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

Summary of findings

Overall summary

The inspection took place on 15 May 2018 and was unannounced. Mill River Lodge is a 'care home'. 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.

Mill River Lodge is situated in Horsham, West Sussex. It is one of a group of homes owned by a national provider, Shaw Healthcare Limited. Mill River Lodge accommodates 70 people across seven units, each of which have separate bedrooms with en-suite facilities, a communal dining room and lounge. There are also gardens for people to access and a hairdressing room. The home provided accommodation for older people, those living with dementia and people who required support with their nursing needs. At the time of our inspection there were 62 people living at the home.

The home had a registered manager. A registered manager is a '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 home is run.

At the previous inspection on 26 August 2016 the home received a rating of 'Requires Improvement' and was found to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to complete an action plan to show us what they would do and by when to improve the key questions of safe and well-led to at least good. This was because there were concerns regarding the oversight of the service. Quality assurance audits, to identify areas for improvement, had not been completed. Actions resulting from the provider's audits had not always been addressed. The provider lacked oversight of the systems and processes within the home. Other areas identified as needing improvement related to the deployment of staff to meet people's needs in a timely manner. At this inspection the sufficiency and deployment of staff had improved. However, we continued to have concerns with regards to the managerial oversight and the provider was found to be in continued breach of the regulations. This is the third consecutive time the service has been rated as 'Requires Improvement'.

Systems and processes were not sufficiently monitored, nor action taken, to ensure that the service was to the standard people had a right to expect. The registered manager had not completed all of the provider's audits to monitor the service. It was not always evident if actions required by the provider had been completed. The provider had conducted their own audits and these demonstrated that the failure to conduct audits and comply with required actions was a consistent and on-going issue. Records to document people's care and treatment, as well as those to monitor the service, were not always completed in their entirety. The registered manager and provider had not ensured that the service people received continued to improve. These areas of practice were of concern.

People and their relatives told us that staff were kind and caring. One person told us, "The staff are very kind". Most people were treated with respect and dignity. However, not all people were treated in this way

and person-centred practice was not always evident. People's needs, preferences and abilities had been documented in care plans. These informed and guided staff's practice to enable them to meet people's needs in a way that people preferred. Despite this specific and person-centred information, staff did not always ensure that people's expressed needs and beliefs were respected. This related to a person's beliefs as well as their preference for female care staff. This was an area of concern.

The provider and registered manager had not always notified us of events and incidents that had occurred at the home. This did not always enable us to have oversight to ensure people were safe.

Risk assessments identified possible risks to people's safety. Staff were aware of how to safeguard people from harm. Staff supported people appropriately to ensure their safety. A reflective culture existed when incidents had occurred or care had not gone according to plan. Although most people received appropriate support to ensure their safety, staff had not always considered the impact of some people's behaviour on others. Staff had not always considered their safeguarding policies and procedures when people demonstrated behaviour that challenged others or when one person had sustained an injury.

People provided mixed feedback with regards to their access to activities and stimulation to occupy their time. Most people told us that they enjoyed the activities and people were seen enjoying the musical entertainment that was provided. They were smiling, laughing and dancing. Some people, however, felt that there wasn't enough to occupy their time.

An area in need of improvement related to gaining people's consent when there were restrictions on their freedom to move around and out of the building. People were not always supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible, however, staff had not always considered if applications to the local authority, to deprive people of their liberty, were required.

People had confidence in staff's abilities. Their needs were assessed and their healthcare needs met by registered nurses as well as external healthcare services. There was a coordinated approach to ensure people's health and they received medicines to meet their health needs. People received appropriate end of life care to ensure their comfort. Safe practices maintained infection control and ensured that people were not at risk of cross contamination.

People spoke highly of the food and had a positive, social dining experience. One person told us, "There is a good choice and it is quite a social occasion". Another person told us, "The food is lovely". People had access to an environment that met their needs. People could spend time on their own or with others and had access to the garden. Signs and themed hallways ensured that people were supported and able to orientate around the building.

Full information about CQC's regulatory response to the more serious concerns found during inspections is published 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 home was not consistently safe

People were not consistently protected from harm. Not all incidents that had occurred had been considered in accordance with the provider's safeguarding policy.

There were sufficient numbers of skilled and experienced staff to meet people's needs.

People had access to medicines when they required them. There were safe systems in place to manage, store, administer and dispose of medicines.

Is the service effective?

Requires Improvement

The home was not consistently effective.

Most people were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity but had not always worked in accordance with this.

People were cared for by staff that had received training and had the skills to meet their needs.

Staff worked with external healthcare professionals to ensure that people received appropriate and coordinated care.

Is the service caring?

Requires Improvement

The home was not consistently caring.

Most people were supported by kind and caring staff who knew their preferences and needs well. However, some people were not always treated with dignity and respect.

People could make their feelings and needs known and were able to make decisions about their care and treatment.

People's privacy was maintained and their independence promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People did not always receive responsive and personalised care to meet their needs. There was mixed feedback in relation to people's access to stimulation.

People were involved in the development of care plans. These were detailed and provided staff with personalised information about people's care.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's quality assurance processes had identified areas in need of improvement. However, these had not always been actioned. There was a failure to ensure the service continually improved.

People were involved in day-to-day decisions that affected their lives. There were links with external services to provide coordinated care.

People, relatives and staff were complimentary about the management of the service.

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.

The inspection took place on 15 May 2018 and was unannounced. The inspection team consisted of three inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to the inspection we looked at information we held, as well as feedback we had received. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 18 people, eight relatives, eight members of staff, a healthcare professional, the registered manager and the operations manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and electronic medicine administration records (MAR) for eight people, eight staff records, quality assurance audits, incident reports and records relating to the management of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We observed people in the communal lounges, their experiences during lunchtime and the administration of medicines. Following the inspection, we contacted three healthcare professionals for their feedback.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 24 August 2016 we found the staffing levels in one area of the home were not sufficient to ensure people's safety. The deployment of staff was not always sufficient for staff to respond to people's needs promptly. This was an area identified as needing improvement. At this inspection, improvements had been made and there were sufficient staff to meet people's needs. However, we found a different area of practice that needed improvement.

At the previous inspection one member of staff had been deployed to work in an area which accommodated 10 people. The member of staff had access to a 'floating' member of staff who worked between the different units. However, there were concerns that for a majority of the time there was only one member of staff to meet people's needs. When the member of staff was required to assist people with their care needs, there were no other staff in the unit who were available to assist others. In addition, people had sometimes had to wait for support with their personal care. At this inspection there were no concerns about staffing levels or the deployment of staff. Staffing levels had increased and there were two members of staff allocated to each unit. There were sufficient staff to meet people's needs. Records showed that staffing levels were consistently maintained. Feedback from people, relatives and staff told us that there were sufficient staff to meet people's needs and our observations confirmed this. Consideration of staff's skills and experience ensured that staff were appropriately allocated to different units of the home. Temporary staff worked alongside existing staff to ensure that staff had a good awareness of people's needs and requirements. Consistency of staff was considered when covering shifts. Temporary staff had worked at the home many times and had an awareness of people's health conditions. People told us and records confirmed, that when people called for staff's assistance, they responded promptly.

People and relatives told us that people were safe. When asked what made them feel safe, comments from people included, "There is always someone around" and "They are always close by and they check often". People told us they felt comfortable around staff and were confident that if they had concerns they could raise these with staff or the management team. These could be raised on a one-to-one basis with staff or during regular meetings. Staff understood safeguarding, they had undertaken relevant training and could identify different types of abuse. Safeguarding adults at risk policies and procedures were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Referrals had been made to the local authority when there were concerns over people's safety. When instances had occurred or care had not gone according to plan, lessons were learned and changes made as a result. However, we found that people were not always protected from harm. Although staff were aware of how to raise concerns, not all concerns in relation to people's well-being had been raised with the local authority. One person, who was living with dementia, often displayed behaviours that challenged others. Records showed that on one occasion the person had been physically aggressive to another person. Although appropriate ways of supporting the person had been implemented, staff had not always considered the safety implications to others. Another person had sustained an injury. Appropriate medical assistance had been sought, however, this had not been considered in accordance with the provider's safeguarding policy. Staff had not consistently ensured that people were protected from harm. This is an area of practice in need of improvement.

People were cared for by staff that the provider considered safe to work with them. Before staff began work, their identity had been confirmed and their previous employment history gained. Their suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC). At times, people had been included in the recruitment and selection of staff. This enabled them to be involved in deciding who would be the most appropriate to support them.

Risk assessments identified risks and advised staff on how to reduce these. People were involved in the development of care plans and risk assessments. Risk assessments were regularly reviewed to ensure they were up-to-date and met people's current needs. Staff were made aware of risks to people's safety through care plans and handover meetings. They had a good knowledge of people's needs and people were supported in accordance with these.

Accidents and incidents had been recorded and monitored to identify patterns and trends. Relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans. These informed staff of how to support people to evacuate the building in the event of an emergency. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe.

People were assisted to take their medicines by registered nurses and trained staff who had their competence regularly assessed. There were safe systems in place for ordering, storing, administering and disposing of medicines. People and relatives told us that people received their medicines on time and were happy with the support that was provided. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. Medication records showed that people had received their medicines on time and in accordance with their needs. Medicines were regularly reviewed by healthcare professionals to ensure they were appropriate and met people's current health needs. An electronic system enabled staff administering medicines to monitor and ensure people were receiving their medicines as prescribed by their GP. Appropriate documentation was in place so that information about people's medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital.

People were protected from infection and cross-contamination. There were good systems in place to prevent the spread of infection. For example, when people had been unwell protocols were followed to ensure that this did not spread to people living in other units. An audit, unrelated to the incident, had identified that the cleanliness of the home needed to improve. A member of staff had been given the responsibility to oversee this and ensure that the home was clean. Changes to the way in which bed linen and towels were laundered enabled staff to spend more time cleaning the home. For example, these had been outsourced to an external laundry. Feedback from people and relatives told us that they thought the home was clean. One person told us, "The most noticeable thing is the lack of odour". Staff had access to personal protective equipment and disposed of waste appropriately to minimise the risk of cross-contamination.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they had faith is staff's abilities. Staff were trained and had the appropriate skills to meet people's needs. One person told us, "Skilled enough at what they do". However, despite this we found an area of practice that needed improvement.

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 make 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 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 home and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People and their relatives told us that staff asked for people's consent before offering support. People were provided with choice and able to make decisions with regards to their day-to-day care. Mental capacity assessments assessed some people's capacity to make decisions. When people lacked capacity most decisions had been made in consultation with others and in people's best interests. DoLS applications had been made to the local authority for some people. Some DoLS that had been authorised had conditions associated to them and records showed that staff had worked in accordance with these. Some people were living with a condition that had the potential to affect their understanding and decision-making abilities. In order to ensure people's safety, some people were continually monitored by staff and would be unable to leave the home without their support. The registered manager had not always considered people's capacity to consent to this nor consulted with others to ensure this was in people's best interests. They had not considered if DoLS applications should be made to the local authority. This is an area of practice that needs improvement.

People were supported by staff who had undertaken appropriate training to meet their needs. In addition to formal training staff could seek advice and good practice was shared by registered nurses and external healthcare professionals. New staff were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures. They gained an awareness of the expectations of their role and completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. There were links with external organisations to provide additional learning and development for staff, such as the local authority and local colleges. Some staff held diplomas in Health and Social Care and were encouraged to develop within their roles.

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervisions took place to enable staff to be provided with feedback about their practice. Learning

and development needs were identified and planned for during these times. Staff told us that these meetings were supportive, however, felt comfortable to approach the registered manager at any time.

People's needs were assessed when they first moved into the home and on an on-going basis. Regular reviews ensured that the guidance provided to staff was current. People's healthcare needs were met by registered nurses and access to external healthcare professionals. When necessary, people were supported to make and attend routine health care appointments to maintain their health. Staff monitored people's health and wellbeing and supported them to access or request referrals to services as and when required. There was a coordinated approach to people's healthcare. Records showed and people told us that staff supported them according to the recommendations of external healthcare professionals. A healthcare professional told us, "We do a carer's care plan for staff to follow and they follow it".

People consistently told us that they were happy with the food. Comments from people included, "There is a good choice and it is quite a social occasion" and "The food is lovely and there is a good choice". People had a pleasant dining experience and could choose where they ate their meals. Some people enjoyed sitting with others in the dining room, whereas other chose to eat in their rooms or the lounge. When people required assistance to eat and drink, staff did this discreetly and sensitively. Aids and adaptations were provided to enable people to maintain their dignity and independence. These included, plate guards and beakers with lids. Care plans provided staff with guidance about people's nutrition and hydration and advised staff on the optimum amount of fluids the person should be supported to consume.

The home was designed in such a way that provided adequate space for people to enjoy time with one another. People also had their own rooms that they could use if they wanted to have their own space. People could choose to enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather. People's diversity was respected and people were treated fairly and equally. People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff. In addition, some people had accessed the local community and one person had a tracker watch that could inform staff of their location. Themed areas supported people to orientate around the building and this was assisted by photographs or memory boxes alongside people's bedroom doors. These had been chosen and made by both people and staff. One person told us that they thought the home was "Light and airy" and that this helped them to move around the building more freely.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that people were treated with compassion and kindness. Comments from people included, "Very caring" and "The staff are very kind". When asked what staff did well and what they thought of the home, relatives told us, "Compassion" and "It is a friendly and happy place". However, despite this we found an area of practice that needed improvement.

Most people were treated with dignity. Staff's interactions with people were mostly kind and caring. Observations showed some staff spending time with people and engaging in conversations. People and their relatives spoke with fondness of some members of staff. A relative told us that one member of staff went out of their way to provide compassionate care. Despite this, not all interactions that were observed were positive. Staff did not always demonstrate a caring approach to people's needs and feelings. One person was sitting in the lounge and asked the registered manager if they would support them to cut their nails as they were long and unclean. They were advised that a member of staff would assist them with this. However, observations later in the morning showed that the person had not been supported with this. This did not promote the person's dignity. The same person asked staff to support them to go to bed. Staff explained to the person that it was almost their lunchtime and that they would be supported to go to bed afterwards. However, the person continued to ask staff, some of whom did not respond to the person. The person began to show signs of apparent distress, they were weeping and looked uncomfortable as they were attempting to change position. An Inspector intervened and asked staff if they could support the person. Staff immediately assisted the person to go to bed. However, this raised concerns as it was not apparent that staff would have supported the person in a timely manner had an Inspector not intervened.

One person, who was living with dementia, was enjoying telling staff and other people a story. The person was engaged by this and was at times laughing. They sometimes repeated words and sentences. Most staff were aware that this was a part of the person's condition and that they preferred to communicate in this way. Some staff demonstrated good practice by engaging in conversation with the person about the topic. However, one member of staff was dismissive of the person's attempts to communicate and told the person, "I've heard that story". The person then stopped talking. Another member of staff noticed a different person walking into the lounge. They said to the person, "Say hello to [person's name]". When the person did not say hello the member of staff said, "Don't then". These interactions did not treat people with dignity and did not demonstrate respect. This is an area of practice in need of improvement.

People's privacy was maintained. When people required assistance with their personal care needs, staff assisted them to private rooms. Conversations about people's healthcare needs took place in private to ensure confidentiality was maintained. Information held about people was kept secure in locked cupboards and offices.

Staff were aware of people's diverse needs. Information about people's lives, background, interests and employment had been documented in their care plans and staff had an awareness of people's differences. People's religious and spiritual needs had been documented and measures had been taken to ensure that people, with different faiths, had access to spiritual support. People could maintain their identity. They wore

clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. People could choose how they spent their time, some spending time in the communal areas, whilst others preferred their own space in their rooms or quieter areas of the home. People's independence was encouraged and promoted. Observations showed people independently mobilising around the home with the assistance of mobility aids to promote their independence.

Regular residents' and relatives' meetings ensured that people could share their views and concerns and be involved in their care. The registered manager had acknowledged that people and relatives might prefer to share their views and concerns in a different way and regular questionnaires had been sent to gain people's feedback.

The registered manager understood the importance of encouraging positive relationships between people and their relatives. People were supported to maintain contact with those that were important to them. People and their relatives told us that they were welcome and could visit and spend time with their loved ones at any time. One person told us, "I feel at home here. Everybody made me feel welcome. I have made friends. It is a home from home".

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to their needs. However, we found an area of practice that demonstrated that staff were not always responsive to people's needs. Person-centred practice was not always implemented. This is an area of practice that requires improvement.

Following an assessment of people's needs, care plans had been devised. These contained specific information about people's skills, abilities and needs. People were involved in the development of care plans to ensure that they were person-centred and reflected the person's wishes and aspirations. People's preferences and life histories provided staff with information to enable them to develop and build relationships with people. Staff had a good understanding of people's preferences and needs and people told us that they had had confidence that staff knew them and their needs well. People's care plans were regularly reviewed by staff to ensure that their care was current and that up-to-date guidance was available to assist staff. Most people's preferences and beliefs were respected. Observations and records, however, showed that this was not always implemented consistently. One person, who was living with dementia, had strong beliefs and personal preferences. Staff had demonstrated good practice by documenting these throughout their care plan. However, discussions with the person raised concerns in relation to their preferences being respected. The person informed an Inspector that they were unhappy with one male member of staff. Records and staff confirmed that the person had been assisted with their personal care needs by a male member of staff. However, staff had been informed within the care plan that the person would prefer female care staff. Staff were asked why the person had received support from a male member of staff. They explained that since the person's condition had deteriorated, they had not shown so much of a preference with regards to having female or male staff. Records for the same person showed that they had strong beliefs. It advised staff on the importance of supporting them to uphold their long-held beliefs. Conversations with staff, about the person's care, raised concerns with regards to the person's participation and access to situations that they would otherwise not have chosen to partake in. There were concerns that due to the person's condition deteriorating, staff had assumed that the person did not mind and had not respected the person's previously expressed wishes. It was not evident that the person, or those involved in their care, had been consulted to identify if the person's wishes remained the same.

People were not always supported in an appropriate, person-centred way. Their needs and preferences were not always respected. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not socially isolated, although they provided mixed feedback with regards to their access to activities and stimulation. Some people and their relatives told us that they had access to facilities and activities that occupied their time. People could maintain contact with their family and friends and some people spent time outside of the home with their families. One person told us, "There is plenty to do, I like the music and I like going out". Observations showed people enjoyed participating in musical entertainment. Some people enjoyed dancing with staff to the music and there was lots of laughter and smiles. Records showed that people had participated in a range of activities. One person's records stated that they had been into the garden to tend to the pots and do some weeding. There were lots of planned,

group activities such as Pets As Therapy (PAT) dogs, music and movement, bingo and skittles. Staff told us that people who did not want to participate in group activities were supported to have hand massages, read or undertake crafts and jigsaw puzzles. However, some people and their relatives felt that there was not enough for them to do. A relative told us that their loved one felt that there were not enough activities offered to them in their room. They explained that they would like to go outside more and enjoy time in the garden. One person told us that they would like some books to read but had not felt that they could ask. Another person told us, "I would like to go out more, I feel like a prisoner". A third person told us, "It is a bit boring here. Sheer boredom". The provision of activities, to ensure that all people have access to stimulation to meet their needs is an area of practice in need of improvement.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The registered manager ensured people's communication needs had been identified and met. People's care plans contained information on the most appropriate way of communicating with people. When people required additional support to access and understand their care plans, staff could adapt their approach to meet people's needs. One person had difficulties verbally communicating their needs. The registered manager had supported them and some of the staff, to learn some basic Makaton signs. Staff told us that the person enjoyed learning the signs and had found it fun. Makaton is a form of sign language designed to support spoken language. Signs are used with speech to support people to communicate. Information for people and their relatives, if required, could be created in such a way to meet their needs, for example, in accessible formats to help them understand the care available to them. Photographs had been taken of meals so that people could visually see what was being offered, therefore supporting them to make choices.

People had access to a call bell. People told us and records confirmed, that when people called for staff's assistance, they responded promptly. For people who were unable to use a call bell, due to their cognitive abilities, other technology, such as the use of sensor mats were used. These alerted staff if a person attempted to stand so that they could go to the person's aid.

People were informed of their right to make a complaint through an accessible complaints procedure. Staff told us that if people required assistance to make their feelings known then they would be supported to do so. People and their relatives told us that they would feel comfortable to raise concerns about people's care. One relative told us that when they had raised a comment, their feedback had been listened to an acted upon. This had related to the lack of parking. In response, the registered manager had communicated with the local authority and this had been resolved.

People who were at the end of their lives had access to care to meet their needs. Staff were competent and had access to external support from local hospices and external healthcare professionals. People could plan for their end of life care, however, if they preferred not to discuss this their rights were respected. Plans that were made incorporated people's expressed wishes. Medicines, in anticipation for people's health deteriorating, were stored so that people had access to them when needed.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 24 August 2016 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of oversight. The registered manager had not always completed the audits that were required by the provider. It was not clear if actions resulting from the provider's audits had been addressed. Following the previous inspection on 24 August 2016 the provider wrote to us to inform us of their plans to improve. At this inspection there were continued concerns and the provider remains in breach of Regulation 17. We have also identified other areas of concern. This relates to the lack of dignity and respect for some people. As well as a lack of notifications submitted to CQC to inform us, and enable us to have oversight of, the actions taken to ensure people's safety. This is the third consecutive time that the home has been rated as 'Requires Improvement'.

Mill River Lodge is one of a group of services owned by a national provider, Shaw Healthcare Limited. The management team had experience within the health and social care sector. There was a management hierarchy which enabled staff to be supported and supervised by team leaders who worked alongside them to meet people's needs. In addition, there was a deputy manager and the registered manager. An operations manager also regularly visited the home to conduct quality assurance audits and to offer support.

The home provided accommodation for 20 people who required support with their nursing needs. The provider had tried to recruit a clinical lead to oversee people's nursing, however, had not yet been successful in recruiting to the post. Registered nurses were provided by agencies. Although the registered nurses were consistent and had worked at the home before, there was a lack of clinical oversight. An external healthcare professional told us, "Sometimes you want to be led a bit more. A bit more direction might be good. Agency nurses don't always know people and can't always share information". There was a lack of clinical supervision for the registered nurses to enable them to work alongside other registered nurses and practitioners to reflect upon their practice, seek support and identify areas of development. The registered manager acknowledged that a clinical lead was required to ensure there was appropriate clinical oversight of people's nursing needs and to ensure consistent care. Neither the deputy or registered manager were registered nurses and therefore were not qualified to provide the necessary clinical oversight. When the registered manager was asked how clinical oversight was maintained they explained that an operations manager was a registered nurse. However, this person was not the usual operations manager for the home and although they could be contacted for advice and support, they did not regularly visit the home to undertake quality checks.

There was a comprehensive quality assurance system to monitor quality and identify areas for improvement. These were conducted by the registered manager, the operations manager and the provider's quality team. The provider had a robust quality assurance system which had identified some areas for improvement. The registered manager was responsible for undertaking various audits on processes such as people's medication records, care plans and risk assessments. Most audits had been completed, however, the audits for people's medicines had not always been undertaken in accordance with the provider's policy. One audit showed that the required monthly audit and associated mandatory actions had not been

completed for a three-month period. The failure to complete the required audits had been identified within three consecutive bi-annual provider audits. However, in the three months since the last provider audit, medication audits continued to not be completed. Medicine systems were safe, however by not undertaking audits, in line with the provider's policy, the registered manager had not assured themselves that there was no potential risk. There was a lack of oversight of the systems and processes in place to monitor people's medicines. A reoccurring theme within the provider's audits identified that the registered manager's audits needed to be uploaded to the provider's system to allow oversight. Actions resulting from the provider's audits needed to be completed within a timely manner and signed off and verified by the operations manager. Although the provider had identified that the registered manager was not consistently completing the required audits and was not accurately recording when actions had been met, they had failed to ensure improvement in this area.

Some care plans were detailed and contained specific information on people's healthcare conditions and support requirements. However, some records, in relation to people's care and treatment, were not always consistently maintained. One person had a health condition that was exacerbated by certain foods. However, neither their nutrition and hydration care plan or their dietary assessment contained details of this. Other records such as daily records and consent forms had not been completed in their entirety. These incomplete records made it difficult to ascertain if people had received appropriate care or if staff had failed to complete the required records. For example, records to monitor one person's weight showed that they had lost 11.6 kilograms within a three-month period. Other records to document the person's care did not show what action had been taken in response to this. When this was raised with the management team they could demonstrate that this had been discussed with a GP. However, there was no record of this in the person's care plan to show that this had taken place or the changes that were required to the person's care. Some records contained handwriting that was not legible which made it difficult for staff to understand the guidance and the treatment provided. Documents to track and monitor the amount and status of safeguarding referrals that had been made to the local authority were in place. However, these were not current and did not provide sufficient oversight to show all the referrals that had been made or their status. The recording of people's consent, illegible records and the failure to ensure oversight of all the safeguarding enquiries had all been identified and raised within three consecutive bi-annual provider audits. They had stated that people's ability to give consent should be recorded. That daily records needed to be fully and accurately completed and that they should be factual, precise and legible. This had first been identified within audits one year prior to the inspection, yet remained a concern.

Surveys were sent to people and their relatives to seek their feedback. People and relatives had provided comments and suggestions on areas for improvement. For example, one person had commented about the food. Another showed that a relative had commented on the practice of staff. It was not evident within the analysis of the surveys what action had been taken in response to people's comments and if people's comments had been used as an opportunity to improve practice.

The lack of oversight and action taken to ensure that areas previously identified as requiring improvement within the provider's audits and at the last inspection, was a concern. The provider lacked oversight to ensure that the actions that were required to improve the care people received, as well as the systems and processes used, were completed. The provider had failed to take sufficient action to ensure that they, as well as the registered manager, assessed, monitored and improved the quality and safety of the service provided. In addition, complete and accurate records were not maintained to document people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always complied with the CQC registration requirements. They had not always notified

us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. These related to safeguarding enquiries that had been made by the local authority. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We will publish the action we have taken in response to this when the process has been completed.

The provider's philosophy of care stated, 'To promote high-quality care in a warm, safe, friendly, supportive and relaxed home environment which promotes independence, provides opportunities and maintains skills'. Whilst a majority of interactions showed people to be supported in line with this philosophy, some did not. Most people were treated with dignity and respect. However, not all people were and it was not always evident that people were consistently treated in a person-centred way.

The provider demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Records showed that people and their relatives had been informed of changes to their care.

Some people were unsure who the registered manager was, whereas others knew who to approach. People were involved in their care and had access to meetings to discuss their needs and any concerns. Staff were complimentary of the support that they received. One member of staff told us that they felt valued as the registered manager regularly thanked them for their work. There were meetings to enable staff to be kept informed of changes to people's needs and to the home. Staff could voice their opinions and make suggestions and told us that these were listened to. There were links with external healthcare professionals, the local authority and local colleges, these helped to ensure that good practice was shared between organisations, to promote learning and to ensure people received a coordinated approach to their care.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Regulation 18 (2) (e) Care Quality Commission (Registration) Regulations 2009 The registered person had not notified the Commission without delay of any abuse or allegation of abuse in relation to a service user.

The enforcement action we took:

We recognised that the provider had failed to notify us of incidents that had occurred at the home. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted the fixed penalty and has paid this in full.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Maintain securely such other records as are necessary to be kept in relation to the

management of the regulated activity.

The enforcement action we took:

A warning notice has been issued.