Valley View Residential Homes Ltd

Valley View Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 and 18 July 2017 and was unannounced. We last inspected the home in February 2017 and found the provider was breaching the regulations in relation to safe care and treatment; meeting nutritional needs; good governance and staffing. Following the inspection we issued warning notices for the breaches of regulation relating to staffing and good governance and requirement notices for the other breaches. The home was rated inadequate and placed in 'special measures'. The provider did not submit an action plan in line with legal requirements following our inspection in February 2017 to show how they planned to meet the regulations. During this inspection we found the provider continued to breach the regulations in relation to safe care and treatment and good governance.

Valley View Residential Care Home is registered to provide accommodation for people who need personal care. It provides a service primarily for older people, including people living with dementia. There were 27 people living there at the time of this inspection.

The home did not have a registered manager. The deputy manager had taken up the post of acting manager with support from an external consultant. 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.

Due to a lack of management oversight at the home progress towards improving the service and meeting the regulation had been delayed. The provider had only just developed a comprehensive improvement plan for the home with most actions not yet commenced.

Quality audits were not completed regularly or consistently such as bedroom and kitchen audits and monthly checks of airflow mattresses and pressure prevention cushions had not been completed since March 2017. Medicines audits lacked scope and detail and not been effective. A new medicines policy was not specific to the home or fit for purpose. Safeguarding concerns, incidents and accidents were not monitored or analysed.

Medicines were not always managed safely. We found shortfalls with the storage and recording of medicines.

Medicines care plans were not in place to guide staff as to people's support requirements to ensure people received their medicines as prescribed.

People, relatives and staff told us the home was safe.

Staff showed a good understanding of safeguarding adults and the provider's whistle blowing procedure. They knew how to raise concerns but told us there hadn't needed to.

There were sufficient staff deployed when we inspected the home. This was confirmed from feedback we received from people, relatives and staff and from our own observations. The provider had effective recruitment checks in place. Pre-employment checks were carried out to ensure new staff were suitable to work at the home.

There were regular health and safety checks in place to help keep the premises safe, such as checks of fire safety check; hot water temperatures, emergency lighting, gas and electrical safety. We observed that staff used equipment such as moving and handling equipment correctly.

Where potential risks had been identified, a risk assessment had been carried out. Risk assessments had been completed for a range of areas such as moving and handling, falls, malnutrition and pressure ulcers.

People and relatives were happy with the care they received and the staff providing it. We found a small number of times when staff weren't as attentive to people's needs as they should be.

Staff confirmed they felt supported, however formal one to one supervisions and appraisals were not being completed. Staff were undertaking training and apprenticeship programmes to develop the skills and knowledge they need in their role. This was on-going when we inspected with some training such as moving and handling having been completed in full.

People received the care and support they needed to ensure their nutritional needs were met. People and relatives gave mostly positive feedback about the meals at the home. Where people needed assistance or specialist equipment this was provided. Accurate diet and fluid records were kept for each person.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. Information relating to whether people had appointed a lasting power of attorney (LPA) was not available.

People were supported to access health care services when required. They was regular input into the home from community health professionals, such as GPs, community nurses, occupational therapy, speech and language therapy and physiotherapy.

Work had commenced to make the environment more 'dementia friendly.' However, this required further development. People living with dementia on the first floor of the home had limited space available to move around and were restricted as to the areas of the home they could access.

There was currently no activity co-ordinator employed at the home. Most activities were based around group activities. Where specific activities were identified as being suitable for individual people, these were not usually available. During the two days of our inspection there were some activities provided, such as bingo, time in the garden and reminiscence. People and relatives had mixed views about the availability of activities.

Care plans were in place and were based on people's needs and preferences. Some care plans had been re-written for priority areas such as nutrition and moving and handling. Other care plans required updating.

Opportunities for people and relatives to give their views required further development. Relatives told us meetings did not take place very often. Relatives, staff and health and social care professionals gave positive feedback about the acting manager.

Relatives' surveys had been carried out with positive feedback given. However, the views of people using the service had not yet been gathered.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Requires improvement' and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not consistently managed safely.

People and relatives felt the home was safe.

There were sufficient staff deployed at the home.

Effective recruitment processes were in place.

Regular health and safety checks were carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff confirmed they felt supported. Supervision sessions, however had lapsed and staff had not received an appraisal.

Staff were undertaking an extensive training and apprenticeship programme.

The provider was not always following the requirements of the Mental Capacity Act (2005) MCA including the Deprivation of Liberty Safeguards (DoLS).

People were supported to with their nutritional needs and to access health care services when required.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed a small number of occasions where staff did not respond quickly enough to people's needs.

People and relatives were happy with the care provided.

Staff were kind, caring and considerate. People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did always have the opportunity to participate in activities that met their choices and preferences.

People had care plans in place and some had recently been updated.

Opportunities for people and relatives to give their views needed improving.

There had been no complaints about the service.

Is the service well-led?

Inadequate

The service was not well led.

The home did not have a registered manager.

Progress towards improving the service and meeting the regulations had been delayed.

Quality assurance needed improving as audits were not completed regularly or consistently.

There had been a significant delay in developing a staffing tool.

People, relatives, staff and health professionals gave positive feedback about the acting manager.

Valley View Residential 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.

This inspection took place on 17 and 18 July 2017. The first day of inspection was unannounced. The second day was announced. This meant the provider knew we would be coming.

On 17 July 2017 the inspection was carried out by two inspectors. On 18 July 2017 the inspection was carried out by one inspector, a pharmacist inspector 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.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also had contact with the local authority commissioners of the service and the clinical commissioning group (CCG). During the inspection we spoke with a GP, two district nurses and an external vocational training assessor.

We did not ask the provider to complete a provider information return (PIR) prior to the inspection. 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 spoke with eight people who used the service and nine relatives. We also spoke with the acting manager, the provider's representative, a senior care worker, a team leader, seven care workers and a member of domestic staff. We looked at a range of records which included the care records for five people, medicines records, recruitment records for five care workers and other records relating to the management, quality

and safety of the service.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in January and February 2017 we found the provider had breached the regulations relating to safe care and treatment and staffing levels.

We found the provider had continued to breach this regulation. We found equipment used to administer medicines was not always clean. We found that medicines pots contained left over powder and spacer devices which are used to assist people in using their inhalers had not been cleaned. Ineffective cleaning of pots increases the risk of cross contamination from residues and increases the risk of declining health due to poor infection control management.

Room and medicines fridge temperatures were recorded daily. Fridge temperatures had been recorded outside of the recommended range on six occasions in July 2017. No action had been recorded as being taken by staff. However, the manager told us they had recently had to restock the medicines fridge due to temperatures not being correct, this was not recorded.

We identified discrepancies in the recording of stock balances of medicines for 10 of the 16 records we reviewed. Carried forward values were not always recorded making stock balance records difficult to determine. This meant we could not be sure that medicines had been administered as prescribed. Where people's medicines administration records (MARs) had been handwritten two staff had not always signed the entry in line with national guidance.

Medicines care plans were not in place in people's care files. There was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only as and when people required them. For example, two people were prescribed a laxative, but there was no information to guide staff when to give this medicine and so the medicines were being given regularly, even days when the person didn't require them. Other people were prescribed pain relief tablets. However, staff did not record the reasons for administering the medicines or if the medicines had had the desired effect. This made it difficult for staff to determine what steps to take next to keep people safe, comfortable and free from pain. Some medicines were prescribed with a variable dose, such as one or two tablets to be given. We saw the quantity given was not always recorded meaning records did not accurately reflect the treatment people had received.

One person kept a small quantity of medicine in their room. Although this medicine was secure, no risk assessment had been completed and no care plans were in place. The medicine was not held in a labelled container so staff could not identify how long the medicines had been in the room. We asked staff to address this during the inspection, as we could not be sure these medicines were fit for use.

Where topical preparations were prescribed such as creams and ointments, senior care staff signed the MAR chart as administered. However, these preparations were often administered by care staff or night staff. We checked application records in people's rooms and found the number of administrations recorded did not always match the signatures on the MARs. This meant we could not be sure creams had been administered as prescribed.

The home had recently received a new medicines policy from a consulting firm. This policy was not specific to the home or fit for purpose. The policy had also not been circulated to staff to read and sign.

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

We checked staffing levels at the service. One person said, "They respond to the buzzer straight away normally." Most relatives told us there were sufficient staff. One relative commented, "Staff are always available." Staff told us that more staff had been recruited. Comments included, "There has been a big improvement in staffing"; and "It's better than it was." This was confirmed by our own observations. One person set off their bed sensor whilst we were speaking with them. We observed staff arrived within a short time to check they were safe. Staff carried out their duties in a calm unhurried manner and had time to provide emotional support to people.

Risk assessments were in place which had been identified through the assessment and support planning process. We noted risk assessments had been completed for a range of areas such as moving and handling, falls, malnutrition and pressure ulcers. The acting manager told us, "If we see a risk we act on it." This meant risks were minimised and action was taken to help keep people safe. Care plans had been updated with priority areas being completed first, such as in relation to nutrition and moving and handling. Staff were usually attentive and took care to maintain people's safety. However, on one occasion we observed a staff member leave a full cup of hot tea on the arm of a chair next to a person. A visitor intervened and poured some tea out and added extra milk to cool it down.

We carried out specific observations in communal areas throughout the home. We saw staff followed the correct moving and handling procedures. Guidance was available to instruct staff how to keep people safe when assisting them. We observed staff using the mobile hoist on four occasions we well as other specialist equipment. We noted this was done correctly and safely. Staff reassured people and informed them what they were doing. Staff commented, "Can you just lean forward so I can put this [sling] behind you?"; "Nearly there, you're doing so well"; and "You're going up in the world" to which the person smiled. There were moving and handling slings available to assist with transfers. The manager told us they were ordering slings for individual people to ensure the correct sling was used and also to reduce the risk of cross infection.

Other specialist equipment was available depending on people's individual needs. For instance, equipment was available to reduce the risk of pressure ulcers. Pressure relieving cushions and mattresses were used if the person had been assessed as being at risk of skin damage. We found equipment was used correctly and electronic pressure relieving mattresses had been set with the person's weight.

People and relatives told us they felt the home was safe. Comments included "Yes I do feel very safe here. I am safe, both mentally and safe at night as well, nobody bothers me"; "When I fall there is someone there to pick me up straight away"; and "It's a nice place, I have nothing to worry about I am safe, everything is hunky dory."

Staff showed a good understanding of safeguarding adults and the provider's whistle blowing procedure. In particular they were knowledgeable about what action they should take if abuse was suspected. Staff members commented, "I would have no hesitation in reporting anything"; "I have never witnessed abuse in this care home. I would report it straight away, I wouldn't tolerate it"; and "I wouldn't hesitate if I was worried or concerned. I would speak with [acting manager] or senior or go further." We viewed the safeguarding log which showed previous safeguarding concerns had been referred to the local authority safeguarding team and investigated.

Staff told us recruitment checks were carried out prior to them starting. One staff member told us, "I couldn't start before they [recruitment checks] all came back and they took a while. I also have a transferable DBS [Disclosure and Barring Service check]." We viewed staff files and found there were effective recruitment processes in place. These included a range of pre-employment checks, such as requesting and receiving references and DBS checks for new applicants. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable adults.

The premises were clean and there were no offensive odours in any of the bedrooms or communal areas we visited. Staff had access to personal protective equipment such as gloves and aprons. Regular health and safety checks were undertaken to ensure the premises were safe. Fire safety, electrical installations, gas and water checks and tests had been carried out.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in January and February 2017 we found the provider had breached the regulations relating to meeting nutritional needs and staffing.

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We found the provider had made progress with meeting the requirements of these regulations. There was a supervision system in place. A plan had been developed to implement one to one supervisions, however not all staff had received supervision. 19 out of 35 staff had not received a supervision to discuss their individual training and development needs. In addition, staff had not yet had an appraisal. Despite these shortfalls, all staff we spoke with said they felt supported. Comments included, "[Name of manager] is so supportive"; "She is very approachable,"; "I've had supervision already and they take me in [for supervision] quite regularly"; and "I can go to [names of provider staff] at any time."

Staff informed us they felt equipped to carry out their roles and said there was sufficient training available. The provider had planned an extensive training programme to ensure staff had the training they needed to fulfil their caring role effectively. Priority training had been completed when we inspected, such as moving and handling, nutrition and medicines management. Other training was planned and was due to be completed by the end of September 2017. Staff had also enrolled on a 12 month apprenticeship programme. We spoke with an external vocational training assessor who told us staff were three months into the apprenticeship and were progressing well. Staff comments included, "Now I'm on so many courses. I've got qualifications coming out my ears"; and "Apparently we weren't properly trained. I have been to three training sessions, they are definitely upping the training."

Relatives told us that staff effectively met people's needs. They said staff were knowledgeable and knew what they were doing. One relative said, "They definitely know what they are doing." A health and social care professional felt the home had made improvements recently. They told us, "They have addressed the staffing and lack of training."

Where people were at risk of poor nutrition, meetings had taken place to agree an individual action plan based on their needs, For one person actions included: completing a nutritional assessment; completing a choking risk assessment; weekly weights; completing food and fluid charts; advice from a GP and an occupational therapy and speech and language therapy referral. Staff had taken advice over the phone from a speech and language therapist as an interim measure until the person could be formally assessed.

People and relatives were mostly complimentary about the meals at the home. One person told us, "It's good food I think they have a new chef. Some of the food can be disappointing but there is always plenty and always extra if I want it." One relative said, "[Family member] wouldn't drink, so they did everything they could to tempt her. [Family member] liked milky coffee so they made her milky coffee. [Family member] also said one day that she fancied some sweets so out they went to get her some sweets."

We spent time with people over the lunch time period. We observed staff showed people both meal choices. This meant they could see and smell the food which was particularly beneficial to people who had a

dementia related condition. One person took hold of the plate with the meal she wanted and said, "Mmmm, oh yes, nice." However, this did not appear to be usual practice, as on the second day of our inspection we saw people were asked verbally to make a choice with less success.

The food was well presented and hot and cold drinks were available. We saw some people required pureed meals. We noted each part of the meal was pureed separately and placed on the plate in distinct portions to make the meal look more appetising and help people to distinguish what they were eating. One member of staff said, "It's all separate, I hate it when you see it all mushed together, that doesn't happen here."

Staff were attentive to people's needs and supported people to eat independently. We heard comments such as "Can you eat a little more"; and "Well done, you've nearly finished." People ate at their own pace and were not rushed at all. Staff showed good knowledge of people's likes and dislikes. There were meaningful interactions between people and staff.

Diet and fluids charts were completed. These were very detailed and were completed accurately. Levels of fluid intake and targets to be achieved were recorded on people's charts. One member of staff said, "We have fluid charts for everyone, there is juice and tea available. They have a better diet and fluids than me!" We examined 34 fluid charts and noted that people had achieved their target fluid intake. We read the GP had visited an individual and taken bloods. Staff had recorded, "[Blood results] have improved drastically which indicates that [name] is having plenty of fluids."

The 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked the provider and registered manager were working within the principles of the MCA and that any conditions on authorisations to deprive a person of their liberty were being met. The manager had submitted DoLS applications in line with legal requirements.

We noted that some mental capacity assessments had been completed. These however, were not decision specific. For example, one MCA assessment we viewed covered two separate decisions; one related to a person consenting to their placement at Valley View Residential Care Home and the other related to consent to a soft textured diet. We noted that mental capacity assessments had not been completed for all restrictions on people's movements such as the use of sensor alarms.

Information relating to whether people had appointed a lasting power of attorney (LPA) was not available. LPA is a legal tool which allows people to appoint someone (known as an attorney) to make decisions on their behalf if they reach a point where they are no longer able to make specific decisions. There are two types of LPA; property and financial affairs and health and welfare. This meant evidence was not available to confirm whether an attorney had been appointed or what type of LPA was held to ensure the correct attorney was involved in the correct decisions.

Relatives told us that staff supported people to access health care services. One relative said, "They got urgent care out to check mother's care. They are spot on with getting someone out." Health and social care professionals were complimentary about the staff and told us they were contacted if any concerns were noted about people's health.

During our inspection, a GP, two district nurses and a physiotherapist visited the home. Records demonstrated that people saw the GP, specialist consultants, dietitians, district nurses, opticians, dentists and chiropodists. A weekly 'doctor's surgery' was carried out. The manager told us, "To be honest, I just refer to everyone." This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of the people were being met, to maintain their health.

Some work had been carried out to make the environment more 'dementia friendly.' The corridors were named after streets in the local community. There was a well maintained garden. Although the garden was not accessible directly from the communal areas, staff supported people to access it. One relative told us, "The environment more than meets [family member's] needs."

We observed however, that people who lived on the first floor, spent most of their time in the lounge which had a key pad entry system. There was a small corridor leading from the lounge. At the end of this corridor there was another key pad entry system. This meant there was limited space for people to walk. The manager and staff were aware of the limitations of this area. The manager told us of her plans to open this area up to enable people to have more space to explore. There was a quiet sensory area located on the first floor near to the secure lounge area. The manager told us that people sometimes likes to sit there.

Requires Improvement

Is the service caring?

Our findings

Although the vast majority of our observations were positive, we observed on a small number of occasions staff were not always attentive to people's needs. For example, at one point during our observations we saw staff were slow to attend to one person who required the toilet. The staff member was prompted by a visitor but then left the lounge with paperwork and returned a short while later to assist the person by which time it was too late. At all other times we saw staff treated people with dignity and respect. They spoke with people in a respectful manner and knocked on bedroom doors before they entered. Staff gave us examples of practical things they did to promote dignity when caring for people. This included keeping doors and curtains shut for privacy and talking to people to explain what they were doing.

We observed at times staff sat in communal areas completing paperwork which took their attention away from people. Staff told us this was due to the amount of paperwork they needed to fill in.

Relatives told us they were involved in decisions about people's care. Although relatives told us they felt involved, this was not confirmed by the records we viewed. The manager told us, "We need to get people involved. We used to get relatives and residents to sign care plans and have key workers and the system just stopped. We also haven't had any recent reviews."

People and relatives told us that staff were caring. Comments included, "All her care needs are met"; "They're as good as gold…I think they are special types of people who work here"; "It's lovely and caring and meets her needs. Nowt is a bother. There's friendly relationships and they are always there to help"; "I always say to anyone who asks, 'She is so well looked after,'"; "My mum speaks to us about how well the staff look after her. She will say, 'I love that one to bits.' She will then say, 'I think that I am their favourite.' Little does she know that we see that they treat everyone as nicely"; "It's brilliant, it's become family to us,"; "Every one of the staff have a heart for the job. It's not a job to them"; "We have no complaints the care is absolutely fabulous"; and "The care is second to none."

Health and social care professionals were also complimentary about the caring nature of staff. Comments included, "Never any issues with caring. They can't do enough to help"; "The lasses are caring"; and "We have a resident downstairs called [name] who doesn't even want to go home because she loves it so much here."

Staff spoke with pride about the importance of ensuring people's needs were held in the forefront of everything they did. Comments included, "If you talk to them you will find out about them. You learn about the person, this is what this job is all about. I know exactly what they are like. I am actually very passionate about my job. They are like my family"; "I love older people and listening to their stories"; "You do build a relationship with the residents"; and "It's like an extended family."

We observed positive interactions between staff and people. Staff displayed warmth when interacting with people. They were very tactile in a well-controlled and non-threatening manner. We saw a care worker gently touch one person's face and the person smiled. A relative told us, "My mother is very tactile, she loves

cuddles and they always respond. They speak to her; they have a laugh with her." Another relative said, "We wouldn't want her to go anywhere else, it's a lovely community feeling here." One staff member said, "It's the little things that make all the difference like sitting and holding hands, they need that connection." There were also positive relationships between people. One person told us, "I have one or two friends who I can mix with here." Another person said, "I have made new friends with other residents."

We heard a member of staff having a conversation with a person who had been a teacher. Discussion ensued about the subject the individual had taught and what action was taken when pupils did not complete their homework. At the end of the conversation, the person who was living with dementia told the care worker, "You're nice."

Staff joined people for lunch to create a social occasion out of the lunchtime. One staff member said, "We've always done this, it makes it into a social experience." Another member of staff said, "It helps encourage them to eat. It's much more sociable than just standing over them."

Staff were knowledgeable about people's life histories and their likes and dislikes. One staff member involved us in a conversation she was having with an individual. She said, "I was telling this lady [inspector] that you love Mateus wine, it is your favourite." The person smiled and said "definitely."

Requires Improvement

Is the service responsive?

Our findings

People did not always have the opportunity to participate in their preferred activities. The home did not currently have a dedicated activity co-ordinator. The acting manager told us they were in the process of recruiting to this position and a staff member had been selected to move into this role. Activity records were available for each person. However, these confirmed that the provision of activities was not consistent. Most of the activities logged for people were based around group activities, chatting with staff or watching DVDs. There was no evidence that activities were personalised to the needs of each person. For example, the previous activity co-ordinator had identified that one person would benefit from one to one sensory activities. However, when we viewed the person's activity record this had not been offered. One staff member commented, "It would be nice to have more time with people."

During our inspection activities were on-going. For example, staff used reminiscence therapy. They showed people olden day photographs of the surrounding towns and villages. One care worker said, "Oh look [name], where's that? Is it Scotswood?" There were various items for people to touch and feel. There were knitted muffs with items attached to help keep people's hands active and busy. One staff member said, "What do you think of this? How does it feel, is it nice?"

Staff assisted some people to sit in the garden. We went out into the garden with a member of staff. She said to one person, "Here's wor [our] [name]." A very vigorous dance ensued! The care worker told us "[Name] loves to dance he has a really good wiggle in his chair."

However, when we spoke with people and relatives, we received mixed reviews from people and relatives about the availability of activities. One person said, "I think they are lost for games to play here, I like to take part in craft sometimes but it doesn't happen often." Some relatives told us that people's social needs were met. Comments included, "I come in on an afternoon and they have had singers and entertainers. They also do bingo and they do the old war songs which they love. They have kids coming in too"; and "They take her for a walk around Winlaton, or around the estate or into the garden." Other relatives were less positive. Their comments included, "There is nothing in the way of activities going on, he would love to play bingo or dominoes but we never get to know what is happening here"; and "There is nothing in the way of activities, nothing to stimulate the residents."

Staff told us people could choose how they wanted to spend their day. Comments included, "With the residents they have the right to refuse anything…They get up when they want. [Name] likes a lie in and have her breakfast later"; and "One resident likes to have a bath at 3.15 and we do this. Their hygiene is very good here." One person told us, "I can come and go as I please, I have no restrictions on me." However, record we viewed did not always show this to be the case.

When we last inspected Valley View Residential Care Home we found bathing records showed people did not have a bath or shower regularly. We found this was still a concern during this inspection. One person us they did not have a bath as often as they would like and had to wait when she asked to have a bath. They told us, "They give you a date for a bath, it may be a couple of days later, but there may be a space available

and they ask if you want to fill the vacant space. I would like to be able to have a bath when I want one." We viewed people's bathing record charts which showed significant gaps between baths or showers, in some cases over two weeks. We raised this with the acting manager who told us people could have a bath when they requested one. They accepted the records did not show this was the case.

Most people and relatives told us that staff were responsive to their family member's needs. One person told us about how they were always cold. They said, "The manager gave me an electric heater to use if I get cold, they told me to use it when I want." Another person told us about how staff were careful to leave their door open because of a particular need they had. Relative's comments included, "The staff are nice, there's nothing I've asked for that they have not done"; "They are brilliant with responsiveness"; "She is independent and they promote this. She walks with a Zimmer frame and they walk behind her to encourage her. It used to be two staff to support her and now there is one. She wanted to dust her room so they gave her a duster"; and "She looks better now than she did when she first came in."

There were care plans in place which detailed what care and support should be provided to ensure people's physical, social, emotional and health needs would be met. Emergency health care plans (EHCP) were in place in some of the care plans we looked at. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems. Care plans were based on an assessment of people's needs and took account of their personal circumstances.

Care records contained background information about each person. For example, a family tree which included information about people's life history, such as their childhood, school days, career, favourite memories, hobbies and favourite things. We noted one person particularly liked country music and books and memorabilia related to the Royal family. All of this information was important to help staff gain a better understanding of people's needs.

There were currently few opportunities for people to share their views about the home. We found no evidence that meetings took place with people using the service and relatives. One relative told us, "I went to one relatives' meeting after the new manager started, there hasn't been any more. I did voice my opinion but nothing came of it". The acting manager told us her door was always open if people or relatives needed to speak to her.

Surveys were carried out to obtain the feedback of relatives. The provider had received 11 replies from relatives with questions asked including whether they were made to feel welcome; whether staff approachable and helpful, whether they were kept up to date, staffing levels and overall care delivery. All responses had been positive. Specific comments had been made. These described the staff as 'all very good'; 'professional and caring'; 'always friendly and helpful' and 'compassionate'. Relatives had also described their family member's care as 'excellent'. However, surveys were not undertaken to find out the views of people who lived there. The manager told us she was aware of this issue and this was being addressed.

We did not review the provider's complaint process during this inspection as there had been no complaints made to the provider about the home. However, there was a complaint process in place should this be required.

Inadequate

Is the service well-led?

Our findings

During our last inspection in January and February 2017 we found the provider had breached the regulations relating to good governance. We issued a warning notice for this breach of regulations. This was because there was a lack of leadership, day to day management and quality assurance of the service.

We found the provider had not made the required progress to meet the requirements of the regulations. We found that due to a lack of management oversight at the home there had been a significant delay in making progress towards meeting the requirements of the regulations. The provider had a history of non-compliance with the regulations. We inspected the home in December 2015, in February 2017 and again in July 2017 and found continuing breaches. A warning notice was issued following our inspection in May which was not complied with by the specified timescale.

Following out last inspection we requested the provider submit a report on the action they planned to take to meet the regulations. We requested this on 22 May 2017 and we specified a timescale of 4 June 2017 to submit the report of actions. The provider did not submit this action plan.

Although the last inspection of the home was in February 2017, a detailed improvement plan had not been developed until 12 June 2017. This was made available to us during our visits to the home in July 2017. The acting manager told us they had just received the improvement plan from the independent consultant and had not seen this document previously. This meant the improvements identified in the improvement plan had not yet commenced. The acting manager also raised concerns with about some of the timescales in the improvement plan.

We found following our previous inspection that regular audits of safety and care were not completed regularly and were not effective. We found during this inspection that this had not been addressed. For example, we found the current audit form used by the home to audit medicines management lacked scope and detail. The audit was not completed for individual people and questions posed in the audit tool were not specific. We viewed completed audits and found some answers within the audit did not compare with what we found during the inspection. We found where actions were required, no action plan had been generated and no lead person was identified to drive improvement.

The implementation plan included an action to instigate a robust system of governance by 31 August 2017. The implementation plan stated this would include a range of audits and checks. For example, checks of care plans and case files; activities; accident and incidents; personal monies; nutrition and hydration; safer food better business; safeguarding incidents; infection control; the management of medicines; the premises; the equipment; recruitment; staffing levels; supervisions and appraisals; training; learning and development; complaints and compliments. We found work to comply with this action had not started at the time of our latest inspection.

The provider and acting manager were open and transparent about areas which still required action such as supervision and appraisals and the quality assurance system. The manager told us, "I want to be open and

honest, how can you improve if you are not" and "It [quality assurance] needs a full overhaul. We have started on some audits last week; we did wheelchair audits and medicines audits." Spot audits of service delivery had also started, however these were not yet fully implemented. They included checks on staff's use of equipment, communication, record keeping and care delivery.

We found there had been a significant delay in developing a staffing tool to provide assurance that staffing levels at the home were sufficient and to provide on-going monitoring of staffing levels. We recommended the implementation of a tool at our inspection in December 2015 and again in February 2017. This staffing tool was still not available during this inspection. A copy of the tool was subsequently emailed to us following the conclusion of our inspection visits.

Due to lack of management oversight, individual supervisions and appraisals which had been planned for May 2017 onwards had not been delivered to most staff members to support their development. We also found care records did not contain information about lasting power of attorney (LPA).

We found the provider was not consistently monitoring and analysing safeguarding concerns and accidents in the home. We saw the monthly monitoring of safeguarding concerns had not been completed in April, May or June 2017. We also found individual accident records were maintained appropriately but there was no evidence that these were monitored periodically. This meant that systems were not in place to identify any potential trends and patterns so that action could be taken to improve people's care and maintain their safety.

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

Relatives, staff and health and social care professionals spoke very positively about the acting manager. Comments included, "[Name of manager] is amazing. She has all the residents' best interests at heart. If you ask her to do something, she will do it. She's on the ball"; "She seems in control and knows everyone"; "[Name of acting manager] knows her staff. She is fab; she is really good with the residents. I have confidence in her"; "We get on well with [name of manager] and all of the staff and we have been made to feel part of the team. They are all just so lovely"; "It's much improved since [name of acting manager] became manager"; "[Name of acting manager] is honest"; and "[Name of acting manager] works so hard." The acting manager spoke enthusiastically about her vision for the future. She told us, "I want to be the best I can. This has been a massive learning curve for me." The acting manager also told us they were in the process of recruiting a deputy manager to support her.

Relatives were also complimentary about the service. Comments included, "We've never looked back since she's come here. I would rate it very good"; and "I would rate them out the roof and recommend them to anyone."

The provider, acting manager and staff told us improvements had been made. Comments included, "I feel we've moved on and improved"; "I know what we need to do and where we are going"; "We want to succeed"; and "It is getting better. Now that [acting manager] has took over, staff have more faith in her that things are going to get better."

The provider was starting to hold staff meetings to discuss areas for improvement in the home. Some of the minutes from these meetings were available to view whilst others were in an audio format awaiting typing.

Staff told us they enjoyed working at the home. Comments included, "I love my job"; and "I now feel happier

coming into work, knowing the paperwork is there and the staff are there. Everything is being done properly." A relative told us, "One of the girls told me, 'I love my job, in fact when I go home, I'd rather be at work.'" We observed this positivity was reflected in the care and support which staff provided throughout the day.

The provider was not displaying their rating at the home or on their website in line with legal requirements. We spoke with the manager who told us that this would be addressed immediately. When we visited on the second day of our inspection the rating was displayed in the reception area. The website still needed updating with the latest rating.

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 The provider did not have effective systems in place to ensure the proper and safe management of medicines. Regulation 12(2)(g).

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(2)(a)(b) and (f)

The enforcement action we took:

We issued a warning notice to the provider.