Shaw Healthcare Limited

Mill River Lodge

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Mill River Lodge provides accommodation for 70 older people. It offers nursing and personal care for older people with physical frailty and for older people who are suffering from dementia. There is a passenger lift to provide access to people who have mobility problems. There were a total of 96 members of staff employed plus the manager. On the day of our visit 66 people lived at the home.

At our inspection to Mill River Lodge in June 2013 we found the provider did not always support people to make informed choices with regard to their care. At this inspection which was carried out on 3 and 17 February 2015 we found improvements had been made. However we identified areas where improvements were still needed.

The service did not have a registered manager. 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

Summary of findings

meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Mill River Lodge has been without a registered manager since June 2013. A new manager has been appointed and was in the process of applying for registration.

People told us they felt safe. Relatives told us they had no concerns about the safety of people. There were policies and procedures regarding the safeguarding of adults and staff knew what action to take if they thought anyone was at risk of harm.

Care records contained risk assessments to protect people from risks and help to keep them safe. These gave information for staff on the identified risk and guidance on reduction measures. There were also risk assessments for the building and contingency plans were in place to help keep people safe in the event of an unforeseen emergency such as fire or flood.

Thorough recruitment checks were carried out to check staff were suitable to work with people.

Relatives and staff told us that staffing levels could be improved. The provider was in the process of conducting a review of staffing levels based on the number of people living at the home. This review also took into consideration people's support needs.

People were supported to take their medicines as prescribed by their GP. Records showed that medicines were obtained, stored, administered and disposed of safely

Each person had a plan of care. However these did not always provide staff with the information they needed to support people effectively. Reviews of care plans did not show who was involved in the review process and any progress or lack of it was not recorded. The provider identified that more information was required in some care plans and was currently undertaking a review of all care plans. Although this was being carried out it had not yet been fully completed for all care plans. Staff knew what support people needed and how this should be provided.

Staff were supported to develop their skills by regular training. The provider supported staff to obtain recognised qualifications such as National Vocational Qualifications NVQ or Care Diplomas (These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.) People said they were provided with the training they needed to support people effectively.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that although the provider had suitable arrangements in place to establish, and act in accordance with the Mental Capacity Act 2005 (MCA) this was not always applied in full. This was because some people who lacked capacity had not yet been fully assessed regarding their capacity to agree to their care and treatment. The provider and manager understood their responsibility with regard to Deprivation of Liberty Safeguard (DoLS) and they had applied for authorisation under DoLS to ensure people were protected against the risk of being unlawfully deprived of their liberty.

We observed activities taking place for people. However improvements could be made in how recording of activities took place. This would help ensure that people were not at risk of social isolation. We observed staff trying to engage with people but as staff were always busy there was little time for social interaction.

People were satisfied with the food and said there was always enough to eat. People were given a choice at meal times. People were able to have drinks and snacks throughout the day and night. Meals were balanced and nutritious and people were encouraged to make healthy choices.

Staff supported people to ensure their healthcare needs were met. People were registered with a GP of their choice and the manager and staff arranged regular health checks with GPs, specialist healthcare professionals, dentists and opticians. Appropriate records were kept of any appointments with healthcare professionals.

People told us the staff were kind and caring. Relatives had no concerns and said they were happy with the care and support their relatives received. Staff respected people's privacy and dignity and used their preferred form of address when they spoke to them. Observations showed that staff had a kind and caring attitude.

People told us the manager and staff were approachable. Relatives said they could speak with the manager or staff

Summary of findings

at any time. The manager operated an open door policy and welcomed feedback on any aspect of the service. Regular meetings were booked to take place with staff, people and relatives.

The provider had a policy and procedure for quality assurance. Weekly and monthly checks were carried out to help to monitor the quality of the service provided. The provider had carried out an audit of the service and identified areas for improvement. An action plan had been put in place to monitor and check that these improvements were taking place. However these improvements were not yet completed or embedded in practice to ensure they could be sustained. We did not find evidence that there were effective systems so management and staff could learn from any accidents, complaints or incidents. We have made a recommendation regarding this matter.

We made a recommendation regarding the information containined in plans of care and the care plan review process.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report

Summary of findings

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.

People told us they felt safe. However relatives and staff told us there were not always sufficient staff to support people safely.

Staff had received training on the safeguarding of adults and this helped to keep people safe. Risk assessments were in place together with risk reduction measures to help keep people safe.

Medicines were stored and administered safely by staff.

Is the service effective?

Requires improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always applied in full. People were subject to restraint without appropriate authority.

People were supported by suitably skilled staff who had received induction and ongoing training.

People had enough to eat and drink and were supported to make informed choices about the meals on offer.

People were supported to access health care services when needed.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring. Relatives said they were happy with the care and support provided.

People's privacy and dignity was respected. People and staff got on well together and the atmosphere in the home was caring, warm and friendly.

People were supported to maintain relationships with their family. Relatives spoke positively about the support provided by staff. Staff understood people's needs and preferences.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans did not always provide staff with the information needed to respond appropriately. Reviews of care plans did not show who was involved in the review process and any progress or lack of it was not recorded.

Although activities took place the recording of activities did not always reflect how people had been involved in any activities or stimulation.

Summary of findings

Staff communicated effectively with people and involved them to make decisions about the support they wanted.

Is the service well-led?

Requires improvement

The service was not always well led.

Although the provider and manager had put quality assurance systems in place these were not yet embedded in practice.

Mill River Lodge did not have a registered manager in post. However a new manager had been appointed and was in the process of applying for registration.

People told us staff were approachable and relatives said they could speak with the manager or staff at any time.

The provider sought the views of people, families and staff about the standard of care provided. However they did not have clear systems in place to learn from accidents, complains or incidents.

Mill River Lodge

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 3 and 17 February 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist with a nursing background and expert by experience conducted the inspection. The expert by experience carried out interviews to ask people and their relatives, what they thought of the service provided by Mill River Lodge. 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 expert by experience had a background in dementia care.

Before the inspection we reviewed information we held about the service including previous inspection reports. We also looked at notifications of incidents which occurred. A notification is information about important events which the service is required to tell us about by law. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with 16 people, nine care staff, two team leaders, three domestic staff, two unit managers, and the manager. We also spoke with a project manager and a clinical supervisor employed by Shaw Healthcare Limited. They were currently working at the home to offer support to the new manager and to oversee an improvement plan which had been put in place by the provider. We also spoke with seven relatives, a GP who visited the service each week and a member of staff from the local authority safeguarding team.

During our inspection we observed how staff interacted with people and how they supported them in the communal areas of the home. We looked at plans of care, risk assessments, incident records and medicines records for 10 people. We looked at training and recruitment records for six members of staff. We also looked at a range of records relating to the management of the service such as activities, menus accidents and complaints as well as quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

The manager told us that staffing levels were based on the numbers of people being supported and their dependency levels. The home was divided into three areas. There was a 10 bedded residential unit, two 10 bedded nursing units and four 10 bedded dementia units. There was a minimum of two members of care staff employed on each of the seven 10 bed units during the day and evening. In addition there was a team leader/unit manager who supervised staff on the residential, nursing and dementia units and they provided additional support as required. At night there were three members of staff on the residential and nursing unit and four staff working on the dementia unit. Night staff were supported by two senior care staff. Currently staffing was provided by permanent staff who were backed up by agency staff. We looked at the homes staffing rota for a two week period covering our visits. This showed that out of the 574 day and night shifts 141 were being covered by agency staff.

We observed that staff were always busy and did not have time to chat with people. However staff did acknowledge people and responded when they were asked for support. Relatives told us they had some concerns regarding the staffing levels at the home. One relative said "I think the staffing levels need to go up sometimes I can be the only person in the lounge". Staff voiced some concerns about the staffing levels and the use of agency staff. One staff member said "Agency staff are frequently used; however they try to get regular staff". Visiting professionals also felt that the high use of agency staff was impacting on the continuity of care provided. The manager told us that there was ongoing recruitment of staff and four new members of staff were due to start employment shortly. This would further reduce the amount of agency staff used.

The manager told us that they were aware that there were some concerns regarding staffing levels and the provider was in the process of conducting a review of this. As part of this review staff were recording in a dependency diary the time they spent supporting each person over a 48 hour period. Once this information was collated it would be sent to the providers head office so that the number of staff required to provide support to people could be clearly identified. However until this review was completed it was not clear if at all times there were sufficient number of staff on duty. On the days of our visit the staffing levels were sufficient to meet people's needs. However staffing levels needed to be constantly monitored due to people's changing needs.

People felt safe at the home, they said staff gave them any help they needed. One person said "Yes I do feel comfortable and safe with the staff". Another told us "The staff work hard and sometimes are a bit short staffed". One relative said "I have not been able to visit for six weeks and I have no worries about my relatives care and safety". However one relative was unhappy and said "there are never enough staff around, you never see as many as there are today". People told us they could see the doctor whenever they wanted. One person said "I know they would get the doctor to see me. The doctor is often around seeing people".

The provider had an up to date copy of the local authority safeguarding procedures. The manager knew what actions to take in the event any safeguarding concerns were brought to their attention. The staff training list we looked at showed five of the 96 staff had not yet received training with regard to keeping people safe. The manager told us that this was due to sickness and maternity leave and that staff would undertake this training when they returned to work. Staff knew how to report any safeguarding concerns to their manager or to a member of the local authority safeguarding team. Staff were able to describe the types of abuse they might witness or be told of and knew what action to take. We spoke with a member of staff from the local safeguarding team who told us Mill River Lodge co-operated and worked with them with regard to any safeguarding incidents. A GP who was a regular visitor to the home told us that they felt people were cared for safely.

Risk assessments were in place to keep people safe. These were contained in people's plans of care. Staff used the waterlow pressure ulcer risk assessment tool to identify those at risk of developing pressure sores. Malnutrition Universal Screening Tool (MUST) assessments were also completed to identify and support those at risk of not receiving adequate nutrition. We saw risk assessments in place for moving and handling and for managing people's risk of falls. Where risks had been identified there was information for staff on the type and degree of risk together with information for staff on how the risk could be reduced. Staff confirmed risk assessments gave them the information they needed to help keep people safe.

Requires improvement

Is the service safe?

The provider had an up to date fire risk assessment for the building. Each person had a personal evacuation plan which recorded any specific actions required in the event of an evacuation. There were contingency plans in place should the home be uninhabitable due to an unforeseen emergency such as total power failure, fire or flood. These plans included the arrangements for overnight accommodation and staff support to help ensure people were kept safe.

Regular maintenance checks of the building were carried out and a full time maintenance person was employed. If staff identified any defects they were recorded in a log and reported to the maintenance person who carried out repairs as required. Once defects were repaired they were signed off. The manager said that any defects were quickly repaired and this helped to ensure people and staff were protected against the risk of unsafe premises.

Recruitment records for six members of staff showed that appropriate checks had been carried out before staff began work. Potential new staff completed an application form and were subject to an interview. Following a successful interview appropriate and required recruitment checks were carried out to ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place.

There was an accident book where any accidents were recorded. The manager was aware of the procedures to follow should there be a need to report accidents to relevant authorities. Records showed that any accidents recorded were appropriately dealt with by staff and medical assistance had been sought if required.

Staff supported people to take their medicines. The manager told us the provider was in the process of updating its policy and procedure for the receipt, storage and administration of medicines for all the registered homes. There was not a specific medicines policy for staff at Mill River Lodge detailing the procedure that were specific to the service and the people living there. This meant that staff had to rely on a lengthy corporate policy to give them guidance. Staff agreed that a service specific policy would help them as the organisation policy may not always reflect the procedures carried out at Mill River Lodge. Only trained nurse staff administered medicines in the nursing and residential units. In the dementia unit medicines were administered by senior care staff who had completed appropriate training and who were deemed competent by the dementia unit manager.

Medicines administration records (MAR) were completed accurately. We observed the lunch time medicines being administered and saw that this was carried out in a calm and unhurried manner. People were encouraged to drink with their medicines and the staff member ensured medicines had been taken before leaving the person and signing the MAR. There were procedures in place for the use of controlled medicines. These were kept in accordance with appropriate guidance.

Requires improvement

Is the service effective?

Our findings

At our inspection to Mill River Lodge in June 2013 we found the provider did not always support people to make informed choices with regard to their care. This because people's care records did not always contain information about the care decisions people could make. At this visit we found improvements had been made and people's agreement to care was contained in their plans of care. However we were not assured the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were applied in full. Staff had not received training but understood the basic principles that people should be assumed to have capacity. However they were unsure how this was established or implemented. They told us if they had any concerns they would speak to the manager. . The manager informed us that care plans were currently under review. Capacity assessments were being carried out and best interests were being recorded for those people who lacked capacity. However this had not yet been completed for all people who were at risk of having their liberty deprived.

In the dementia unit one person who lacked capacity had a care plan for personal care and challenging behaviour. There was no information in the care plan about what these behaviours were or how staff should support the person. The care plan stated 'two staff to shower and one to use minimal restraint whilst giving personal care' There was no explanation of what 'minimal restraint' was or how restraint should be applied. When asked about this the staff member said "if (x) is trying to hit us, we hold their hands". The staff member said they had no training on restraint, although challenging behaviour was covered during induction. This person had not had their capacity assessed and no best interest's decisions had been recorded.

The lack of clear guidance on the use of restraint and the omission of relevant best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had just updated their policy and procedure for complying with the MCA and DoLS. This was a comprehensive document and included sample assessments of capacity and examples for establishing best interests.. We spoke with the lead person for MCA and DoLS. They said they had just completed the company training course and said this was extremely useful. The manager said that all of the senior staff will be completing this course in the coming weeks. Once this had been completed for senior staff it would be rolled out for all staff.

People told us they got on well with staff and they were well supported. Relatives told us the staff provided effective support to people. One relative said "I only have to ask and they get things done". However one relative said "If I was not here I am not sure my relative would get the support they need because the agency staff does not know them well enough". People told us the food was good. One person said "The foods fantastic, in fact I've put a bit of weight on in here". Relatives said their relatives were happy with the food provided. People said their health needs were met. People said they could see the doctor whenever they wanted. One person said "I know they would get the doctor to see me. The doctor is often around seeing people". A relative said "I know the physiotherapist, speech therapist and occupational therapist have been involved in my relatives care".

As we toured the home we observed the environment had wide corridors with good lighting and signage around the home to assist people finding their way around. People's doors had visual interests displayed and had a door knocker and post box. People's names were on their doors.

The manager told us about the training provided for each member of staff. Training was provided through the providers own training team and via computer based E learning. These helped staff to obtain the skills and knowledge to support people effectively. Training records showed that staff had completed training in the past six months with regard to; fire, health and safety, manual handling training, infection control, safeguarding and food hygiene updates. We did not see any training for managing challenging behaviour or for the use of restraint. The manager told us that this will be booked for all care staff.

The provider encouraged and supported staff to obtain further qualifications to help ensure the staff team had the skills to meet people's needs and support people effectively. Of the 96 staff employed 61 had achieved qualifications equivalent to National Vocational Qualifications (NVQ) or Care Diplomas. These are work

Requires improvement

Is the service effective?

based awards that are achieved through assessment and training. To achieve an NVQ candidates must have proved that they have the ability and competence to carry out their job to the required standard.

New staff received a structured induction in line with the Skills for Care common induction standards which are the standards people working in adult social care need to meet before they can safely work unsupervised.

The manager told us that previously supervision had been lacking for staff. They told us this was an area they had recognised required improvement and they had made steps to rectify this. Staff said that they had not been receiving regular supervision in the past but this was now taking place. We saw a supervision plan on the notice board in the manager's office giving dates for staff supervision. This plan showed that consistent supervision was planned for all staff so they could receive the support they needed. Staff confirmed there was a supervision plan in place but not all staff we spoke with had received supervision in the past three months.

Two people we spoke with told us that they sometimes had difficulties in communicating with staff where English was not their first language. One comment was "sometimes trying to get them to understand you and to understand them is difficult, you feel like just giving up". We spoke to the manager about this issue who told us the provider was arranging lessons for those staff who were having difficulties with the English language. Another member of staff also told us "there is a lot of communication breakdown between team leaders, you get told one thing by one and then another says something different, it would be helpful if they all sang from the same hymn sheet". The manager said that this was an issue that had been identified and an action plan was in place to improve communication.

We observed lunch time on the 1st floor dementia unit. There were 15 people eating in the lounge/dining room.

Two people were being assisted by staff and one person was assisted by their relative. There were enough staff on hand to assist people with their lunch. Several people required prompting or some assistance. Staff assisting people were chatting and encouraging. We saw that people were served their vegetables individually from a platter and not just put on plates. People were given time to eat their meal and were not rushed. Observations showed that people in the nursing and residential units were also appropriately supported with their meals. People were asked for their menu choices a day in advance. We asked the unit manager of the dementia unit about this as people could find it difficult to remember what they had chosen. They told us that the menu sheet came down with the meals but if someone saw something different they wanted, this was not a problem as there was always enough food sent down so people could change their minds.

People's healthcare needs were met. People were registered with a GP of their choice and the manager and staff arranged regular health checks with GPs, specialist healthcare professionals, dentists and opticians as and when required. We spoke with a visiting GP who told us they carried out a weekly visit to Mill River Lodge. They toured the home and spoke with staff and attended to patients as required. They said that this arrangement had resulted in an improvement in the standard of health care provided for people. Care records showed that people had received support from a range of specialist services such as speech and language specialists as well as mental health and occupational therapy teams. Staff said appointments with other healthcare professions were arranged through referrals from their GP. Following any appointment staff completed records to show the outcome of the visit together with any treatment or medicines prescribed. These helped to provide a health history of the person to enable them stay healthy.

Good

Is the service caring?

Our findings

People were happy with the care and support they received. They told us they liked the staff and said they were really kind and they were well looked after. Comments included "The staff are very careful, tender and helpful". "I've been here a while and I'm happy here, it' pretty good and a happy place". "The main girl that looks after me knows me very well she asks me what I want and knows how I like things to be". Relatives said the staff were friendly, caring and considerate, they are always bright and cheerful". A visiting GP told us "Staff genuinely seem to care for people they are supportive and treat people as individuals.

Each person had an individual plan of care. These guided staff on how to ensure people were involved and supported. Each person's care plan contained information about the person's past history. They also detailed the person's likes and dislikes. Staff told us this enabled them to positively engage with people. Staff said whenever possible they liked to spend time talking with people and encouraging them to talk about things that were important to them.

Staff talked about people in a caring manner, for example they knew about people who were not well and how they were cared for. A staff member said "I asked myself, 'is this a home I would be happy for my nan to go to?' And the answer is yes". Staff talked about wanting to spend more time with people, and how they had got to know them.

Staff were knowledgeable and understood people's needs. We observed that staff were caring in their approach, prompting and assisting people where required, people were spoken to respectfully and kindly. For example a person was standing alone and appeared confused. A staff member came up to them and said "come on (person's name) do you want to come and sit with me?" and they took the person to sit with them in the lounge. Staff explained what they were doing and gave people time to decide if they wanted staff involvement or support. This approach helped ensure people were supported in a way that respected their decisions, protected their rights and met their needs.

We observed a relative giving a drink to someone in a spouted cup. A staff member came over and said "if you don't mind can I let you know that (person's name) can drink from an ordinary cup and it seems easier for them than using the cup with the spout". The member of staff demonstrated what they meant and the relative and person concerned was very happy with this. The interaction was handled in a caring, sensitive manner for both the person and relative.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. Observations showed staff had a caring attitude towards people and a commitment to providing a good standard of care. We observed staff supporting people in various units and conversations between staff and people was warm and friendly and not just care focused.

We observed people were walking around the home freely and unrestricted. As we toured the building people were happy to engage with us and we saw staff smiling and checking with people how they were but did not interfere unless someone asked for support.

All staff, including those with domestic and catering roles interacted well with people. All staff were seen to treat people with dignity and respect. There was a good rapport between staff and people and they got on well. The atmosphere in the home throughout our visit was warm and friendly. Staff knocked on people's doors and waited for a response before entering.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in a staff communication book which was a confidential document or discussed at staff handovers which were conducted in private. A staff member said "we give personal care either in people's rooms or the bathroom or toilet, we close doors, personal care is only carried out in private".

Regular residents meetings were conducted and all people were invited to attend. These were used to discuss any issues they had and these gave people the opportunity to be involved in how their care was delivered. Minutes of these meetings showed people were involved and put their views forward. These were listened and responded to.

Good

Is the service caring?

People were supported to dress in their personal style. We saw that everyone was well groomed and dressed appropriately for the time of year.

Requires improvement

Is the service responsive?

Our findings

People said staff were good and met their needs. Comments from people included "They (the staff) do everything I want and I've got everything I need", "They remember what I like and don't like", "I'm pretty independent but I can ask for help if I need it and they always respond" and "I'd recommend it here and so would my family". A relative said "My relatives mobility has deteriorated but they can still get around the unit and staff will give support when needed". Another said "I am able to take my relative home and this is important to both of us".

Each person had an individual care plan which had information on the support people needed together with information on what the person could do for themselves. Care plans also contained information on people's medical history, mobility, communication, and essential care needs including: sleep routines, continence, care in the mornings, care at night, diet and nutrition and socialisation. These plans provided staff with information so they could respond positively, and provide the person with the support they needed in the way they preferred. In the residential unit there was also a 'quick information' plan which gave staff some information about peoples support needs. These were not in sufficient detail and did not provide all the information staff needed. These quick information plans were confusing. For example the quick information plan for one person stated that the person needed to be transferred using a hoist. However there was no information about the type of hoist or the type of sling to be used. A more detailed care plan was kept in the office but this was away from the residential unit and not always accessible to staff. Therefore staff may not have sufficient information readily to hand to support people effectively. We spoke to the unit manager who told us that they would update the quick reference care plans so staff had clear information to follow. The manager told us that they had already identified that changes were needed and all care plans were currently being reviewed. Senior staff were currently working to update and re-write people's care plans.

The manager told us when any changes to care plans had been identified this was recorded. We were able to confirm this in the care plans we saw. However in the majority of the care plans we looked at the recording was only a one line comment of 'no changes'. Reviews did not contain an evaluation of how the plan was working for the person concerned. Any progress or lack of it was not recorded or monitored and the reviews did not show if the person concerned or any relative had been involved in the review process. Staff told us that they had to record on each individual care plan rather than reviewing the care plan file as a whole. This was a time consuming process and staff felt that a simpler and more effective system (such as one review for the whole care plan file) would benefit both staff and people who used the service.

We recommend that the provider seeks appropriate guidance to ensure that all care plans contain sufficient information for staff to ensure that people's assessed needs are met and that care plan reviews ensure that care plans reflect people's current needs and support.

Staff told us information about people's changing day to day needs came from the handover at the start of each shift. The off going team leader on each unit would give a handover to the oncoming team leader. They would complete a handover sheet and this would provide information on any issues or incidents that had taken place. It also provided information on any appointments that were planned. The team leader would then pass this information to all of the oncoming staff for the unit and ensure that staff were directed appropriately. Staff said the handover sheet was relatively new but said it was working well and helped avoid any confusion.

The provider had organised for the West Sussex Care Home In Reach Team to provide workshops for staff. This team had made recommendations to improve the quality of service for people living with dementia and helped make staff more responsive to people's needs. The manager told us that some of these recommendations had already been put in place. For example, soft background music was now being played in the dementia unit and a range of magazines and books were now left on tables for people to look through. The In Reach team also recommended a sensory room be put in place in the dementia unit as this would be beneficial for people with dementia. The manager told us they had identified a suitable room and this would be converted to a sensory room in the next few weeks.

Staff recorded the support that had been given to people in care notes. Staff recorded information regarding daily care

Requires improvement

Is the service responsive?

tasks, including the support that had been provided and personal care tasks that had been carried out. This information provided evidence of care delivery and how staff had responded to people's needs.

A GP who visited the home each week told us how the provider had managed an outbreak of flu at the home. They said they had taken the advice provided by the GP and had worked closely with the GP surgery to manage the situation. The GP said the response to the outbreak was dealt with efficiently and prevented the spread of infection as much as possible. The GP said the provider takes seriously any concerns they have and act accordingly.

There was a programme of activities in place. These were displayed on notice boards around the home. Activities included movement to music, collage, crafts, card games, memory quiz and church services. The provider employed an activities co-ordinator who engaged people in various activities throughout the day. We saw this staff member spending time with people showing them old magazines and reminiscing in their conversations. People were smiling and interacting with the staff member. Activities were recorded in people's individual care plans, however this only recorded when people actually took part in a planned activity. We explained to the manager the need to show what other interactions were offered to people each day in order to ensure that people were not at risk of social isolation. The manager told us they would introduce an activities book to record all activities that took place in each unit. This would show what activities had been offered to people and help staff to monitor those people who did not take part in activities.

We observed how staff responded to people's needs. Staff spent time with people and responded quickly if people needed any support. When staff were giving support to people they ensured people had enough time and did not rush people. People told us that the staff in the home knew what support they needed and provided this as they needed it. Call bells were answered in quickly and people confirmed that staff responded in good time.

People were supported to maintain relationships with their family. A relative told us they were in regular contact with the home and were kept informed of any issues regarding their relative. They said whenever they visited they could talk to the manager or staff and they would inform them of how their relative was progressing. Families we spoke with told us that they were able to visit their relatives whenever they wanted. They said that there were no restrictions on the times they could visit the home. One person said, "I come on different days and times and it's never a problem".

The provider had a complaints procedure in place and copies of the complaints procedure were given to people and relatives when they moved into the home. A copy was also on display on the notice board in the home. Concerns and complaints were recorded on the computer system and passed to head office. Staff told us they were not always informed about any complaints and they heard about them through other staff. They said the management did not discuss complaints with them unless the complaint was relevant to them. They said there was currently no system in place for staff to learn from concerns or complaints. The manager said that in future complaints would be discussed at staff meetings so that learning could take place.

Requires improvement

Is the service well-led?

Our findings

People told us the manager and staff were very approachable and they could talk with them at any time. One person told us "If I had any issues I would speak to (x) she's lovely, very good I know I can always speak to her". Relatives told us they could visit at any time. Comments included "You can speak up and tell them if you are not happy". "The atmosphere is a lot better" "The communication is very good they always keep me informed" and "It's much improved – very different to what I would have said six months ago"

The home did not have a registered manager. At the time of our inspection a manager had just been appointed and was in the process of applying to become the registered manager. Mill River Lodge had not had a registered manager since June 2013. The provider had appointed three different managers but they had not stayed in post. During this time the home lacked consistent leadership and staff told us it had been a difficult period. Staff said they did not yet really know the new manager so could not comment on their approach and management style. They told us that previously new managers never stayed for long and this was unsettling for staff. However they mainly dealt directly with the team leaders and unit managers and confirmed they could speak with them at any time. Staff said in the past couple of months there had been improvements in staff morale and felt the home was moving forward and improving.

We spoke to a project manager and a clinical supervisor employed by the provider who have been spending time at the home to support the previous acting manager. They said they were also supporting the new manager and senior staff to move the service forward. They encouraged open communication and operated an open door policy, welcoming feedback. They were confident the home had made improvements and were continuing to strive for this.

The provider had undertaken a full audit of the service provided at Mill River Lodge and found that improvements were required in a number of areas such as care planning, staff meetings, supervision and management and leadership. They produced an improvement plan in November 2014 and this detailed the changes required. We saw this plan was being monitored weekly. Monitoring showed that some actions had been completed while others were ongoing.

Staff felt supported by senior staff and would talk with them if they had any concerns. Staff said they had no hesitation in raising concerns. They could make suggestions and these were listened to and acted upon as necessary.

Regular staff meetings had not taken place over the past six months. However dates for meetings have been booked for remainder of this year. Staff said that previously meetings had been 'a bit hit and miss'. But these were now happening more regularly. They said that if they were unable to attend, copies of the minutes were displayed in the staff room.

We saw there was a weekly head of department meeting and minutes of these meetings were kept. The manager said that this was organised to help to improve communication throughout the departments and to help ensure a consistent message was sent to staff.

Staff told us that any incidents were reported on an incident form which was given to team leaders who sent these to the manager. Staff said incidents on their unit were discussed at handover. They did not know if these were shared with other units so all staff could learn from incidents as a whole team in order to make improvements to the home and people's care. The manager said that any incidents that affected the home in general would be discussed at staff meetings. However we did not see effective systems in place where staff could learn from incidents.

Questionnaires had been sent to families in July 2013 and July 2014, outcomes had been collated. Comments seen from relatives in questionnaires were positive. The manager said she did not know if any other questionnaires had been sent. She did tell us that questionnaires for people, relatives and other stakeholders would be sent out in June 2015.

The manager told us relatives meetings were held three or four times a year and these meetings were used to discuss issues in the home. These meetings enabled people, relatives and staff to make comments and influence the running of the home. Communication between people, families and staff was encouraged in an open way. The last meeting took place on 9 February 2015. The manager said that this was a positive meeting and relatives had recognised the improvements that were being made.

Requires improvement

Is the service well-led?

The manager told us they operated an open door policy and welcomed feedback on any aspect of the service. The manager said they felt confident relatives and staff would talk with them if they had any concerns.

While we saw that improvements were being made many of these were still a work in progress and were not yet embedded in practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010. Safeguarding service users from abuse.** **How the regulation was not being met: The lack of clear guidance on the use of restraint and the omission of relevant best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010.** 11 (2)(a)