors. Our observations of their behaviour and their care records indicated to us this was not a low priority matter. The manager told us they would speak with the supervisory body and make them aware of people's changing health status.

We asked people what they thought of the meals in the home and the reviews were generally positive. One person said, "There's not as much choice as there used to be, it's more repetitive. There are usually two choices and sometimes we get treats of chocolates and crisps." Another person told us, "The food choice and delivery is good." A further two people said, "There's a good and varied breakfast service with top ups when you ask."

We spoke with the cook who told us staff informed them of people's dietary preferences and specific dietary needs. They also told us staff informed them if people were losing weight and explained how they fortified meals with butter and cream to provide a high calorie intake. We saw butter, cream, and full fat milk were being used. We also saw homemade chocolate cake, flapjacks, crisps, chocolate biscuits and marshmallows were available.

On the first day of the inspection we observed the mealtime process on both floors and found people's experience depended on whether they resided on the first floor or ground floor. We found issues on the ground floor where the majority of people were living with dementia.

We found the meal time experience on the ground floor to be disorganised and not a pleasant, social

experience. People were not served meals and drinks in a timely way and staff were not enabling people to make informed choices.

At breakfast time on the ground floor we saw tables had been set with tablecloths, linen serviettes, cutlery and crockery. There were no condiments on the tables. We heard staff offering people a choice of cornflakes, porridge or cooked breakfast. Mostly the staff member decided for the person based on what they usually ate. No one was offered any fruit juice and people were only offered tea to drink. The tea was made in a large pot in the kitchen area, poured and taken to the individual. Service was slow with some people waiting over 25 minutes to get anything to eat or drink. We saw people getting agitated and restless, getting up from the tables and moving away.

We saw some people were having their food and fluid intake monitored. We noted at 11:20am nothing had been entered on any of these charts. We also saw one member of staff had given one person a cup of tea, which they did not drink. Another care worker came to assist and one of the inspectors pointed out the tea was now cold. This care worker made a fresh beaker of tea and gave it to the person. As neither care worker made any entry on the chart the effectiveness of the monitoring was questionable.

We saw one person being offered a late breakfast. The communication between the agency worker and the individual was poor, with clear misunderstandings; resulting in the person getting a different breakfast to the one they had ordered.

At 11:50am we asked one of the care staff if people had been given a mid-morning drink and snack. They told us usually people would have had a drink and snack between breakfast and lunch but this had not happened. We then saw people being given drinks of juice and snacks at 12:20pm.

At 12:35pm people were being asked to go and sit at the dining tables ready for lunch. Tables had been set with tablecloths, linen serviettes and cutlery. We saw the knives and forks had been put in the wrong positions (knives were on the left and forks on the right). We asked the care worker who had set the tables if they were left handed as the knives and forks were the wrong way round. They told us, "No, it's just the way I do it."

We saw the picture board menu showed a choice of sausages or minced beef, mashed potatoes and mixed vegetables. We heard staff offering people with advanced dementia if they wanted meat pie or frittata. This got more complicated as staff tried to describe what a frittata was. One of the inspectors asked staff to show people on one table the two plates of food so they could make an informed choice. They did this but did not use the visual prompts with anyone else. We saw staff served the frittata with mashed potato, broccoli, carrots and then poured gravy on it. People were not asked if they wanted gravy and we found this to be an unusual combination.

We saw one person finished their meal and was scraping their plate with their knife and then licking the knife. Staff did not pick this up and did not intervene. One of the inspectors asked the person if they would like some more lunch and they said they would. Staff then served them with a second helping, but would not have done this without being prompted.

People were given blackcurrant squash part way through the meal, apart from three people sat on one table. The inspector asked them if they would like a cold drink and one person said, "That would be nice." The inspector pointed this out to two different members of staff but neither of them responded. The inspector went and got a jug of juice and checked with the deputy manager that there was no reason why the three people could not have a drink of juice. They said they should have been served with one already.

At 3:45pm we saw staff serving drinks and snacks. We saw them put marshmallows, Cheesy Wotsits, crisps and a finger of Kit-Kat all on the same plate and then serve it to people.

We spoke with the acting manager about the mealtime process and our observations. They told us they were disappointed as mealtimes had been discussed in individual staff member's supervision sessions. We concluded staff required additional training and support to understand the importance of creating a good dining experience.

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

We attended the handover between night staff and day staff on both inspection days. We noted where any issues with people's health had been identified, staff were making decisions to involve the GP or district nurse. One relative told us, "They do call a GP if (name) is unwell." Care records showed us the community mental health team were involved with some people and people had been seen by the optician and chiropodist.

The district nurse team visited the home every day and staff often asked for their advice. One of the district nurses told us on one occasion they felt staff should have contacted the emergency services, rather than wait for them to visit. We concluded staff were involving health care professionals but needed additional training to make sure they sought the most appropriate treatment.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service about the staff. One person said, "The girls [staff] are very nice." Another person told us, "Things have always gone well for me and I'm happy." A third person said, "I don't know whether I dare ask things;" and a fourth person, "They are good but how do you find out things if people don't tell you or talk with you?" One relative told us, "I have written Mum's life history twice but it is still not in her care plan."

We found people's experiences of the care they received was not consistent.

We saw practices that showed a lack of respect for people. These were some examples: In the ground floor lounge the orientation board was showing the right date of 8 March 2016, however, the clock was showing 9 March 2016 as the date. We saw a care worker dropped a piece of cutlery on the floor, picked it up and used it to set the table. We saw one person putting their hands in another person's food. The care worker asked them to stop and moved them to another table, but did not replace the other person's food.

We heard staff referring to people who were receiving end of life care as 'the palliatives' and also saw this terminology being used in someone's daily records. We also heard staff referring to people as 'the doubles' meaning people who required the support of two staff to meet their care needs. This showed a lack of respect for people.

We saw one person sitting in the lounge with just their nightdress on, they told us they were cold. We told a member of night staff and they brought the person a dressing gown. The person then asked the inspector if they could get them some slippers because their feet were cold. This request was again communicated to a member of night staff, who brought the person a pair of sandals. We asked the care worker if the person had any slippers and we were told they were in the laundry.

On the ground floor there was a second lounge with doors to a secure outside garden area. The doors were locked and had a sign on them stating "Do not open." We asked the handyperson about this and they told us one of the hinges on the door had been broken since May 2014, which made it hard to open. We saw one person go into the lounge and they wanted to go outside, but was unable to as the doors were locked.

We saw staff missed opportunities to maintain people's skills and independence. For example, staff poured people's cold drinks at lunchtime. When one of the inspectors gave one of the people using the service a jug of juice they happily poured themselves a drink and one for the person sitting next to them. Staff did not ask anyone to assist with setting the tables or to wash up. On the second day of our visit tea pots and milk jugs had been put on the breakfast tables but staff made the tea in a large pot in the kitchen area and took the cups off the tables to pour milk and tea into them. Having empty tea pots and empty milk jugs on the table seemed to add to people's confusion.

We saw people's experiences of care and support depended on the skills, experience and understanding of the staff who were on duty. We have therefore concluded staff required more training and support so people

received consistent care and support.

After lunch we saw one person had a dish cloth and was trying to wipe the tablecloth. There was a full glass of juice on the table and although staff were in the room it was a relative who stopped the drink being spilt on the floor. Staff and this person's relative told us they loved to clean, however, on neither of the two days we were present did staff encourage them to do this.

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

We asked people who used the service if they were involved in planning their care and if they knew about their care plan. One person said, "What's that? (meaning care plan) Never heard of it."
This was echoed by all other people we spoke with. Two visitors told us they looked at their relative's care plans so they could check their welfare and to find out what was going on. Another relative told us they had never been involved in the care planning process and did not know what it was.

One care worker we spoke with told us they used the life histories in people's care plans to reminisce with people and to find out about their past lives and experiences. We saw some care workers interacted well with people getting down to their level to engage them in conversation.

We noted some conversations with people were kind and respectful with people being given explanations as to what was happening. For example; one person could not remember the outcome of a recent GP visit. They asked a member of staff who told them the GP had prescribed a new medicine and explained what it was for and why they needed to take it.

We saw some staff knew people well, including their likes and dislikes and how they liked things done. We observed staff chatting with people about their families and things they enjoyed and people responded positively.

Visitors we spoke with told us they were made to feel welcome and said staff were friendly. They also told us staff would make them a drink or they could do this themselves if they wanted. Relatives also told us they could stay for a meal if they wanted to.

Inadequate

Is the service responsive?

Our findings

We looked at six care plans and found most were out of date and did not reflect people's current needs. Many had been formulated in 2014 and had not been reviewed since September or October 2015. This meant staff did not have clear care plans to follow to make sure people's needs were being met.

On the first day of the inspection at breakfast time we heard one person asking to go to the toilet repeatedly for 15 minutes. The care worker acknowledged this request but nothing happened. The person was becoming distressed and said, "I'm weeing and all now." One of the inspectors brought this to the attention of the care worker in the dining room who said, "The other staff are doing the 'doubles' (meaning people who require the support from two members of staff to meet their needs) and I can't leave the floor." It was a further 10 minutes before this person was taken to the toilet.

On the second day of the inspection we saw the same person asking to go to the toilet and having to wait until two members of staff could assist them. We saw on both occasions this delay was because two staff were not available to support them. We concluded there were not enough staff to respond to people's care needs in a timely way.

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

We spoke with a visitor who raised concerns about the management of their relative's continence needs, as when they visited they have often found them 'wet through.' They told us when their relative needed to go to the toilet they became agitated, unsettled and started to rub their legs. They went on to explain when their relative had been in hospital, they had been assisted to the toilet every 2-3 hours and this enabled them to remain comfortable and settled. We looked at this person's continence care plan, which had not been updated since October 2015. It did not give staff any guidance about how often staff should offer to assist them to the toilet or about the management of the continence products they were using.

Another visitor told us their relative's incontinence pads were often soaked and urine had gone through to their clothing. Both relatives said people were not taken to the toilet unless they were able to ask.

A third visitor told us their relative was prone to developing urinary tract infections and did not think staff made sure they had enough to drink. We looked at their care plans and there was no guidance for staff about how much they should be drinking or about any additional checks which should be made to detect any early signs of infection.

The district nurses we spoke with also told us people's continence needs were not well managed and they frequently found people wearing urine soaked and faecally stained incontinence pads when they were delivering nursing support. They also said they rarely saw staff taking people to the toilet.

This showed us people's continence needs were not being met. Suitable risk assessments were not in place

to inform staff about what action they needed to take to meet people's continence needs.

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

We spoke with two district nurses who told us, staff did not always follow their instructions. One told us they had asked for one person to be repositioned every hour to prevent further damage to their skin. Staff had not evidenced on the repositioning charts that this had been done and the district nurse reported the pressure sore had got worse. The other district nurse had asked staff to get one person ready for a special test. This had not happened and the district nurse had to return in the afternoon to complete this task.

On the first day of our visit one of the district nurses had been asked to see someone who had fallen the previous evening. The district nurse told us when they sat the person up in bed, they complained of feeling sick. The district nurse asked a member of staff for a sick bowl. The member of staff told them they were on the trolley and offered no further assistance. There were none on the trolley so the district nurse took one from someone else's bedroom.

We asked people using the service what activities were on offer to keep them occupied. One person said, "A lady comes in for exercise, but it's very short staffed and there isn't time to bother with people." Another person told us, "There's very little activity, no outings or trips!" A third person said, "There's not much to do here." Another two people said, "We don't do anything during the day." A sixth person said, "It would be nice to get out more, I sit here and look out of the window, it's busy down there." A seventh person told us, "I watch the world go by." One relative told us, "There is not much going on to keep people occupied."

The manager told us the service did not employ an activities co-ordinator and therefore the care staff had to arrange activities for people as and when they had time. There was a daily activities programme on the notice board on both floors of the home.

On the first day of the inspection we spent time in the ground floor lounge during breakfast and lunch staff put on music, which some people were enjoying one was singing and others were clapping and tapping their hands or feet in time to the music. However, having music on during the meals meant people were not being encouraged to interact during the meal to make it a social occasion. After breakfast there was no music and nothing going on to keep people occupied. We saw people falling asleep after breakfast there was very little interaction with staff.

There were notice-boards on each floor stating what activities take place during the week. However, on the first day of our visit we saw the activity in the morning was listed as 'singing with staff, and in the afternoon 'nail treatment and art by staff', we saw neither of these activities took place.

We concluded there was a lack of activities and occupation for people using the service.

When we inspected the service in 2015 we found complaints were not always being recognised or responded to. We asked the provider to make improvements. On this inspection we found the complaints procedure was not on display, however, the relatives we spoke with told us they were aware of the complaints procedure and would have no hesitation in making a formal complaint if they felt the manager or staff were not listening to their concerns. We looked at the complaints log and saw complaints which had been received had been investigated and responded to; apart from one which the manager told us they had investigated and were in the process of making a response. This showed us complaints had been identified and taken seriously.

Inadequate

Is the service well-led?

Our findings

The provider for Mill View was Ideal Carehomes Limited, which has been taken over by Anchor Trust within the last 6 months. This has not changed the registration.

The registered manager left after Christmas. Other staff had also left or were in the process of being performance managed. This had left a heavy reliance on agency staff until new staff had completed the induction process.

Anchor Trust put a temporary manager in place in January 2016 who told us they have been 'fire fighting' as there had been so many issues to address. We spoke with the new district manager following the first day of inspection. They put an immediate voluntary suspension on admissions at the home and arranged for the regional home manager to assist the manager. They told us new admissions to the service would not take place until improvements had been made and the service had been stabilised.

A new manager had been appointed but had not taken up their position at the time of our visit. Staff who had met the new manager told us they were very approachable.

Following our feedback on day two of the inspection they sent us an improvement plan telling us what improvements they would make within very tight timescales. This showed us the provider had taken our concerns seriously and took immediate action to make improvements.

We asked people using the service who was in charge and no one was able to tell us who the manager was. One relative told us, "It's disorganised and there is a lack of leadership and direction." This view was shared by the two district nurses we spoke with.

On the first day of the inspection, other than the manager and deputy manager the service had no senior care staff on day duty. This meant the care staff, many of them employed through an agency, lacked leadership and direction.

The manager confirmed they used a dependency tool to establish staffing levels. However, they confirmed it did not take in to account the size or layout of the building which might affect response time to call bells. We concluded this tool was not effective as there were not enough staff on duty to meet people's needs in a timely way.

The main office was disorganised and the manager had difficulty finding some of the records and reports we requested. For example, the gas safety certificate and electrical wiring certificates could not be found.

The manager and other senior manager who was present on the second day of our inspection were very open and transparent about the lack of documentation and told us many of the audits had not been completed and they had been unable to find records in the office.

We wanted to see how people were consulted about the management of the service. We asked to see residents and staff meeting minutes we were given a file, but the last documented meetings were in January 2015. We asked to see the results of any quality assurance surveys but were told there were not any which could be found. This meant we could find no evidence of people being consulted about the way the service was run or how they could influence any changes.

We saw some audits were taking place for example audits of medicines, pressure sores, care plans and weights. However, these were not effective and had not picked up issues identified at the inspection. For example, risk assessments and care plans being out of date.

There were no audits taking place in relation to dignity in care or people's mealtime experience.

We asked to see the provider visit reports, but were told by the manager none had taken place.

During the inspection we found issues in a number of areas such as the premises, infection prevention, dignity in care, medication, planning of care, staff training and staffing levels. If there were effective systems in place all of the issues should have been identified by the provider and measures put in place to ensure they were rectified. We concluded there were no effective quality systems in place.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably qualified, competent, skilled and experienced staff. Staff had not received appropriate support, training and supervision to enable them to carry out their duties Regulation 18 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

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

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to mitigate the risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided.The provider did not act on the feedback they received from relevant persons.Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

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