Shaw Healthcare Limited

Mill River Lodge

Inspection report

Dukes Square
Denne Road
Horsham
West Sussex
RH12 1JF

Tel: 01403227070
Website: www.shaw.co.uk

Date of inspection visit:
24 August 2016

Date of publication:
04 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This service is registered to accommodate 70 people who require nursing care or support with their personal care. The service specialises in supporting older people, people with dementia and other health conditions such as Parkinson's, diabetes and pressure area care. There were 57 people living at the service at the time of the inspection three of whom were in hospital.

This comprehensive inspection took place on the 24 August 2016 and was unannounced.

The accommodation was arranged over three floors. The upper floors were accessed by a shaft lift or flight of stairs. There was level throughout and access to a secure garden. There is limited allocated parking at the location and car park passes are available to visitors.

The service had 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.

At the last focussed inspection in September 2015 the provider was heavily reliant on agency staff and that on two nights in the months leading up to the inspection the service had operated without a registered nurse. This was an area of practice we identified as needing to improve. At this inspection we found the service had always operated with a nurse on duty and the provider had recruited more care staff. People told us they felt safe in the service however the deployment of staff in one area of the service was an area of practice we identified as needing improvement.

There was a comprehensive quality assurance system in place to monitor quality and identify areas for improvement however this was not being effectively implemented. Therefore opportunities to identify and rectify shortfalls in the quality of the service and drive improvement had been missed. At the last comprehensive inspection in February 2015 we assessed the provider needed to make improvements in relation to recording people's involvement in meaningful activities and reviewing of their care however these improvements had not been made.

People were supported to eat and drink sufficient amounts and enjoyed the food. Special diets were catered for and drinks and snacks were freely available throughout the day. People were provided with appropriate levels of support at meal times.

People's privacy was protected and people were treated with dignity and respect by kind and caring staff. A relative told us "The staff are very helpful and very friendly, so far mum is very happy". Another relative told us "Staff know her, they understand her". Visitors were welcomed and had the opportunity to attend 'family meetings' at which they could give their views on the running of the service and make suggestions for improvements. People were able to personalise their rooms and bring their own furniture and thought had

gone into making the environment dementia friendly and assist people with orientation around the service and to their rooms. .

People's health care needs were met and professional advice and support was sought from health care professionals such as GP's and district nurses as and when needed. People were supported by competent staff who received the training and support they needed to undertake their role and effectively meet people's needs. One person told me "They know their jobs".

People received their medicines on time and they were administered by staff who were trained to do so. Measures were in place to reduce the risk of harm occurring and protect people from abuse. Accident and incidents were recorded, collated and analysed to identify and themes and trends so the provider could take steps to reduce the risk of reoccurrence. Staff understood the need to gain consent and worked in accordance with the Mental Capacity Act (MCA).

There were processes in place for complaints to be responded to. People told us they would speak with a member of the care staff team if they had any concerns or wanted to make a complaint and one person commented "They listen to me".

Recruitment procedures were robust and included identity and security checks were completed before staff were deployed. All new staff completed an induction to the service and were introduced to people before they worked unsupervised.

People and staff felt supported by the management. The registered manager was aware of their legal responsibilities and kept up to date with good practice by attending management meetings.

There was one area where the provider was not meeting the requirements of the law. You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were sufficient numbers of staff on duty to meet people's assessed needs however the deployment of staff in one area of the service needed improvement.

People were protected by staff who knew how to recognise and report suspected abuse.

People received their medicines as prescribed and intended.

Recruitment procedures were robust.

Is the service effective?

Good

The service was effective.

There were systems in place to ensure that staff received the induction, training and support they needed to meet people's needs effectively.

People's liberty was not unnecessarily restricted and people were supported to make choices about their day to day lives.

People's health care needs were met and people were supported to access support from health care professionals when needed.

Is the service caring?

Good

The service was caring.

People were supported to be independent by kind and caring staff.

People were treated with dignity and respect.

Visiting were welcomed into the service and visiting was not restricted.

Is the service responsive?

Good

The service was responsive.

Staff had access to up to date guidance on how people wanted and needed to be supported.

Staff were knowledgeable about people's support needs. A wide range of activities were available that people enjoyed.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always consistently well led.

The providers systems and processes for assessing and monitoring the quality of the services provided and to drive improvement had not been consistently applied.

Management were approachable and the registered manager was aware of their legal responsibilities.

The registered manager kept up to date with good practice.

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 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 comprehensive inspection took place on 24 August 2016. Three inspectors and an expert by experience completed this inspection. An expert by experience is a person who has experience of this type of service. At both the last comprehensive inspection which took place on 3 February 2015, and the last focussed inspection took place 6 September 2015, we assessed there were some areas of practice, including staffing levels, that needed to improve. At this inspection we checked whether these improvements had been made.

Before the inspection we reviewed the information we held about the service and the statutory notifications they had sent us. A notification is a form that the provider completes to inform us about incidents that have occurred which they are required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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. This is because we completed this inspection earlier than originally planned.

During our inspection we observed the care being delivered at meal times in four areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff administering medicines and some of the activities as well as the care provided to people throughout the day. We spoke with eleven people who used the service, the registered manager, the deputy manager, two team leaders one of whom was a registered nurse, eight care staff, the activities organiser, the four visiting relatives and three visiting health care professionals. We looked at ten people's care plans, three people's medication records, the staff duty rota, five staff recruitment files, meeting minutes, the complaints log, accident and incident records, an overview of training that staff had completed and an overview of the supervisions and annual appraisals that had taken place. We also looked at some of the providers' health and safety records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found although staffing levels were safe the provider had been heavily reliant on agency staff and had operated on two occasions without having a nurse on duty during the night . Whilst no harm had occurred as a result of this, it was an area we identified as needing to improve. At this inspection the provider was still reliant on agency staff particularly agency nurses but had continued to maintain the number of staff they had assessed as being sufficient to meet people's needs and had always operated with a nurse on duty. However we found the staffing levels in one area of the service was not sufficient to ensure people's safety and the deployment of staff was not always sufficient for staff to respond to people's needs promptly.

The provider employed sufficient numbers of staff to meet people's assessed needs. They had assessed the staffing levels as being five people to each care staff but that they were operating with a higher ratio of care staff to people than that because the service had 13 vacant rooms. They also told us they had reduced the number of care hours covered by agency staff from 700 to 300 per week and records confirmed this. The provider confirmed that there were still some vacant nursing hours and the positive actions they were taking to address this, which included a review of admissions policy and recruitment campaign. Staff duty rotas confirmed there was usually 15 direct care staff on duty including, one registered nurse supported by a team leader, a senior support worker, and 12 care staff during the day and an additional two care staff that worked from 4pm until 10pm. Activities organisers, kitchen, domestic, administration and maintenance staff were also employed. However, staff had not always been deployed in sufficient numbers to promptly respond to calls for assistance from people living in one area of the service. We saw that one member of staff had been deployed to work in this area which accommodated 10 people. Albeit the registered manager told us this member of staff was supported by another staff member that 'floated' from area to area to provide cover where needed, our observations were that the majority of the time there was one staff member present in the communal lounge of this area and when this staff member was supporting people with their personal care, there were no other staff present. One person who lived in this area of the service told us they had occasionally been incontinent because their call bell was too long in being answered. They commented "Well I can't blame them. Look, there's only one on today, I'm used to it now, so I just wait". The provider explained that due to the temperature on the day, more people than usual had chosen to stay in bed and they had experienced higher than usual requests for assistance and they had not received any complaints about the number of staff deployed to work in this area. However they also acknowledged that the deployment of staff in this area of the service was an area of practice they needed to 'look at'. Deployment of staff in this area of the service is an area of practice we identified as needing to improve.

People were supported to take their medicines safely. Medicines were managed and stored in line with the provider's policies and procedures. People received their medicines when they needed them, for example people who needed their medicines at specific times of day received them on time and were administered staff were trained to do so.

There was a range of effective assessments which assessed the risk to people and the actions to reduce the risks for example people who had been assessed as being at risk of developing pressure areas were using

pressure relieving equipment. One person described their pressure area care to us and confirmed they had no problems. A visitor showed us the pressure prevention equipment their relative was supported to use and described how staff regularly supported them to change position. Another person who presented with swallowing difficulties had been assessed by a Speech and Language Therapist (SALT), who had provided guidelines for how to prevent the risk of this person choking. There were also measures in place to prevent possible complications of poor nutrition, such as a skin integrity care plan and regular weight measurements. We saw risk assessments undertaken regarding falls, included footwear, environmental hazards and medicines management.

People told us they felt safe. Systems were in place to protect people from abuse and keep them free from harm. Staff had received training in safeguarding adults at risk and were knowledgeable in recognising signs of abuse. One staff member told us, "I've done safeguarding training online. We do it every year so I feel confident I would know what to do if I suspected abuse was going on". Another staff member said, "If I had to, I would go outside the home to make sure residents are protected".

Appropriate checks were undertaken before staff began work. The provider followed safe recruitment practices and relevant employment checks, such as criminal records checks, proof of identity, right to work in the United Kingdom and appropriate references had been completed before staff began working at the service. Checks were also made to ensure that nurses were registered to practice in the United Kingdom. There were processes in place for regular checks to be undertaken in relation to the safety of the premises and equipment. Portable electrical appliances were tested annually to check they were safe to use. Firefighting equipment had been serviced regularly and people were aware of the need to evacuate the building in case of fire. The gas safety and insurance certificates were up to date and measures were in place to reduce the risk of legionella.

Good

Is the service effective?

Our findings

People told us they felt well cared for by staff. One person told me "They know their jobs". A relative told us "The staff are very helpful and very friendly, so far mum is very happy". Another relative told us their loved one was "Well looked after". Visiting health care professionals told us staff "Highlighted problems" to them and "once they had picked up on something they followed it through".

People were supported by staff who had the skills and experience to meet their assessed needs. The provider had policies and procedures in place to ensure that staff completed an induction to the service which included shadowing experienced members of staff and service and familiarising themselves with the providers policies and procedures prior to working unsupervised. The registered manager explained that the provider also required all new staff to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It is designed to give confidence that workers have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Records confirmed that the majority of staff had completed or were working towards obtaining this certificate or its equivalent.

Staff had completed training in subjects the provider considered to be mandatory such as infection control, health and safety, moving and handling people, fire awareness and safeguarding vulnerable adults. Most staff had also undergone training to meet the needs of people living with dementia and some staff had also attended training provided by the Dementia In Reach Team in relation to meeting people's specific needs such as pressure area, nutrition and end of life care.

The provider had systems in place for staff to receive one to one supervision with their line manager at which they could discuss in private their personal and professional development and for an annual appraisal of their performance to take place. Staff felt supported by their senior managers and their colleagues. Staff told us they had received recent, formal supervision. One staff member said, "The manager is really good and they will always listen". Another staff member told us, "Yes, supervision is there. I will go and speak to the manager if I need to in between".

People were supported to have sufficient to eat and drink and to maintain a healthy diet. People's comments on the food provided ranged included "It's all right", "The food is really good" and "Very good. It's the first time I've been in a home. I come from a family that enjoys food and my children are very pleased. It is much better than I expected". One visitor told us their relative required a pureed menu and was satisfied with the meals and the additions of ice-cream and yoghurt and other soft puddings. Another person told us they did not always want the food on offer told us "They cook things like chicken nuggets to order for me. They are good like that. No fussing". We observed people received the support they needed to eat and drink. People were offered drinks throughout the day and chocolates, sweets and other snacks from a 'snack trolley' between meals. Another person told us staff offered them plenty of hot drinks and will make them a hot chocolate in the middle of the night if they wanted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked 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. Management told us an applications to deprive people living at the service of their liberty in specific circumstances had been submitted to the local authority for their approval. The registered manager demonstrated a firm understanding of the MCA. The providers training planner showed that 51 staff had completed specific training in relation to the MCA and DOL and the majority of the remaining 37 staff had covered these subjects either on other training such as safeguarding or when studying towards gaining a national qualification in care.

Staff told us and we observed they gained consent from people before supporting them and delivering care. We were told the principle of assuming people had capacity to make their own decisions was followed. Staff told us that everyone was able to make their own day to day decisions and that if they were not able to make a decision for example whether to receive medical treatment then their family members and the persons social worker would be consulted. One staff member told us, "I know we wouldn't assume someone didn't have (mental) capacity. We have to prove it". Another staff member told us, "We would only stop someone doing something if they didn't know what they were doing and it was dangerous".

People's health care needs were met. People told us they were supported to see their GP and dentist when needed. A referral had been made for people to see a Speech and Language Therapist (SALT) when needed and input from other health care professionals such as psychology, Parkinson's nurses, MacMillan nurses, physiotherapists and tissue viability nurses had also been sought. Records detailed when health care professionals had been contacted for advice and when people had attended healthcare appointments.

Good

Is the service caring?

Our findings

Staff knew people well and demonstrated understanding of the preferences and personalities of the people they supported with whom caring relationships had been developed. People were at ease with staff and each other and jokes were shared in the many conversations we heard throughout the day. Staff communicated with people effectively in a warm, friendly and sensitive manner that took account of their needs and understanding. A staff member told us the reason they worked at the service was because of the relationships they had built with people and commented. "I come in for my Residents". One person told us "The staff are good. They look after us, I'm good to them, and they are good to me". Another person told us "The new ones (staff) that have come in are quite nice". A third person commented "It's a nice place". A visiting health care professional told us the staff were "Definitely caring; always trying to do their best". In relation to their loved one a visiting relative told us "Staff know her, they understand her". Another relative spoke about staff being "Supportive and inclusive".

The registered manager and staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. They told us they that they were free to do very much what they wanted throughout the day. They told us they were able to get up and go to bed when they wanted to and were not woken in the mornings. No one ever felt rushed by staff and all told us they were able to take showers, with assistance, as often as they wanted. One person told us "I'm allowed out when I like".

Visitors were welcomed and there were no restrictions on visiting times. One person told us "My daughter comes whenever she pleases and stays as long as she likes". Another told us "My family come as a group and get on well with the staff. They stay as long as they want to". People told us they liked the fact that some visitors brought their dogs with them. One visitor told us they were happy with the care their relative was receiving.

People's privacy and dignity were respected and promoted. Staff told us about how they protected people's dignity such as when helping them with personal care. They demonstrated they had a good understanding of the importance of maintaining people's dignity and treating people with respect. One member of staff told us "We always close the doors when people are receiving personal care". Our observations confirmed that doors were kept shut when personal care was being delivered and that staff knocked on people's doors and waited for a response before entering their rooms.

We observed staff treated people with kindness and understanding. Interactions and conversations between staff and people were positive. People told us they felt staff were kind and we observed staff showing patience and understanding, for example by giving people who struggled to communicate verbally time to express what they wanted to say. Staff made time to talk to people whilst going about their day to day work. It was clear staff knew people well but equally people were familiar with staff and happy to approach them if they had concerns or worries.

We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently people, where possible, were empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose for example, at lunchtime we observed two people at the dining table engaging in a verbal altercation. Staff stepped in and acted quickly to defuse the situation in a calm and professional manner to the satisfaction of all parties.

Some people chose to stay in their bedrooms, others in the communal areas. Each person had their own room which had been personalised with their belongings and memorabilia. For example people had family photographs on display and were able to bring their own furniture. One person had brought their own table and another had brought their own bed. Thought had been given to make the environment dementia friendly and assist people with orientation around the service and to their rooms. Some areas of the service had been decorated with a theme for example the sea side. Some people had chosen to have a picture of themselves outside their bedroom and bedroom doors were designed to look like traditional front doors furnished with door knockers and painted different colours.

Information about people was stored securely and staff made sure that doors were shut when we were discussing the needs of individuals.

Good

Is the service responsive?

Our findings

At the last inspection care plans did not always provide staff with the information needed to respond appropriately to people's needs and was an area of practice that needed improvement. At this inspection improvements had been made. People were able to visit the service and have their needs assessed before they made a decision about whether they wanted to move in. People's initial assessments had been used as a basis on which to formulate a care plan. It was evident from the information they contained that individuals and or their relevant family members had been consulted. One person's relative told us they had been "included in care planning and decisions". Most care plans were detailed and provided specific guidance for staff to follow when supporting people with their individual needs. The care plans and risk assessments were reviewed and updated monthly and signed by staff.

People's care plans contained information about people's care needs and actions required in order to meet them. They included 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. Steps were taken to ensure that people's needs were monitored. One person was living with dementia and was prone to falling. We noted this person's care plan contained specific guidance and action planning around these issues for example it stated 'Staff to support when mobilising'. Following a fall this person had been monitored for 72 hours and checked regularly for signs of bruising. Plans reflected whether people would like their bedroom door open at night and gave staff direction as to whether sensor mats needed to be in place at the side of people's beds to alert them if people got out of bed in the night.

There was a range of activities which were advertised on posters around the service such as arts and crafts, flower arranging and manicures but the venues and times for these activities were not displayed and neither people nor staff could tell us where and when these activities would take place. The activities organisers explained they informed people verbally of this each day and asked them if they would like to join in. We saw some people were supported on an impromptu trip out to see an art exhibition which they enjoyed. We observed two people attended and enjoyed an arts and crafts activity in the activities room and were told that some people who spent time in their rooms had been offered the opportunity to have a hand massage. One person told us they used to be a gardener and was supported to continue this interest with support from staff. Staff explained they were trying to raise funds to install raised flower beds to make gardening more accessible for people. Some people told us they liked to spend time in the garden and had enjoyed a summer fete that had been held at the service to which relatives had also been invited. One visiting health care professional told us "It's hard to get hold of people between all the activities there's so much going on".

The service had a pram and life size dolls for people and that some people carried soft toys which they treated as pets. Staff interacted well with people about their 'pets' and encouraged people to talk about them. parts of the service had been repainted and that people and their relatives had been asked for their views on what themes to use for the decoration of different areas of the service. The chairs in one of the communal areas of the home had been arranged so as to create areas for people to sit in small groups where they could see and hear each other which promoted conversation. There were links with a local

school whose pupils visited to do a 'Getting to know you' session where they showed people how to use hand held electronic devices and play games. We saw staff checking on some people who spent time in their rooms to make sure they had everything they needed. We heard one member of staff asking a person whether they would like their TV switching on to which they replied "Yes please". They chatted to the person about the kind of programmes they liked to watch and found a programme the person was interested in.

Staff knew people well and had a good understanding of their care and support needs. There were processes in place to ensure staff had up to date information about people's changing needs. Staff told us information they were informed about people's changing day to day needs at the handover at the start of each shift. The off going team leaders provided information on any issues or incidents that had taken place. They also provided information on any appointments that were planned. Staff also told us there were always staff and management on duty they could go to for advice or provide them with updates on their return from a leave of absence from work.

There were systems in place to respond to complaints. People were provided with information about how to make a complaint when they moved into the service and the complaints procedure was on display in the reception area of the service. Complaints received by the provider had been recorded and responded to appropriately. People told us they would speak with a member of the care staff team if they had any concerns or wanted to make a complaint. One person told us they felt very confident in voicing concerns and commented "They listen to me. Fair enough".

Requires Improvement

Is the service well-led?

Our findings

Staff told us they felt supported by management and each other and that management were approachable. We observed staff coming to speak with management about a range of issues during the day for example to ask to speak to the registered manager in private or to say hello and pass the time of day. Most people could not recall having met the registered manager but told us they would speak to the care staff or team leaders if they had any concerns. Visiting health care professionals told us they usually met with the team leader or nurse on duty but would have no reservation in raising concerns they may have with the registered manager if they had cause to.

There was a comprehensive quality assurance system in place to monitor quality and identify areas for improvement however this was not always being effectively implemented. The provider had Monthly Service Quality Audits in place which included checks of care plans, the environment, infection control and risk assessments. The registered manager told us they had not been completing these audits in line with the provider's policies and procedures. Following the inspection the registered manager sent us an audit for August 2016 which was only partly completed. Therefore the provider could not be assured that shortfalls in the areas that had not been audited would be identified. For example the records of staff supervision and staff appraisals had not been audited and we identified 34 of 88 staff had not received an appraisal within the last twelve months in line with the provider's policy.

The provider also had a Quality Team that undertook bi-annual Quality of Life Audits at the service. These audits covered every aspect of care and generated action plans to drive improvements where identified. The provider's last 'quality of life audit' had been completed in May 2016. This audit checked that records had been completed in line with the provider's policies and procedures and detailed any actions that were needed to be taken to rectify shortfalls they had identified. We saw that most of the actions had been set for the registered manager to complete on or before July 2016. The date of completion of many of these actions had not been entered. Some of them were ticked and others stated what was happening or going to happen complete the action. Therefore the provider could not be assured all the actions had been completed or that they had been actioned within the timescales they had set.

One action the provider identified as needing to be completed as part of their quality of life audit was to 'Ensure all service users are able to access meaningful activities that they choose'. The associated action plan stated 'Speak with and record conversation of what residents like to do and would like to do now. Plan for new ideas to meet resident's needs and wishes'. Another action identified by the provider was 'Involvement documents to be completed on a regular basis with planning and reviewing care with service users and next of kin'. The action plan stated 'Update where appropriate'. The date the provider specified these actions were to be completed by was July 2016. However no date had been entered to indicate if these actions had been completed. Not all the care plans we viewed documented people's involvement in their care plan reviews and though care plans included information on people's history hobbies and interests, records lacked detail about whether they were involved in activities meaningful to them. The Monthly Service Quality Audit for August 2016 included the auditing of two people's care records and also identified these shortfalls but did not detail the action that would be taken to rectify this. These issues were

also identified as needing to improve at our last at the last comprehensive inspection on 3 February 2015.

The provider had not ensured the processes they had in place to monitor quality and identify areas for improvement were effectively implemented and some shortfalls in the services provided to people had not been addressed. This is a breach of Regulation 17 of the Health and Care Act Regulations 2014.

There was an effective management structure in place. Since the last inspection the manager had become registered the Care Quality Commission. They, told us they received support from the area manager with whom they had weekly contact, a deputy manager, team leaders and an administrator. The registered manager told us their biggest challenge was the recruitment, induction and training of new staff but they felt the staff team was more stable than it had been for several years. They told us whilst the recruitment of nurses continued to be a challenge they had increased the salary for the post of clinical lead which they had not been able to fill for several years and were hopeful this would encourage suitable applicants to apply. The deputy manager for one of the providers' other services was providing clinical support to Mill River Lodge and worked at the service two days one week and three days the following week.

The registered manager had informed the commission of notifiable events at the service by completing statutory notifications as required. They were aware of the Duty of Candour regulation. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided. Records showed that they had kept people's relatives informed of any accidents and incidents people had been involved in. The last inspection report and rating was on display at the service and on the provider's website as is required by law. The registered manager kept up to date with current good practice guidelines by attending managers meetings at which they shared learning and discussed new developments in care. The registered manager told us their focus was supporting people to live the lives of their choice and working towards the delivery of care being centred on the needs and wishes of the individual. They told us they recognised that work was needed to be done to change the culture of the service for this to be effective. For example they wanted people to have the opportunity to become more involved in activities of daily living such as washing up and laying the table and explained that one of the things they had done to facilitate this was to remind staff of the providers' key worker policy. A key worker is a named member of staff that people can go to with any concerns they may have and who has specific responsibilities for spending time with named individuals to obtain feedback from them about their preferences as well as to co-ordinate aspects of their care such as chiropody and hairdressing appointments. They told us they had sent a copy of the provider's 'Staffing and key worker policy' with their pay packets in order to remind staff of these responsibilities.

People were given the opportunity to give their views on the service. A 'family' meeting had taken place in June 2016 minutes of which showed that a new 'you said we did' section had been introduced. Minutes detailed that relatives had requested a newsletter and to have the dates for future meetings scheduled for the year ahead and these had been implemented. The registered manager told us that resident and relative's surveys were used to gather people's views but that this year's survey had not yet been sent out. They also explained people were provided with details of how to provide feedback to a third party about their experiences of the service. We saw people could provide their feedback by completing and posting a pre-paid questionnaire or on line. The registered manager told us not many people had taken up of this opportunity and to date there had been no issues arising from the feedback that required them to take any corrective action.

Accidents and incidents forms were collated by the registered manager. They were then analysed at the provider's head office to identify any themes or trends which would help inform them of strategies they could use to reduce the risk of reoccurrence.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes they had in place to monitor quality and identify areas for improvement were effectively implemented.