Stockport Metropolitan Borough Council

Millview Short Stay Respite

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

Summary of findings

Overall summary

Millview short stay respite service is a care home that offers a short breaks service to people who have a physical disability, a learning disability or both. The home is managed by Stockport Disability Services who are part of Stockport Metropolitan Borough Council. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Millview is a purpose build unit registered to accommodate 4 people for respite care and support. At the time of inspection, the service was providing respite care to 42 people. Milllview is part of a wider provision of supported accommodation for people with learning disabilities which included supported housing.

The first day of inspection took place on the 30 July and was unannounced. We returned to the service on 1, 6, 17 August 2018.

The service was previously inspected in March 2016 and at that time was rated good overall. The service was rated as being good in the four domains of effective, caring, responsive and well-led and rated as Requires Improvement in the Safe domain. This was because we found the provider to be in breach of Regulation 12, safe care and treatment. The provider was not taking reasonably practicable steps to reduce risks in relation to good infection control processes.

Following the last inspection, we asked the provider to complete an action plan to show how they would ensure they met the regulations. The action plan detailed the arrangements made to ensure the service was compliant with Regulation 12.

At this inspection we found the service continued to be in breach of this Regulation. This was because effective infection control policies and procedures were not in place to ensure the cleanliness of equipment, and health and safety and environmental checks were not being completed consistently. We also found new breaches of this regulation relating to how the service managed risk.

We identified breaches of three further regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to Regulation 11, Need for consent, Regulation 17,Good Governance and Regulation 18, Staffing.

We identified two breaches of the Care Quality Commission (Registration) Regulations 2009. These were a failure to submit notifications of incidents, accident and safeguarding concern and failure to have a registered manager in post.

It is a condition of registration that the service has a registered manager in place. At the time of inspection, the service did not have a registered manager. 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. The CQC had not received an application from the registered manager to deregister when they had left their post in April 2017. We advised the current manager to begin the process of registering with CQC as a matter of urgency and we took action to deregister the previous manager from the location.

The service kept records of accidents and incidents and these were investigated and monitored within the service. We could see that action was taken to reduce the risk of accidents reoccurring.

We looked at how people were supported to take their medicines safely. We found that people were supported appropriately with this but that checks were not being completed to ensure medicine that required storage at low temperatures could be stored safely.

We saw records that demonstrated staff received training, supervision and spot checks. However, the records indicated that some training needed updating

The service had systems for governance in place but these were not sufficiently robust to provide quality assurance. The management team had identified this as an area for improvement and we saw this was documented within the service action plan.

People had their needs assessed prior to attending the respite service and had care plans developed in line with these support needs. The service had identified improvements to be but these were not yet in place.

Care plan records and risk assessments were in place. They required reviewing and updating to ensure peoples current care needs were being met.

We looked at peoples care records and found that people were not supported to have maximum choice and control of their lives. We saw that people were subject to a number of restrictions but these had not been assessed under the Mental Capacity act (MCA) and Deprivation of Liberties Safeguards (DoLS).

We saw that the service was working in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Systems to support the safe recruitment of staff were in place. We saw references and Disclosure and Barring Service (DBS) checks were being completed before a member of staff began working for the service.

There were policies and procedures in place to safeguard people from harm. Staff were trained to respond to safeguarding concerns.

People and relatives told us that staff were kind and respectful. We saw that people's privacy and dignity was respected.

There were records of peoples' eating and drinking needs including preferences and support plans readily available within the kitchen. Staff had a good understanding of how to meet peoples' dietary needs and promote independence.

There was a complaints procedure in place and the unit manager told us how they work with people and their families to address concerns when they are first raised.

The service had good links to other agencies and worked closely with people and services to enable them to deliver tailored package of care.

The rating from the last CQC inspection was displayed in the reception area.

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

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.

Infection control practices were not sufficiently robust.

Risks were not regularly reviewed to ensure the on-going safety of people.

The system to safely store medicines that required storage at low temperatures were not being monitored effectively.

The service operated systems to ensure the recruitment of suitable staff.

Staff had a good knowledge of safeguarding and were able to identity and respond to safeguarding issues.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not have best interest assessments or Deprivation of Liberties safeguards (DoLS) for the people regularly accessing respite who were subject to restrictions.

Staff were receiving supervision and support but some training areas were in need of updating.

Is the service caring?

Good

The service remained caring.

People told us the staff were kind and caring.

We saw that staff knew people and their care needs well.

Is the service responsive?

Good

The service remained responsive.

The service worked closely with people and their families to support them accessing respite care.

Care plans and risk assessments were in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the time of the inspection there was no registered manager in place.

The service was not sending statutory notifications to the Care Quality Commission.

People, relatives and staff spoke positively about the current management team.

The service manager had identified a number of concerns prior to the inspection and developed an action plan to address these issues which was on going.

Millview Short Stay Respite

Detailed findings

Background to this inspection

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

This inspection took place on the 30 July, 1, 7, and 17 August, day one was unannounced. The inspection team consisted of an adult social care inspector and inspection manager on day one. Subsequent visits were undertaken by one adult social care inspector. and an adult social care assistant inspector contacted people who receive respite care at Millview Short Stay and their families/ carers to gather their views about the service.

Before the inspection we reviewed the information that we held about the service and registered provider. This included notifications and safeguarding information that the service had told us about. Statutory notifications are information that the registered manager is legally required to tell us about and include significant events such as accidents, injuries and safeguarding notifications. At the time of the inspection we had not received any recent statutory notifications.

We liaised with the local authority, other local commissioners of service and Healthwatch. Healthwatch is an independent organisation which collects people's views about health and social care services. None of the services we contacted shared any concerns about Millview short stay respite service.

The registered manager had completed a Provider Information Return (PIR) prior to leaving the service in April 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the action plan that the registered provider had developed following the last inspection in 2016.

During the inspection we observed how the service ran and reviewed a variety of documents. These included examining four peoples care records and medication records, two staff recruitment files and

information relating to supervisions, training and competency checks and file audits. We looked at the service's policies, procedures and documents and other audits and checks completed by the service.

Six permanent members of staff were employed at the time of the inspection. We spoke with the service manager, unit manager, unit supervisor, a member of the quality team and three members of staff. We spoke with two people who used the service and nine relatives of people accessing the service.

Following our visits to the home we received updates and further information from the service manager and unit manager, local authority health protection nurse and quality assurance team.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection of the service in March 2016 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not have effective systems in place to reduce the risk and spread of infection. The overall rating for this key question was requires improvement. Following the last inspection we asked the provider to complete an improvement action plan to show what they would do and by when to improve the key question to at least good. The service provided us with an action plan. This included a schedule of cleaning and regular audits and checks

During this inspection we found there continued to be concerns in this area.

On the tour of the building we found the home looked clean and was free of any malodours. People and relatives told us the home was clean and told us, "Yes its spotless" and "I would like their cleaner at my house. Its spotless but homely". However, we saw that good infection control practices were not always being followed. We saw evidence that cleaning schedules were being completed by domestic staff but there was no evidence that cleaning audits had been completed as agreed within the action plan. Staff told us that cleaning audits were undertaken but these were irregular and there was no evidence that any feedback was given following these audits.

The service had audits to look at staff hand hygiene but we could only see that this had been completed with one member of staff recently. Staff had access to personal protective equipment (PPE) such as disposable gloves and aprons. This meant that people were protect from the risk of cross infection when receiving support with personal care. We spoke to the management team about securing items such as PPE and personal care products so that only staff could readily access them.

Following the inspection, the health assessment nurse visited the service to review infection control practices at the service. They found that issues were mainly in relation to procedures and processes and up-to-date training of staff. We saw that the management team had taken immediate action to address concerns in relation to cleaning practise and maintenance of equipment and had plans to focus on developing the appropriate policies and procedures following the infection control audit.

People and relatives generally told us that they felt the service was safe. However, three relatives expressed concerns as their family members had been involved in incidents whilst staying at Millview.

We looked at the record of accidents and incidents. The management team told us they investigated incidents and input details into the system. This is then analysed by the health and safety team to look for patterns to reduce potential risk and learn from mistakes. We saw that there were clear records of incidents and these had been investigated and appropriate action taken. The service manager told us this was difficult at times as the building was managed by an external provider, changes required to the building and décor had to be requested and were then completed by this external provider.

The management team told us they recognised the impact that incidents had upon the families and that work needed to be undertaken to rebuild trust when people had an accident whilst being cared for at Millview. We saw evidence of two significant accidents which had not been reported to the CQC as is required under the Health and Social Care Act 2008. This is discussed further in the well-led section of this report.

The service had a safeguarding and whistleblowing policy in place and the staff we spoke with had a good understanding of safeguarding issues. Staff had received training in safeguarding and understood the different forms of abuse and risk. We reviewed the minutes from safeguarding minutes and could see that the service engaged with safeguarding investigations and reviews. However, the service had not sent the appropriate notifications to the CQC as required under the Health and Social Care Act 2008. This is discussed further in the well-led section of this report.

We saw from reviewing a sample of peoples care records that assessments of risk had been made. However, these had not been regularly reviewed and did not cover all potential areas of risk. For example, we noted that in two peoples' care records bed rails were being used but there were no risk assessments in place to ensure that these were used safely, as per the requirements of best practice guidance. We spoke with the unit manager and supervisor and asked them to address this immediately, on the second day of inspection this has been completed. The service manager told us there were plans to improve risk assessments and support aspirations and positive risk taking.

The above is a breach of regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (safe care and treatment).

We looked at how peoples' medicines were stored and found that medicines were stored correctly within people's bedrooms but medicine that required storing at a low temperature in a fridge was not being stored safely. This was because checks of the temperature of the fridge were not being completed daily as required. This meant that peoples medicine may have become ineffective due to being stored at an incorrect temptation. This is discussed further in the well led domain of this report.

We saw that medicine was signed in by staff when people were admitted for respite care and that people's medication administration record (MAR) sheets were being accurately completed by staff. However, MAR sheets were not completed in line with best practice, we found some people's medication had not been booked out on their MAR sheet when they returned home from the service. We spoke with the manager about best practice and ensuring that paperwork was fully completed. This would ensure that people had the medicines they needed and this did not get lost when people returned home. We saw the audits of people medicine records were competed but this was not occurring regularly. This is discussed further in the well led section of the report.

The service manager told us of changes being made in recruitment. Person-centred job descriptions were being developed to enable matching of interests between people and staff members supporting them. There were plans to allow families and people using the service to engage in the recruitment process where possible, such as participating on interview panels.

The service used a person-centred staffing rota and would increase staffing levels to meet peoples care needs. This meant that when people with high levels of care needs or dependency were being supported at Millview additional staffing would be made available, However, we could not be certain there were always sufficient staff to meet people's needs. During the inspection we observed the two members of staff, unit manager and supervisor were all busy supporting people with care needs. This left one person with limited

mobility and required staff support to meet all their care needs alone in the lounge for some time. This indicated insufficient staffing levels.
A relative we spoke with expressed some concerns about the levels of staffing and said, "Just lately it's a lot of bank staff" and "Its agency staff that have not got the training, that's where we've been let down." We spoke to the management team about staffing and both staff and management told us that generally there are enough staff to meet peoples care needs. The service manager told us that cover can quickly be arranged through the on call or desk manager system when this is needed. The service used bureau staff, who were employed by the provider on a casual basis, when additional cover was needed. The managers told us that they tended to use the same bureau staff who knew the people well and had the relevant training and experience.

We found this to be a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (staffing).

We visited the main office and looked at staff recruitment files. The records confirmed the required checks were completed and no member of staff commenced work until they had received appropriate references and they had information from the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff being employed. The service had updated its policies since the current staffing team had joined to ensure they met current good recruitment practice.

We saw the service had policies and procedures on staff recruitment, equal opportunities, sickness, codes of conduct and disciplinary matters. These helped staff to know and understand what was expected of them in their role.

We saw that there were a variety of safety checks in place including daily, weekly, monthly and six-monthly checks of the environment. These covered issues such as fridge temperature, water temperatures, alarm checks and environmental and equipment checks. However, these were not consistently being completed and it was not clear how this information was being used. This made it difficult for staff to identify potential risks and maintain peoples' safety.

During our tour of the premises we looked at the laundry. We noted that the premises were not always securely managed as the door to the laundry was wedged open. This meant there was a risk that people could access potential dangerous and toxic chemicals. There laundry had a system in place to reduce the risk of cross infection between the dirty soiled laundry and that which was clean. We were told that red bags were used to manage soiled items. Red bags are water soluble bags which make soiled items easily identifiable and managed in the laundry.

One relative told us they worried about their family members' safety saying, "The kitchen door is open and [person] could go in and pick the hot pans up. I think it needs risk assessing." We could not see that there were up-to-date risks assessments of the environment.

The maintenance of the premise was undertaken by a private company and consequently the service was not able to evidence that all maintenance had been completed. We saw evidence that health and safety checks were completed annually and fire risk assessments of the property were completed and the relevant actions had been taken. The service completed fire drills and we could see that checks of fire equipment, emergency lighting and alarms were undertaken but were not being consistently completed. We saw records which demonstrated that gas and electrical equipment was tested and serviced annually.

We saw that some peoples had personal emergency evacuation plan (PEEPs) within their care records which told staff how to support the person in the event of an emergency. There were business continuity plans in place. We spoke with the management team about ensuring these plans were specific and detailed to ensure staff were clear on the required actions.

Requires Improvement

Is the service effective?

Our findings

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of the inspection there were no authorised DoLS in place, and no applications had been made. We found evidence that people liberties were being restricted but there was no evidence of best interest assessments and decisions to authorise the use of these restrictive practices. The management team showed us that they had identified people at Millview who were subject to restrictive practices and were looking at best interest and least restrictive options in line with the Mental Capacity Act.

The above is a breach of the Health and social care The above examples demonstrate a breach of regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent).

People told us staff ask consent "every time" and we saw that people were encouraged to make choices and make decision about their care as much as possible.

We looked at peoples care records and found that there was holistic information about peoples care and support needs which included health, mobility and safety. People and their relatives told us that they had been involved in the assessment process. Staff told us there was an introductory process to help people settle when they first begin accessing respite services. This allowed people to develop relationships with the staff and an understanding of the service, helping them to feel secure, prior to staying overnight.

The service used a communication book to handover important information and changes in peoples care records. Staff updated themselves by reading peoples care records and the communication book at the beginning of shift and we observed that staff did this.

An induction process was in place and people who were new to care work were supported to complete the care certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. All the staff working at Millview had worked in the home or for the provider for a number of years. The most recent member of staff had the opportunity to shadow an experienced member of staff as part of the induction process.

Staff told us they had team meetings and had begun attending carer forums and developing champions to

promote various aspects of care. The service manager told us they had plans in place to improve learning from across the different locations. This would improve staff knowledge and understanding of best practice we will monitor this at our next inspection.

We looked at the recent training matrix and saw that some of the training needed updating. This had been identified by the management team and at the time of the inspection was currently being implemented to ensure staff attended the required training and the records of training were accurately maintained. We spoke with three members of staff who told us they had completed numerous training sessions throughout their employment at Millview. They had a good knowledge of areas such as safeguarding, moving and handling and how to meet people's needs. The staff told us they could nominate themselves for training and had recently requested training in dementia and diabetes.

The above examples demonstrate a breach of regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (staffing).

The service used bureau staff when additional staff were required and to cover annual leave and staff sickness. The manager told us when developing the staff rota they ensured that people on shift have the necessary training to meet people's specific needs. The service manager told us that they try to ensure that learning is shared across the properties which include Millview and other supported housing tenancies to improve knowledge and good practice.

Staff told us they were receiving regular supervision and had recently completed an annual appraisal. We looked at two staff members supervision records and saw that these had been completed and were detailed. Staff told us that the current management team were supportive and things had improved in this area. Staff told us that they had competency checks regarding administering medication annually and the unit supervisor told us they would do these more often if there were concerns around the administration of people's medicines. We saw evidence that staff had recently had an administering medications competency check. Relatives told us they felt staff were knowledgeable and well trained in this area.

We saw the kitchen had a file which included information about people's dietary preferences and needs. However, we found this file did not contain information relating to everyone who accessed the respite service. Staff told us they used this information and their knowledge of the person's likes and dislikes to decide what meals to provide depending on who is currently receiving respite care. When people could tell staff what they wanted or could prepare food for themselves, staff would support them to do this. This meant that people were being offered food that they liked and enjoyed.

Some of the people accessing Millview had specific needs such as feeding tubes and this information was readily available for staff to access. Feeding tubes are medical device used to provide nutrition to people who cannot obtain nutrition by mouth Records contained clear details about how this support should be provided. People with specific needs had monitoring charts and assessments and care plans related to their specific needs. These were comprehensive and included information about preferences, how to support people with eating and manage high risk foods. However, there was no evidence that they had been recently reviewed. This is discussed further in the well led section of this report.

The unit manager told us they worked closely with a variety of different services such as peoples GP's, Social workers and Occupational therapy as well as the various day centres and resources that the people accessing Millview attended.

There was a communication book in place to share information with families about the person's time at

Millview. Relatives told us that staff contacted them if the person's needs changed and said, "Yes, they're very good", "If [person] has any fits or [seizures due to epilepsy] anything they let me know, I have a communication book as well" and "Information is always passed on, good handover." This meant that families knew what support had been provided to the person whilst at Millview and if there had been any concerns or changes in the person's needs.

People and their relatives told us the premises were suitable they said, "The setup is modern and restful, that's what I love about it." We saw that efforts had been made to make the shared living spaces homely and comfortable.

The service had arranged for specialist equipment such as pressure relieving mattresses to enable people to receive the required care they needed. All the bedrooms had ceiling hoists to ensure people with moving and handling needs could be appropriately supported. The unit manager told us they had recently purchased light projectors for the bedrooms to support people with sensory needs and that these were waiting to be fitted. The unit manager told us about plans they had in place to improve the building. This included changing the décor and ideas for a sensory garden. We will monitor this on our next inspection. The manager acknowledged the adaption and decor of the premise was a challenge due to the wide variety of physical and learning difficulties the people accessing Millview experiences. We recommend the service consider best practice guidance when consideration adaptations and the décor of the premises.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind and caring and respected their privacy and dignity. They told us, "They knock before they come in my room. It's all common sense but they do it." Relatives were positive about staff and told us, "They are very pleasant and respectful, I can't fault that respect", "Yes they're smashing", "They are friendly and kind. [Person] looks forward to seeing them" and "Yes, they talk like friends, they're lovely."

People and their families generally told us that they felt independence was promoted. They told us "[Person] does their own food, they supervise" and "[Person] does what they want to do."

People and relatives told us that they felt listened to and involved. One relative told us, "They listen to me, they ask me how I deal with things."

We saw the service had received numerous compliment cards which said things such as; "Thank you for the wonderful tender loving care" and "Thank you for all your help."

We observed that staff were kind and caring with people they were supporting. Staff told us, "We want it to be more like a holiday for the people coming here", "Respite should be a nice experience" and "They [people who used the service] are the centre of it all."

Millview had a stable core staff team and it was clear that staff knew people and their care needs, preferences and interests well. Staff had received training in Makaton to promote communication with people and we saw that staff had a good knowledge of people's non-verbal communication. Makaton is a language programme using signs and symbols to help people to communicate.

The unit manager told us they try to arrange admissions so that people stayed at Millview with people they have a good relationship with and similar interests. When this was not possible additional staffing was put in place to manage the potential risks.

The unit manager had identified that there were certain people who attended for respite who preferred a quieter environment than the main living space provided. As a result they had ordered a sofa to a quieter area of the home to make it more comfortable for people to access. People were supported to spend time where they wished and private time was given.

The provider had introduced the 'daisy standard' which focused on promoting dignity in care and there were plans for a member of staff on the unit to become a 'daisy champion' and promote this within the home. This meant the service recognised the importance of providing dignified quality care to people and wanted to promote this approach.

Staff told us it was a happy place to work and told us, "If they go out with a smile we've done a good job."

Good

Is the service responsive?

Our findings

The management team gave us examples of how they had supported people and their families to overcome the barrier to access respite. The provider had a process for helping people become acquainted with the service and settle in before they first begin accessing respite care which included at least two induction visits. They worked closely with family members to overcome barriers such as admission times and transport arrangements to allow people to access the respite service more easily.

We looked at peoples care records and saw these contained details about peoples care and support needs. Care plans included information about how to deliver care to people and in some areas these were detailed and specific. There was evidence that risk assessments had been completed and these included; medical conditions, road safety, eating and drinking. Records showed that promoting people's choice was considered and that people had been involved in developing their care plans where possible. People we spoke with told us they "Knew the ins and outs of it [their care plan]" and some relatives told us they were involved in reviews. There was not always evidence that care plans had been recently reviewed. This meant that people could have been receiving care which was not in line with their current support needs. This is discussed in the well led section of this report. However, relatives told us there was good communication with the staff either verbally or through the communication book which ensured that staff were aware of changes in peoples care needs. The management team told us they recognised the importance of building good positive relationships with family members to enable staff to effectively support people accessing respite care.

The management team had identified that care plans and risk assessments needed reviewing and updating and we spoke to them about making these records person-centred. The service manager told us they had introduced a format of care plan which was person-centred and outcome based and that this was beginning to be used at Millview. The service manager spoke about work that was being undertaken in the provider's other locations regarding positive risk management and supporting people to work towards their aspirational goals.

Staff maintained daily records and had separate log books for recording activity in relation to people during the day time and night time. We saw the night time logs also contained detailed information about people's night time routines. The management team explained this was to enable staff to easily access this information in order to provide the right level of support so that people could settle for the night.

Staff told us they took time to ensure that people had the opportunity to engage with a range of activities during the evening. We saw that there were various resources and games available on the unit. However, one relative told us that they would like to see more resources such as magazines and games. Another relative expressed concern that electrical items such as televisions and DVD players were not always working and available to people. During our inspection we found the TV and DVD players to be working. The service would support people to engage in daily living tasks if they wished, such as cleaning and helping in the office. People brought in their own things to personalise their room and make it comfortable during their stay. We saw that whilst staying in Millview people were supported to continue their usual activities and

interests and they continued to attend activities at daycentres and colleges.

The management team told us they tried to arrange for people to receive respite care with other people they knew and shared interest with as much as possible. This helps people accessing support at Millview to build and maintain positive relationships with other people. The service manager told us about a "friends reunited" events they had arranged to support building and maintaining relationships. At the time of the inspection the service manager was arranging a "festival" for both people who used the service and the local community to access to help build community relationships.

The service was introducing new technology and had an electronic tablet so that people could access the internet. The unit manager noted this was particularly effective in helping one person manage distress, as they could use certain 'aps'. The service had also recently ordered a voice controlled system which would allow people to request music and find out information.

We looked at whether the service complied with the Equality Act 2010 and ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the manager, staff, and people demonstrated that discrimination was not a feature of the service. We saw that staff supported people with activities and interest of their choice and they respected peoples' cultural values.

The service had an accessible information policy and the manager told us how they met accessible information standards. They told us they adapted information in accordance to people and their families preferred method of communication. This could include making information accessible in a different language and large formats, using translators to communicate verbally or using sign language and information in pictorial formats. The accessible information standards set out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

There was a complaints procedure in place and although there had been no recent formal complaints we saw that the service responded appropriately to concerns. The management team were using information from incidents and working with families to address concerns as a result.

At the time of the inspection the service was not providing support for people at the end of life.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection the service was not meeting two of the requirements of the Care Quality Commission (Registration) Regulations 2009. This is due to the fact there was no registered manager in place and statutory notifications were not being submitted to the CQC as required. We are currently considering what action to take. These circumstances mean that the well-led domain cannot be rated better than requires improvement.

The previous registered manager had left the service in April 2017. We saw that the service manager had attempts had been made to deregister the previous registered manager with the CQC but was able to process this as they were not the registered person. The service had a manager in place but they had not yet registered with the CQC.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009 (Registered manager conditions).

Following the inspection, we reviewed the evidence in relation to the previous registered manager and took steps to begin the deregistration process. The service manager informed us the current manager had taken steps in applying to become the registered manager.

People and their relatives were positive about the management team. They told us "[the manager] is lovely" and told us they felt able to speak with management team. The said when mistakes were made the management team "couldn't apologise enough." Staff told us that the management team would always respond to family members phone calls and queries quickly.

Audits were being completed at a local level at Millview and at a strategic level by the provider. The service manager told us that an audit of supervision had been completed recently at a strategic level. This had highlighted concerns and lead to action being taken to ensure all staff received supervisions. The records we saw demonstrated that staff at Millview had received a recent supervision.

Audits of MAR sheets were being completed but these were not consistently and regularly undertaken. This meant that should an error in the administration of people's medicines occur this could go unnoticed for some time meaning that people did not receive the support they needed in a timely manner. Checks of temperatures to ensure appropriate storage of medicines was not being completed regularly. The unit management team completed additional audits and environmental checks within the building to ensure the safety of the premises but these were not always completed consistently and regularly.

At the time of inspection there was no current evidence that care plans had been audited and reviewed. This has been identified as an area of improvement as part of the service managers action plan to ensure peoples care records were current and relevant to the person.

At the time of inspection, the service had not completed a recent survey with people and relatives. The

manager had identified this as area for improvement and was looking at placing a suggestion box in the reception area which could be used for people, relatives, staff and other visitors to provide feedback. People and their families told us they found the management team approachable and that they responded to feedback.

The above demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

The management team had identified a number of issues prior to the inspection and an action plan to improve the service and quality of care being delivered at Millview was in place. There was a member of the local authority quality team working closely with the service to implement the action plan.

The service was in the process of a restructuring at the time of inspection and permanent arrangements for the management team were yet to be implemented. We could see that upon completion of this, improvements could be actioned as there would be a management team in place with sole responsibility for Millview. At the time of the inspection the management team had many responsibilities across a number of the provider's supported living properties in addition to Millview making it difficult to complete tasks effectively. Stability with the management team would ensure clear lines of responsibility and provide consistency for people and staff within the service. Staff told us they wanted, "continuity of manager which is good for the service."

We saw that staff were being well supported by the current management team and staff told us, "[Manager and supervisor] are the best managers we've had" and "They are very good, on it, know what they are doing." Staff told us the management team were approachable and effective and said, "They're very approachable, we get on well as a team" and "We work together, [managers] are interested in staff input, it's two way, they are hands on and work together."

We saw that there were team meetings being undertaken where updates, staffing information and other information was shared.

There was evidence that accidents, incidents and complaints were investigated and actioned. For example, we could see following one incident alarm systems had been put in place so that staff were aware when external doors were not secure. Following the inspection, the service made interim arrangements for ramps to be placed in situ until the curbs had be lowered.

The service was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notifications of other incidents) as it had not notified the Care Quality Commission of accidents and incidents.

We saw that the service had policies and procedures in place to support the safe running of the service. Many of these were local authority polices and the service had identified that work to ensure they had relevant service specific policies in place that were being undertaken.

The service was exploring improvements to the booking system for people to access respite including developing an online system. The management team told us they were in the process of developing a website. This will improve the systems for people and their families to arrange access to respite care allowing the service to be more responsive to people's needs.

The service had close working relationships with other services within the local learning disability sector and

accessed care forums to improve processes for sharing information. The service received regular updates from good practice forums such as the autistic society and transforming care. Millview short stay respite service was part of a wider provision of supported accommodation for people with learning disabilities and worked closely with other agencies in the sector.

The service manager told us about a number of initiatives to promote community relationships including health events and a local festival. These initiatives further allowed people to participate within the community.

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 11 HSCA RA Regulations 2014 Need for consent The Service was not working with the Mental Capacity Act and people were subject to restrictive practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not have systems in place to ensure the prevention and control of infection Care plans and risk assessments were not being effectively reviewed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have sufficient staffing to meet people's needs. Staff training was out of date.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The system for governance was not robust and audits and checks were not being consistently completed.

The enforcement action we took:

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