Care UK Community Partnerships Ltd

Mill View

Inspection report

Sunnyside Close
East Grinstead
West Sussex
RH19 4AT

Tel: 01342337220

Date of inspection visit:
30 October 2018

Date of publication:
06 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Mill View on 30 October 2018, due to information of concern that we had received regarding an incident at the home. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risks of choking. This inspection examined those risks.

The team inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led? This report only covers our findings in relation to those key questions. No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them.

The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mill View on our website at www.cqc.org.uk At the previous inspection on 28 February 2017 we rated Mill View as Good. At this inspection we identified areas in need of improvement and this meant that the overall rating of the home has changed to Requires Improvement.

Mill View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mill View accommodates up to 70 people in one purpose built two storey building. On the day of this focussed inspection there were 62 people living at the home. People living at the home had a range of needs including nursing needs, mental health needs and some people were living with dementia.

The home had a registered manager who was present during the focussed inspection. 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.

Some people were not receiving the support they needed to eat their food. Staff were not deployed effectively to support people in a timely way at lunch time and staff were not always aware of people's needs. This was identified as a breach of the regulations.

Risks to people had been assessed. However, care plans did not always give staff clear guidance in how to manage some risks and some staff were not all accessing care plans. This meant that people were at risk of not receiving the care they needed. This was an area of practice that needed to improve.

Quality assurance systems were not always effective in identifying shortfalls. Analysis of incidents had led to positive changes in supporting people at meal times. However, these changes were not yet fully embedded and sustained in all areas of the home. This was an area of practice that needed to improve.

People told us they felt safe at the home. People were receiving their medicines safely and staff were knowledgeable about infection control. There were enough staff on duty and recruitment procedures were robust. However the deployment of staff was not always effective, for example at meal times.

People had confidence in the staff skills. One person said, "They are very good here. The staff know how to care for people well." Staff had received the training and support they needed. One staff member told us, "We have training all the time. The dementia training was very powerful." Staff described effective team work and there were systems in place to support communication between staff. People's needs and preferences were assessed in a holistic way. Staff understood their responsibilities with regard to seeking consent for care and treatment.

There was a clear management structure and the registered manager provided visible leadership. There were positive links with the local community. People, relatives and staff were engaged with developments at the home.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Risks assessments and care plans did not always provide clear details to guide staff. Staff were not all accessing risk assessments and care plans. This meant that people were at risk of not receiving safe care consistently.

People were receiving their medicines safely and medicines were stored and disposed of safely. Incidents and accidents were monitored and improvements were made when things went wrong.

There were enough staff on duty. Staff had been recruited through a safe recruitment system. Staff understood their role in safeguarding people from abuse. Lessons were learned when things went wrong.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some people were not receiving the help they needed to have enough to eat.

Staff received the training and support they needed. Staff demonstrated a clear understanding of their responsibilities to seek consent.

People were supported to access the health care services they needed. Their needs and choices had been assessed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were not consistently effective in identifying shortfalls in the quality of the service.

There was a clear management structure and staff understood their roles and responsibilities.

Staff had made positive connections with local organisations.

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.

The inspection was prompted in part by notification of an incident where a person using the service had died. This incident is subject to a possible criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of choking. This inspection examined those risks.

The inspection took place on 30 October 2018 and was unannounced, which meant that the registered manager and staff did not know we were coming. The inspection team consisted of four inspectors and an assistant inspector.

Before the inspection we reviewed the information we held about the home which included the information of concern and information we had received from the local authority. We used this information to decide which areas to focus on during our inspection. A Provider Information Return (PIR) is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to complete a PIR. This was because our inspection was unplanned and we were responding to risk.

During the inspection we spoke with seven people who use the service and one relative. We spent time observing how staff interacted with people. We spoke with 12 members of staff, and the registered manager. We looked at a range of documents including policies and procedures, care records for ten people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information which included recruitment, supervision and training.

At the last inspection on 28 February 2017 the home was rated as Good overall.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Mill View. One person said, "They look after me well, they have got my illness under control." A relative said, "They are safe here, the staff are constantly looking out for people." Despite these positive comments, some areas of practice needed to improve.

Risks to people had been identified and assessed. The provider used an electronic record system and there were comprehensive risk assessments in place. However, there was not always clear guidance in place for staff to follow in order to manage risks safely. For example, some people had been assessed as being at risk of choking. Risk assessments and care plans included details of the support people needed including modified diets, however there was no guidance for staff about what to do if someone was choking.

We asked the registered manager how they were assured that staff would know what to do if a person was choking. They explained that care staff would call for help immediately and a senior staff member would be able to assist the person. They stated that staff would know what to do and would perform first aid until a senior staff member arrived. This guidance was not included within the care plan. The registered manager said that staff would know what to do because support with choking was covered within first aid and basic life support training. The provider's training matrix showed that this was considered as essential training for staff and staff had attended this training. However, the registered manager said that they were not sure if agency staff had received training in how to support someone who was choking. Agency staff were used regularly at the home. This meant that there was a risk that some staff may not know what to do if a person was choking and the risk assessment and care plan did not provide clear guidance. This is an area of practice that needs to improve.

Risk assessments and care plans were recorded on an electronic system and had been reviewed and updated when people's needs changed. Staff could access this information on computers and some information was also printed and stored within people's files. During the inspection we observed that some care staff were not referring to people's electronic records or their paper files. Staff told us that they did not have time to access information electronically. One staff member said, "We get updates on everyone through handovers." Other staff said they relied on handover information and verbal guidance from other staff members. Although comprehensive risk assessments were in place, staff were not all using this information. This meant that there was a risk that people would not receive consistent care, safely and in the way that people preferred. One person told us that the staff were not all familiar with their care needs, saying, "They don't always know the best way to deal with my condition." Another person told us, "The regular staff know me well and they are good, but it's more difficult with new ones and agency staff." This is an area of practice that needs to improve.

Risks associated with people's mobility had been assessed. Some people needed support to move around and manual movement care plans guided staff in how to support them safely. We observed staff supporting people to move around safely. One person was supported to move with the use of a hoist. Staff were confident and reassuring throughout the procedure and took care to ensure the person's comfort and that their dignity was maintained. People were supported to maintain their skin integrity and staff were

knowledgeable about how to prevent pressure sores from developing.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Personal Emergency Evacuation Plans (PEEPs) were in place for each person to identify the support they would need to evacuate the building in the event of a fire or other emergency. Staff demonstrated awareness of infection control procedures. The home was clean and tidy and cleaning schedules were used to ensure that hygiene was maintained. One person told us, "It's always clean and tidy here, they hoover and dust regularly."

People were receiving their prescribed medicines safely. Medicines were administered by trained nurses. Medicine Administration Record (MAR) charts were completed consistently. We observed people receiving their medicines in a calm and unhurried manner and in the way they preferred. Some people were prescribed topical medicines, such as creams. Body maps were in place which instructed staff exactly where to apply these. Records showed people regularly received their prescribed creams. Appropriate secure storage arrangements were in place for medicines. Some people were prescribed 'as required' medicines. Protocols were in place instructing staff under which circumstances to give these medicines to help ensure a consistent approach to their administration. There was a system in place to make sure all medicines could be accounted for and an auditing system ensured that safe practice had been maintained.

Staff demonstrated that they understood their responsibilities about safeguarding people from abuse. Staff could describe the signs that might indicate different forms of abuse. They described how they would report any concerns and felt confident that managers would take the appropriate actions. Appropriate referrals had been made to the local authority in line with the Provider's safeguarding policy and with local arrangements.

There were enough staff on duty to care for people safely. The provider used a tool to assess how many staff were needed according to people's individual needs. Staff told us that there were enough staff on duty and they had time to care for people. One staff member said, "I feel we don't rush people, which is important." Records showed that agency staff were regularly used to maintain staffing levels. The registered manager explained that use of agency staff had reduced following recruitment to some vacant posts. People told us that staff attended quickly when they rang their call bell. Records of call bell usage showed that staff response times were consistent.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. We sampled records for staff who had been recruited since the last inspection on 28 February 2017. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Documentation confirmed that nurses employed had up to date registration with the nursing midwifery council (NMC).

The provider had an electronic system for recording and monitoring incidents and accidents. We checked to see how lessons were learned when things went wrong. An incident was recorded when a person had fallen but sustained no injury. The registered manager had noted that this was the second time the person had fallen in that month and had taken a number of measures to reduce risks of further falls. This included a referral to the GP and the falls team for advice and the introduction of a sensor mat to reduce the risk of falls in the person's bedroom at night. This showed that the registered manager was making improvements

following lessons learned when things went wrong.

Requires Improvement

Is the service effective?

Our findings

People told us they had confidence in the skills of the staff. One person said, "They are very good here. The staff know how to care for people well." Despite these positive comments we found some areas of practice that required improvement.

People told us they enjoyed the food and that they had enough to eat and drink. One person said, "The food is very nice, I sometimes ask for more." A relative told us their relation was happy with the food saying, "He has put on weight since he has been here, he likes the food." We observed people's mealtime experience and found this varied in different parts of the home.

Some people were not receiving the help the needed to eat their food. One person was given their meal and supported to pick up their fork. A staff member sat with them initially but was called away to help someone else. We observed that the person ate very little and appeared to be struggling to get food onto their fork. Staff were supporting other people with their meals, but did not offer this person support or encouragement for more than thirty minutes. A staff member returned and asked, "Would you like some help?" however they did not offer to reheat the meal which would, by then, have been cold.

The person's care plan showed that there had been previous concerns about the person's nutritional intake and their weight remained low. A risk assessment identified that they needed support with eating and were at risk of choking. The person had been referred to both a speech and language therapist (SALT) and a nutritionist. Their advice included providing a modified diet, monitoring the person's weight on a weekly basis and encouraging and supporting them with their intake at meal times. We noted that staff had been monitoring the person's weight regularly, and this showed that they had been losing weight every week in the past 6 weeks with a total weight loss of 2.5kg. However, there was no indication of what actions had been taken because of this weight loss. We asked staff about the support the person needed at meal time, staff told us the person was sometimes reluctant to accept assistance. This was not reflected within their care records and our observations were that the person had accepted support when it was offered.

Some people were receiving help to eat their food. We observed staff supporting people in a kind and caring way. However, this was not consistent in all areas of the home. One staff member was observed standing in front of a person when supporting them to eat. This did not support the person's dignity or help them to feel that there was no rush to eat. Another staff member was sitting beside a person who needed support, but they did not engage with the person, other than to instruct them to open their mouth. In other areas of the home we observed good practice and saw that staff were skilled at supporting people with their meal. We saw staff engaging with people, checking when they were ready for their food and asking them if they were enjoying their meal. Records for people who were living with dementia included clear guidance for staff in how to support people with behaviour that could be challenging to others at the meal table. We noted that staff were following this guidance.

We observed that some people had to wait a long time to receive the help they needed because staff were busy helping other people. Four people were observed to have fallen asleep at the table whilst waiting for

their meal. One person told us that staff were "always very busy, particularly at meal times." A relative said, "They (staff) are obviously really busy around lunch times." We asked how staff were deployed at meal times. A staff member explained that team leaders were responsible for directing staff to support people at meal times. Some people required a modified consistency for food or drinks, including having thickeners added to their drinks. This information was included within people's care records. A system was in place to identify the specific risks, needs and preferences for each person. We observed team leaders reminding staff about people's individual needs and the support that people needed.

Inconsistent practice at mealtimes meant that whilst most people were well supported, some people were not getting the support they needed. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed in a holistic way and considered the full range of people's diverse needs. People's needs and choices had been assessed to take account of people's physical and mental health and their social needs. Appropriate assessments were undertaken to identify how to achieve effective outcomes for people. For example, risks to one person's skin integrity had been assessed using an accredited tool in line with good practice guidance.

Staff told us that they had access to the training and support they needed. One staff member said, "I've just completed four days team leader training." Another staff member told us, "We have training all the time. The dementia training was very powerful." Records confirmed that staff received training that was relevant to the needs of people they were supporting and that training was updated regularly. Staff were receiving supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Staff told us they felt well supported and could discuss any concerns with managers when they needed to.

Systems were in place to support effective team work. Staff meetings were held regularly. Daily hub meetings were held with senior staff and shift leaders to ensure that information was passed on appropriately. This included changes in people's needs and confirmation of actions that had been taken. Staff told us that this had improved communication between staff and led to better oversight from managers when difficulties or risks emerged. We attended a hub meeting and observed how staff discussed issues such as forthcoming hospital appointments, changes in people's behaviour and referrals that had been made or were needed. Significant events, such as people's birthdays, were also discussed to ensure that people received a personalised service.

People were supported to access the health care services they needed. We noted that staff contacted health care professionals in a timely way, when they noticed changes, to ensure that people's health needs were addressed. Advise received from health care professionals was included in people's care plans to guide staff.

The premises were suitable for the needs of people who lived there. Signs around the home were appropriate for people who were living with dementia and supported people to be as independent as possible. The home was purpose built and had a number of areas where people could spend time with visitors including a café.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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

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 or authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and demonstrated a clear understanding of their responsibilities about the legislation. We observed that staff were checking with people before providing them with care or support. Staff gave clear explanations of the purpose and meaning of DoLS. Documentation was clear and identified how people's mental capacity had been assessed when making specific decisions. For example, a sensor mat had been introduced for a person following more than one unwitnessed fall. A mental capacity assessment identified that the person lacked capacity to consent to the introduction of the sensor mat, which could be a restriction on their freedom to move around unaided. The decision to use the mat to support the person's safety had been made in their best interest and this was clearly documented with details of who had been involved in making this decision.

Requires Improvement

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The home's manager had become registered with CQC since the previous inspection on 28 February 2017. People and relatives spoke positively about the management of the home. One person told us, "I can't think of anything I would change." Staff were also complimentary about how the home was run. One staff member said, "All the management listen and take care of the staff." However, despite these positive comments we found areas of practice that needed to improve.

There were a number of management systems in place to monitor the quality of the service and to identify risks. Systems were comprehensive but were not always effective and reliable in identifying inconsistencies in practice across the home. For example, during the inspection we identified that some people were not being effectively supported at mealtimes. Staff were not always deployed effectively to support people in a timely way and staff practice was variable. The provider's quality monitoring system had not identified these shortfalls.

A management system recorded incidents and accidents and these were monitored and reviewed by the registered manager. Analysis of an incident had led to changes in the way staff supported people at mealtimes to ensure that staff were aware of risks to people. However, these improvements had not been fully embedded across the home. Staff were not always aware of risks to people and care plans did not give clear guidance about the actions staff should take, for example, if someone was choking. There was inconsistent practice in staff referring to people's care plans with some staff reliant on verbal communication and handover information. This had not been identified by the provider's management systems. Having robust systems to identify shortfalls in the quality of the service is an area of practice that needs to improve.

Staff told us that leadership at the home was visible and described effective methods of communication. One staff member said, "The good thing here is that we have the opportunity to express ourselves. The company want to know what works and where we have any difficulty." Staff were clear about their roles and responsibilities and described being well supported. One staff member told us, "Senior management are always available on-call. One day of each weekend has a manager here, either clinical lead or deputy."

Staff described working collaboratively with other agencies. For example, a number of local organisations had made positive links with staff at the home. A charitable organisation held a coffee morning to promote their befriending service. Another charitable organisation was working with staff to plan a carol concert and to arrange a joint Christmas party. An organisation supporting informal carers held regular meetings at the home and another organisation dedicated to improving care for people who were living with dementia also held meetings at the home. This meant that there was an open culture at the home and people benefitted from positive links with local organisations.

People and relatives told us that they were involved in developments at the home. A relative told us that they attended regular relative's meetings. Records showed that residents' meetings were also held regularly. On the day of the inspection a coffee and comments meeting had taken place. One person told us, "I went to the meeting today and said that we should have nice spaghetti bolognaise - they said they would." Another person said, "I try to attend the meetings unless I have a hospital appointment." People said they felt their views were listened to. A staff member said that having an informal meeting with coffee had been successful because it was attractive to some people who were more likely to attend then the more formal residents' meetings.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always met.