Advinia Care Homes Limited

Mill View Care Home

Inspection report

Bridgeman Street
Bolton
Lancashire
BL3 6SA

Tel: 01204391211

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 27th and 28th November 2018 and the first day was unannounced. This was the first inspection carried out under this provider. The home was inspected under the previous provider in September 2017 when it was rated requires improvement overall. At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance.

Mill View is a care home providing nursing and personal care. It is situated about half a mile from Bolton town centre. The home is situated in its own grounds with garden areas and car parking available at the front of the home.

Mill View Care Home 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.

The care home accommodates up to 180 people within six separate houses. Each house caters for different needs including residential care, specialist dementia care and nursing. One the day of the inspection there were 164 people using the service.

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 was a registered manager in place at the home.

Some of the documentation relating to medicines was not accurate and some medicines not given safely. Care files included relevant health and personal information. However, there were some inconsistencies and gaps with regard to care plans and risk assessments.

People told us they felt safe at the service. Safeguarding and whistle blowing policies were in place and staff had received training and were aware of how to raise a concern. Health and safety measures were in place.

Staffing levels were sufficient to meet the needs of people who used the service. The recruitment system was robust. General and individual risk assessments were in place.

The home was clean and tidy and infection control measures were in place. However, a number of infection outbreaks had been experienced by the home.

Staff regularly took mandatory training refresher courses and supplementary training was delivered as required. We saw evidence of staff supervisions and appraisals.

Nutrition and hydration needs were addressed by the service and there were choices of meals and drinks on offer throughout the day. People's specific dietary needs were adhered to.

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

Staff interactions with people who used the service were patient and kind. Privacy and dignity was respected. The home had appropriate policies around confidentiality and data protection and staff were aware of its importance.

There was an appropriate policy and procedure in place with regard to equality and diversity and staff had undertaken training. Communication needs were recorded within care plans and information could be produced in a number of different formats to suit people's needs.

People were involved in their care and support planning and reviews. People who used the service were encouraged to be as independent as possible. All appropriate equipment was in place for people to aid people's independence. The equipment was well maintained and in good working order.

People told us they felt the service was responsive. Care files included person-centred information and people's choices were respected.

Activities had improved at the home and were offered seven days and two evenings per week. We saw evidence that the service was looking at more meaningful one to one activities for the future.

There was an appropriate complaints procedure and complaints were responded to appropriately. We saw a number of compliments received by the service.

People were supported to remain at the home when nearing the end of their lives if this was their wish.

There was a statement of purpose in place which set out the aims and objectives of the company. It also outlined dignity and privacy, safety and support.

People told us the management were accessible and approachable. Staff told us they were well supported by the management and had regular supervisions and staff meetings.

The company had a number of quality assurance processes in place. However, these processes had failed to identify the concerns we identified around medicine management and accurate maintenance of care records. There was evidence of good partnership working. The service had good links with the wider local community.

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.

Some of the documentation relating to medicines was not accurate and some medicines not given safely.

Safeguarding and whistle blowing policies were in place and staff had received training and were aware of how to raise a concern. Health and safety measures were in place.

Staffing levels were sufficient to meet the needs of people who used the service. The recruitment system was robust. General and individual risk assessments were in place.

The home was clean and tidy and infection control measures were in place. However, a number of outbreaks had been experienced by the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care files included relevant health and personal information. However, there were some inconsistencies and gaps with regard to care plans and risk assessments.

Mandatory training refreshers were undertaken regularly, and supplementary training delivered as required. We saw evidence of staff supervisions and appraisals.

Nutrition and hydration needs were addressed by the service and here were choices of meals and drinks on offer throughout the day.

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

Is the service caring?

Good

The service was caring.

Staff interactions with people who used the service were patient and kind. Privacy and dignity was respected.

Staff had undertaken training in equality and diversity. Communication needs were recorded within care plans and information could be produced in a number of different formats to suit people's needs.

People were involved in their care and support planning and reviews. People were encouraged to be as independent as possible.

The home had appropriate policies around confidentiality and data protection and staff were aware of its importance.

Is the service responsive?

Good

The service was responsive.

Care files included person-centred information and people's choices were respected. Activities had improved at the home and were offered seven days and two evenings per week.

There was an appropriate complaints procedure and complaints were responded to appropriately. We saw a number of compliments received by the service.

People were supported to remain at the home when nearing the end of their lives if this was their wish.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems to manage the overall quality of service provision had not identified inaccuracies in medicine documents and care records.

People told us the management were accessible and approachable. Staff told us they were well supported by the management and had regular supervisions and staff meetings.

The company had a number of quality assurance processes in place. There was evidence of good partnership working. The service had good links with the wider local community.

Mill View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 carried out on 27th and 28th November 2018 and the first day was unannounced. The inspection team consisted of an adult social care inspector and an assistant inspector from the Care Quality Commission (CQC), a medicines inspector, two specialist advisors who had expertise in nursing and two experts 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. The experts by experience for this inspection had experience of older people and people living with dementia.

Prior to our inspection we contacted the local authority commissioning team and the safeguarding team. We also contacted the local Healthwatch service. Healthwatch England is the national consumer champion in health and care. This helped us to gain a balanced view of what people experienced accessing the service. We looked at notifications received by CQC. Statutory notifications are information that the service is legally required to tell us about and included significant events such as accidents, injuries and safeguarding notifications. We had received a provider information return form (PIR). This form asks the provider to give us some key information about what the service does well and what improvements they plan to make.

During the inspection we spoke with the registered manager, the deputy manager, the regional director, the quality manager, one of the clinical service managers, the learning and development manager, two activities coordinators, three house managers, four nurses and three care assistants. We spoke with ten people who used the service and six relatives/friends who were visiting. We also spoke with two visiting health professionals to gain their views.

We looked at records including 14 care plans, six staff personnel files, training records, health and safety records, audits and meeting minutes. We observed care throughout the day and undertook a Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who cannot not talk with us.

Requires Improvement

Is the service safe?

Our findings

We asked people if they received their medicines in a timely way. One visitor told us her relative always got their medicines on time, which was important as it was for Parkinson's and needed to be given at the correct time. Other comments included, "Oh yes I've never had a problem with that and I have been here for five years, they are very good".

We saw evidence of regular staff competency checks with regard to medicines administration and management. Training was in place with regard to all aspects of medicines administration.

We looked at medicines and records about medicines for 28 people living in three of the six houses at the home. We identified areas of concern where medicines were not managed safely placing people's health at risk of harm.

The policy about medicines management in use did not relate to the current provider and did not support the safe management of medicines. We found that most medicines, including creams and thickening agents, were given as prescribed and could be accounted for. However, we saw that some medicines were not given safely. For example, paracetamol must be given with a minimum of four hours between doses. No record was made about the time each dose was given which meant it was not possible to tell if doses were given safely. Medicines that needed to be given 30-60 minutes before food were not always given at the correct times. One person was given a dose of another person's medicine and this was being investigated by the home, but the doctor had been contacted and said that no harm was caused.

We looked at records for eleven people who were prescribed medicines to be taken "as required", or with a choice of dose, and we found, although there was some additional guidance in place for staff to follow when administering these medicines, it lacked sufficient detail to ensure they were given safely and consistently. There was also a lack of information recorded to ensure that insulin was administered safely.

Some people needed to be given their medicines covertly by hiding their medicines in food or drinks. It is important that advice from a pharmacist is obtained to explain how to give each medicine safely. We saw that sometimes this guidance was missing and when it was available staff failed to follow it. There was also limited practical guidance, to guide staff as to how people took each of their medicines.

One person was fed using a percutaneous Endoscopic Gastrostomy (PEG). This is a medical procedure in which a tube (PEG tube) is passed into the person's stomach to provide a means of feeding when the person cannot take food orally. However, the system for ordering nutritional feeds was not robust. Staff had failed to recognise stock was running low and they had to borrow some from the local hospital to ensure the person did not miss having food.

We found that the medicines administration records (MARs) did not have up to date allergy status on them. The manager explained that this was due to a change in supplying pharmacy and by the second day of the inspection new MARS had been supplied with this important information on.

Each house had a dedicated medicines storage room that was locked and tidy. In each storage room fridges were used to store temperature sensitive medicines. Fridge and room temperatures were monitored in accordance with national guidance. In one house we saw that a medicine that was no longer required was stored with current and new medicines. There was risk that this old medication could inadvertently be administered. Discontinued medicines must be disposed of in a timely manner. We found that waste medication was not stored safely in accordance with The National Institute for Health and Care Excellence (NICE) guidance. In the same house, we found that thickener was not stored safely. Supplies were left unattended in the lounge where people who used the service were sitting whilst the medicines round was taking place. There is a risk of choking if this powder is inadvertently swallowed and it must be kept out of reach of vulnerable people.

The above findings demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as suitable processes for the safe management of medicines were not in place.

We asked if people felt safe at the home. One person told us, "Everywhere is locked up, people can't just walk in". Another told us, "The doors are closed at night and the fire alarm is tested every Monday". Other comments included; "There's no reason not to [feel safe]. I've never given it a thought"; "There's always somebody around"; "Nobody can get in"; "I've got the buzzer".

We asked if people worried about safety when staff used equipment to move them. People told us they had no concerns about this. One person told us, "Oh no definitely not they all know what they are doing here, I do feel safe at all times".

There were relevant safeguarding and whistle blowing policies and procedures in place and staff were aware of where to locate them. Staff told us their safeguarding training was up to date, and this was confirmed by the training matrix. There were posters around the home outlining the safeguarding contact procedures. Staff we spoke with were aware of how to recognise and report a concern. Safeguarding referrals were made appropriately and an analysis of concerns was completed to aid learning and improvement.

A dependency tool was used to look at each person's level of need and inform staffing rotas. The service used an electronic rota system to inform them of the number of shifts to be filled. There were sufficient numbers of staff on duty on both days of the inspection. Records confirmed numbers were consistent and flexible, the service increasing the numbers of staff if required.

A professional visitor to the service told us, "Staffing levels are generally good, they [the home] very rarely use bank staff". A staff member told us they already had their Christmas rota and that the rotas were fairly fixed. They told us agency carers were rarely used, but if they were required, the service endeavoured to use the same staff to help ensure consistency.

People we spoke with about staffing said, "Mostly (enough staff). Sometimes they have to rush about, but they get help if they're short"; "Sometimes they're busy and we have to wait a bit, but not regularly"; "They're a bit short but it doesn't really affect me. They're [staff] at it all day none stop"; "They answer the call bell quickly"; "The carers are always busy and through the day are busier still, they never stop, we probably could do with having a few more carers in the day".

The recruitment system was robust. Staff files we looked at included an application form, full employment history and investigation of any gaps in employment, interview notes, appropriate references, proof of identity and proof of professional registration, where relevant. Each file included evidence of a Disclosure and Barring Services (DBS) check. DBS checks help the employer ensure staff are suitable to work with

vulnerable people.

We saw evidence that the service followed their protocols with regard to disciplinary matters. Actions from disciplinary meetings were recorded and followed up appropriately.

General risk assessments with regard to health and safety and environment were in place. In response to concerns raised by staff, some improvements had been made to the external areas. For example, lighting and uneven paving flags in the grounds had been improved to make the environment safer.

There was an up to date fire risk assessment and the home had 12 fire marshals in place who were trained to assist people in the event of a fire. There was a personal emergency evacuation plan (PEEP) in place for each person who used the service. A PEEP outlines the level of assistance a person would need in the event of an emergency. These were updated weekly and kept in a file near the entrance of the building for ease of access. The home had 20 first aiders whose training was updated on a three-yearly basis. All staff were given basic life support training on induction. The service had a business contingency plan in place in case of emergencies.

All equipment was safely installed, tested and maintained and we saw evidence of fire equipment tests and servicing. Certificates were in place for fire extinguishers, alarms, lights, lifts, water, boiler, portable appliance testing (PAT), gas safety, emergency lighting, kitchen equipment, waste, and the nurse call systems. Water checks were all in place. However, the water in one bathroom was found to be extremely hot. This was dealt with immediately by the maintenance person on site.

Accidents and incidents were responded to, recorded and reported appropriately. These were analysed for patterns and trends, to aid learning and improvement. We saw that the home was clean and domestic staff followed cleaning schedules on a daily basis.

Care staff and nurses we spoke with were able to give a good account of the infection control procedures and the safe management of the linen. They confirmed that all linen went directly into a red bag and went straight through to the laundry for washing and that this would be washed separately.

However, one of the houses at the home had had a number of infection outbreaks and had needed to be closed to visitors for a period of time. A person who used the service told us "It was awful, we couldn't have any visitors either in or out. I understand that they need to do this, but it was really boring, and I felt depressed as I think it went on for nearly three weeks". There was one person with an infection on the day of the inspection and this was being dealt with according to the home's procedures.

The home was working closely with the local infection control team to reduce the instances of infection and deal efficiently with any outbreaks. External audits carried out on two of the houses had been positive, the houses achieving 78% and 82% overall. New cleaning schedules for the bedrooms had been developed as a response to some issues raised. Internal audits were undertaken at the home on a quarterly basis, action plans developed and completed as required.

Requires Improvement

Is the service effective?

Our findings

Care files we looked at showed evidence that collaborative needs had been assessed and they included relevant care plans and health and personal information. There was information around mobility, mental capacity, moving and handling, continence, nutrition and hydration. Risk assessments were in place for issues such as bed rails, falls, skin integrity and use of equipment. We saw advice from other agencies, such as Speech and Language Therapy (SALT) and dieticians.

Overall records were comprehensive, complete and easily read and understood. However, we found some inconsistencies and gaps. We noted a falls risk assessment in one plan which was rated as high, but as the person was now end of life and nursed in bed, this may have been no longer relevant. The change of circumstances was not reflected in the assessment. Another person had been referred to a dietician for weight loss who had advised giving fortified shakes and record weights on a weekly basis. This had not been done and no explanation given within the care plan. For a third person we saw that a recent fall had occurred, but no follow up action had been identified, such as a review of the care plan, or referral to the person's GP. We saw that there was no record of the person's family being informed. A fourth person was prescribed a long-term steroid which was not included on the Waterlow chart and would have taken their risk from high to very high. For a fifth person who had diabetes, notes did not show consistent and careful management. These issues were brought to the attention of the registered manager and had been addressed by the second day of the inspection.

This was a breach of Regulation 17 (2) (c)of the Health and Social Care Act 2008, (Regulated Activities) 2014 as accurate, complete and contemporaneous records were not maintained.

During our observations of the home we saw one person who was in bed and had a catheter leg bag. This would not drain effectively when the person was in bed, possibly leading to a urinary tract infection and the person should have been using a night bag. Staff said they were waiting for night bags to be delivered but managed to find one within 15 minutes and attach this.

People we spoke with told us they could see a doctor if they were unwell and relatives were informed. We asked if staff were skilled and competent. All those we spoke with were positive. Comments included, "Most of them, there's no problem whatsoever"; "Yes, they're very good".

A professional visitor we spoke with told us, "Staff are a consistent team and we have a good relationship with them. House managers are experienced. They are pro-active in calling us out and are pro-active in trying to reduce the need for medicines to keep a good balance. Staff are very quick to report any signs of pressure sores or bruising and they document well. They give readings when asked. Staff work together with families to explain the transition [into the home]".

One house had been changed from nursing to residential, meaning some people who used the service had to move to a different house. A relative told us, "The transition from Dove (House) to Victoria (House) was very smooth. It was done over period of time. The room is a mirror image of [relative's] previous room to

help reduce confusion. Staff made the move easier – some staff moved over with him".

The service had an induction programme, mapped to the Care Certificate. The Care Certificate is a set of standards that care staff need to adhere to. The induction period had recently been extended to two weeks and included an initial day with an introduction to the company, discussion around roles and a speaker from human resources to give an overview of staffing issues. Mandatory training was in place and in-house coaches delivered practical training, such as safer people handling. A log was given to new employees for completing e learning and after four weeks there was a test of their knowledge. In January the service planned to introduce a workbook for new employees to complete. Following the induction, a probation period was completed, with a probationary appraisal to ensure staff were up to standard with skills and abilities.

Mandatory refresher training was undertaken regularly, and supplementary training was sourced from a training partner company. One staff member told us they had had additional support around caring for people with diabetes, end of life and advance care planning and how to use a syringe driver safely. The learning and development manager explained that training was always under review and constantly evolving to help ensure staff were given the right skills and knowledge to carry out their roles.

Some issues had been encountered with the e learning package and this was being addressed. Support was being supplied for staff who struggled with technology or language to help ensure they all had equal access to the training resources. We spoke with the Learning and Development Manager and the Leadership Practice Coordinator who were enthusiastic and positive about current and future training.

We saw evidence of general supervisions, where progress and learning needs were discussed. There were also specific supervision and clinical meetings with staff where issues such as medicines, nutrition, equipment and safeguarding were discussed. Appraisals were undertaken annually to give staff the opportunity to reflect on the previous year and plan for the year ahead.

We looked at how nutrition and hydration were addressed by the service. Specific dietary needs were recorded within the care files and weights were monitored where required. The service made referrals to other agencies for support and advice when necessary.

We asked people about the food. One person told us, "I'm very funny with my food, they've just made menus, so they bring what I like. A girl has just spent two days making lists of what I like and what I don't like". Another person said, "Perfect, I get enough and it's good quality. If I don't like the options I'll have cheese on toast". Other comments included; "Perfect, there's plenty of it, it's well cooked and well served"; "It's not so bad, I'm one for English food. You have a choice and you always get an alternative"; "It's not too bad. Some of the meals are nice and some are like school dinners, but there's a good variety".

A relative told us, "[Relative] likes the food. He has a full English breakfast every day and thoroughly enjoys it. There is plenty of food and drinks all the time". Another relative said, "[Relative] never complains about the food". A third commented, "I believe [relative] eats quite well".

Staff told us there was lots of food and drink on offer throughout the day and we observed that this was the case. One staff member told us, "[Well-known local] pasties are on account now after being requested by residents in conversation with the activities coordinator".

We observed the lunchtime meal on three of the houses. No menus were available, but people had made their choices the previous day. If people had changed their mind they were given whatever they wanted on

the day. One of the observations we carried out was a short observational framework for inspection (SOFI) which is a way of observing care for those who cannot speak with us.

In one house there was music playing, though this was not the case in other houses. Some houses had a more calm, relaxed atmosphere than others. However, the lunchtime experience was pleasant with tablecloths, napkins, flowers on the tables along with condiments and also sachets of sauces. Jugs of juice available and hot drinks were also offered to people. Those who required clothes protectors were supplied with them. There was a choice of meals and extra alternatives were given to those who did not like the options. People were offered a bread roll with soup. We saw that one person was struggling to eat their soup and a staff member promptly responded by suggesting it was put into a mug. They managed this much better and were able to eat independently in this way. Encouragement and assistance was given where required and interactions between staff and people who used the service were friendly, patient and respectful.

In one house most people sat in their own lounge chairs, only a few sitting at the dining table. The people at the table were not served together and there was a 35 minute gap between soup and main course for some. Portions were a good size and where people required a pureed meal to help with swallowing, each component of the meal was pureed separately to look appetising. One person was left to sleep through lunchtime and was later seen to still be in the same position. However, 30 minutes later the person was given something to eat and drink. We observed the same person on the second day of inspection and they were awake and supported to have adequate nutrition and fluids.

We looked around the premises and there was only one house on which there was a slight odour at the entrance. We spoke with the registered manager about this and she told us there was a sluice room located there, which may be the cause of the problem. The odour was addressed immediately.

Around the home the houses varied in décor and furnishings. In some there were reminiscence type pictures around the walls and signage to help people find their way around. Communal areas had large clear clocks and boards with time, date and season to help people with orientation. Christmas decorations were in place in all the houses. Some bedroom doors had names and photos on them, but not all, and not all memory boxes were complete. In some houses the signage could have been more dementia friendly. A refurbishment had been planned and a dementia project had been accessed to look at making the environment more dementia friendly. One house was about to trial pyjama style scrubs to wear at night to help people with orientation to time.

We noted that on one house there were two TVs in close proximity to each other which were both switched on. People were trying to watch these, but it was difficulty to hear either clearly. The registered manager told us she would bear this in mind during the refurbishment and try to ensure there were areas where people could watch TV or listen to music without encroaching on other activities within the same house.

There had recently been friendly competitions between the staff to improve the environment on the houses. For example, there had been a better bathrooms contest, better dining room and better office contests. These had resulted in staff supporting people who used the service to choose and shop for décor and wall hangings and they had collated photos of these improvements.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 authorizations to deprive a person of their liberty were being met. There was an appropriate policy with regard to consent and we saw that verbal consent was sought by staff when offering personal care and assistance. One person said, "They always ask for your permission you know when they are working with you, that's what I like, they just don't go ahead and do it as I am still very independent". There were consent forms within the care files for issues such as access to care documentation.

People's mental capacity was assessed in regard to agreeing to residence at the home and for the use of equipment, such as specialist recliner chairs. Where people lacked capacity there had been best interests decisions made and these were clearly documented within the care files. For one person where there was a care plan to manage agitated behaviour, the terminology was very respectful, there were behavioural assessment tools in place and a de-escalation plan and least restrictive options being explored. DoLS authorisations were in place for people who required them, and staff were aware of who was subject to an authorisation and what this meant in practice.

Good

Is the service caring?

Our findings

We spoke with people about what was the best thing about the home. One person said, "Being able to do what I want". Another told us, "The food, everything is good". Other comments included; "The friendliness and my friend"; "The atmosphere. The people are nice, and they do everything they can to help us"; "Everybody's pleasant. If I say something, they follow it up right away"; "Lovely, homely and happy. I don't think you could get a better home"; "I can make it my own and I can do what I want, my room has my own things"; "We're well looked after. It's a perfect, happy place".

People told us the staff were kind and caring. Comments included, "They're very good, kind. Some are better than others"; "Lovely, I'm always laughing with them. If they do something silly, I tell them"; "They're grand staff, they never snap at anybody. I've been very, very happy here"; "Alright, no trouble, they're kind"; "They treat me like a person, they're kind".

A relative told us, "[Relative] seems comfortable and the staff seem quite caring". Another said, "They treat [relative] very nicely". A third commented "They seem OK. [Relative's] ability to walk seems to have decreased". A fourth commented, "They are all lovely with [relative], her room is closest to the office just so they can keep their eye on her in case she tries to wander off. They do care I believe it's like an extended family home there's always a lovely atmosphere when you walk in, everyone makes you feel welcome". A fifth person commented, "Caring is very good, [relative] is happy".

A visiting professional told us, "Service users look clean and well cared for". As we walked around the home we saw that people were nicely dressed, in coordinating outfits. They were well presented, with some ladies wearing jewellery. Blankets were provided over knees for those who felt cold.

We were made welcome around the home and we saw that people were addressed by their preferred names. We saw some lovely interactions between staff and people who used the service. The staff were patient and compassionate and appeared to know people very well. Everyone told us there were no restrictions on visiting times and they could have visitors at any time.

We saw many instances of privacy and dignity being respected, with carers offering personal care discreetly. We asked people who used the service about privacy and dignity. One person told us about a male carer, saying, "One day I had an accident and he just came in to clean me up without a word being mentioned about the incident. He did his job in a very nice way and even stayed later than he should just to make sure I was alright, there's not many like that". Another said, "The door is closed when I am getting dressed. The staff knock and don't come in unless I tell them to". The home had appropriate policies around confidentiality and data protection and staff were aware of its importance.

We did witness one incident where the house manager, seeing a person upset, had a rather sensitive conversation with them in a communal area. This would have been better done in a more private setting. We brought this to the attention of the registered manager, who agreed to address it with the staff member in question.

There was an appropriate policy and procedure in place with regard to equality and diversity and staff had undertaken training. The home also had access to independent advocates if these were required to support people.

Communication needs were recorded within care plans and information could be produced in a number of different formats to suit people's needs. Staff gave clear explanations to people living with dementia to assist their understanding. The service could offer the use of picture cards or spelling boards as an alternative way for people to communicate. We saw that the home responded to people's diverse needs. For example, one person who used the service understood little English as this was not their first language. There were staff on site who could speak this person's first language and they were able to communicate well with them. We saw that a recent movement of staff had been changed to allow these two staff to remain on the house where this person resided to help address their communication issues. The staff were happy to stay.

Communication was said to be good between families and the home. One relative told us, "They [staff at the home] communicate well when for example [relative] falls". Residents' and relatives' meetings were held on a regular basis to keep people up to date with on-going developments and any changes. We saw minutes of a recent meeting which had been well attended. An action plan was formed from the feedback received and minutes were posted within all the houses for people to read. The service had a Facebook page, which helped them keep in touch with relatives for those people who used the service who had given permission. A professional visitor told us, "I come in and do reviews, I get on fine with the staff. They are always very friendly and welcoming".

There was some evidence within care plans that people had been involved with decisions around their care planning and reviews. People we spoke with had mixed views about their involvement. One said, "Initially two years ago [was consulted]". Another told us, "It's not been discussed at all. They said [relative] should be in a nursing unit and they're thinking of transferring her". However, many other relatives spoken with said they were very involved with all aspects of their relatives' care and support.

We asked if people were encouraged to be as independent as they could be. One person said, "I'm very independent, I give my own insulin". Others told us they did as much as they wanted to for themselves, with staff helping with the things they couldn't do. The examples they gave were washing hands and face and eating independently. One person had been provided with a bowl from home so that they could eat their meals without using a plate guard. We also saw different cutlery and a variety of drinking vessels designed to help people with independence. All appropriate equipment was in place for people to aid their independence. The equipment was well maintained and in good working order.

Good

Is the service responsive?

Our findings

We asked people if they felt the service was responsive. One person told us, "I'm happy enough that if my [relative] needed a carer straight away, they would be here. We've only been here around nine weeks but already really like it, they are always lovely to me as I visit every day to see my [relative]". Other people agreed that staff responded quickly to call buzzers.

Care files included a great deal of information about people's backgrounds, food and drink preferences, hobbies and interests, family, work history, religious and spiritual needs and routines. People we spoke with told us they could get up and go to bed when they wanted to. They chose where to sit in the lounge and dining room and some people stayed in their bedrooms. People told us they could decide whether to have their bedroom doors open or closed, whether they preferred male or female staff and where their buzzer should be for ease of use. We saw people being given choices of food and clothes. We heard a staff member say they were keeping someone's lunch for them as they were attending an appointment.

We saw evidence of regular care plan and risk assessment reviews within the care files. Changes to health, care and support were recorded and plans updated. A professional visitor told us, "New service users are reviewed within seven days and have six monthly reviews after that".

Activities had improved at the home and were offered seven days and two evenings per week. Every person received a weekly programme of activities for their room which covered seven days. Major activities were held on one house and people from any of the other houses could attend. The activities team had been expanded. We spoke with one of the coordinators who told us, "I think we can do the little things that the carers sometimes miss, [for example] putting the music on. The [activities] lady that works the evening will do it at teatime". They went on to say, "They [activities] have improved so much. We try and make sure we reach each unit every day. We tend to do a lot of resident led activities. We will do musical bingo, which is good for those who can play, and the others can enjoy the music. Relatives can join in with activities and relatives get involved with Christmas fair". The service also celebrated key dates, such as Burns Night.

People who used the service told us, "I read quite a lot. I don't like to join in, but I get a list of activities in my room every week"; "I like being on my own"; "I read a fair amount, I've got a crossword book. I watch the telly, I don't want to join in"; "Playing scrabble, reading, crosswords and watching television"; "I do gardening in the summer and I enjoy the bingo"; "I enjoy it when we have bingo, I also have my nails cut and hands manicured, oh its lovely".

A relative said "I don't think [relative] joins in the activities. She used to like singing". Another told us, "[Relative] tries to join in". A third told us, "There are more activities now. [Staff member] brought lego and [relative] enjoyed making things".

We saw that there were TVs on for most of the day and it was unclear who chose the channel or whether people had the option to change this. On the inspection days we saw some reminiscence therapy being done, some people were helping to make Christmas decorations and a staff member was reading the paper

with a person who used the service. There was age appropriate music on in most of the houses and some had rummage boxes for people to use. We also saw an animal therapy activity. There was a range of animals from chinchillas to millipedes, snakes, owls and a tarantula. The majority of the people were really keen and enthusiastic about touching them. One person stated, "It's a great experience and breaks up the boredom when they do things like this, I enjoy something different".

There was an on-site café which was open two afternoons per week for people who used the service and their families to access. The home had recently obtained money from a grant which they had used to create the 'Village Green', with a greenhouse and garden area which was easily accessible for people with restricted mobility. They had set up a garden shed which was being used as 'Santa's Grotto' at the time of our inspection, to encourage families to bring their children to visit. A local nursery had been involved in the opening of the 'Village Green', which people who used the service had thoroughly enjoyed, and they were now planning to visit on a regular basis. Other local school groups also visited regularly to chat and read with people who used the service.

Some people were taken on shopping trips, and evening socials, where families and visitors were welcome, were a regular occurrence at the home. These included karaoke and quizzes as well as visiting entertainers and pantomime. There were also occasional trips further afield, for example, one person told us, "We went to Blackpool to see the illuminations, we went for a meal first which was lovely and then onto Blackpool we didn't get back until it was late, we had a lovely time".

We saw evidence that the service was looking at more meaningful one to one activities, for example, one staff member took time to read religious scriptures with a person, two or three times per week. Training in meaningful activities was on-going for staff.

There was an appropriate complaints procedure and we saw that complaints were responded to individually, in line with the procedure, and an overview was regularly analysed for patterns and trends. We asked if people were aware of how to complain. Comments included; "No, but my granddaughter would"; "Not really, you don't know who the boss is"; "Yes, I'd shout from the house tops". Everyone else said they would speak to a member of staff. Two people said they had made complaints in the past but these were dealt with promptly.

There was a compliments register, and we saw a number of compliments. One said, "Just to say how much I am impressed with the care and attention, I find the staff most diligent and caring". Another, following a relative's death at the home, read, "I am eternally grateful that [relative's] last hours at Mill View were happy ones, I am so glad that he was able to enjoy a glass of shandy while we were with him. I want to thank you and all staff for the level of care and kindness he received, without exception".

Future decisions, where these had been expressed, were recorded within care plans. People were supported to remain at the home when nearing the end of their lives if this was their wish. The service was liaising with the local palliative care team to arrange training around end of life care, and care after death. A professional visitor told us, "Plans are put in place if people wish to remain at the home at the end of their lives".

Requires Improvement

Is the service well-led?

Our findings

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 was a registered manager in place at the home.

There was a statement of purpose in place which set out the aims and objectives of the company. It also outlined dignity and privacy, safety and support.

We asked people if the management of the service were accessible and approachable. Some people who used the service were unsure who the manager was, but most people we spoke with told us they were. One person said, "If I had a problem or concern I would either go to the office or speak with [registered manager], the big boss, and they would sort it out straight away, I'm confident about that"; "No concerns about the service. [registered manager] is brilliant". One relative told us they were much happier with the care recently and felt they were listened to. Other relatives told us, "The manager is accessible"; "You can get hold of people easily, including the manager".

Staff told us they were well supported by the management and had regular supervisions and staff meetings to facilitate discussions. Comments included "[Registered manager] is supportive – all the way. All the management are supportive"; "It's a really, really good home, staff are friendly and motivated. [Registered manager] supports the staff and brings in new ideas, listens to staff and takes things on board. She is open to trying new things"; "[House manager] is brilliant, I can talk to her about anything".

A visiting professional told us, "Not much change [since the transition from one provider to another], it is helpful that there are still the same staff, really good that they have kept hold of [registered manager]. It is seamless for the residents. The core staff here don't really change, the main staff on each unit".

There were regular daily handovers on each house, daily meetings for the heads of department, as well as specific staff group meetings. We saw minutes of recent meetings where discussions included rotas, workload, training, environment, complaints, new policies, food, uniforms, charts, MCA and safeguarding.

The company had a number of quality assurance processes in place. Audits were carried out on each house and discussed in the daily head of department meetings. We saw audits relating to areas such as health and safety, environment, dining experience, infection control, care plans, accidents and incidents and falls. Action plans were formulated where needed and actions completed in a timely manner.

Whilst systems were in place to gather information about the service, these were not sufficiently robust to identify the concerns we identified around medicine management and accurate maintenance of care records identified in the 'safe' and 'effective' sections of this report.

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

Accidents, incidents and falls, and complaints were fed back via the manager's monthly report for analysis and to look at lessons learnt. There were regional governance meetings and the regional director and quality manager fed back information where appropriate.

Internal quality inspections were undertaken by the regional quality manager and the data used to look at risks and areas for improvement. There were monthly regional director visits and we saw that these included interviewing staff, people who used the service and relatives, looking at premises, events, medicines, maintenance, staff issues and documentation. These resulted in the formulation of action plans to aid improvement to service delivery

We looked at a recent survey completed by 12 people who used the service. This showed that 100% were satisfied with the care home, staff, food, bedroom and communal spaces, 91% were satisfied with activities. The service was looking to improve the activities by asking for volunteers, inviting external speakers and clubs, and expanding the activities team.

We saw evidence of good partnership working. The service had recently received compliments from the local Clinical Commissioning Group (CCG) as follows; "The care plans I reviewed were excellent in [two of the houses], they were beautifully written and reflected the patients' needs accurately". The service had also been complimented regarding the reduction in the number of patients being sent to the local A and E department and call outs, due to a successful working relationship with the local GP practice.

The service had good links with the wider local community, including nurseries, schools and colleges. They attended local forums to share information and good practice with other homes and clinical professionals to aid improvement to service delivery. They had established links with local community policing service who visited regularly to help build confidence in people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Suitable processes for the safe management of medicines were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous records were not maintained. Systems in place to gather information about the service were not sufficiently robust.