Bupa Care Homes (CFHCare) Limited

Mill View Care Home

Inspection report

Bridgeman Street
Bolton
Lancashire
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Mill View is a care home providing nursing and personal care for up to 180 mainly older people within six houses. Each house caters for different needs including residential care, specialist dementia care and nursing. Mill View is situated about half a mile from Bolton town centre. The home is situated in its own grounds with garden areas and car parking available at the front of the home. At the time of the inspection there were 174 people living at the home.

The registered manager at the home had recently left their employment and a new manager had been employed by the service. They were in the process of registering with the Care Quality Commission. On the day of the inspection the new manager had been in post only a few days. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The unannounced inspection took place on 28 and 29 November 2016. At the previous inspection on 15 and 16 June 2015 the service was given a rating of good overall. This inspection was brought forward due to concerns received from HM Coroner around an incident that had happened at the home. The concerns were around the lack of appropriate training in relation to assisting people with swallowing difficulties to eat. Information received from the provider and evidence gathered at the inspection demonstrated that the service had responded to the concerns appropriately. They had produced an action plan, updated staff guidance around assisting people to eat and included more specific instruction and guidance within the nutritional training for all staff.

There was a house manager for each of the six houses as well as two clinical service managers who oversaw the running of three houses each.

People told us they felt safe at the home. Appropriate individual and general risk assessments were in place and these were reviewed and updated on a regular basis.

Staffing levels were appropriate to meet the needs of the people who used the service. Staffing was based on the dependency levels of the people who used the service. Recruitment procedures were robust and the induction of new staff was thorough.

The premises were clean, tidy and warm with no malodours. The premises and equipment were maintained and serviced regularly to help ensure they remained fit for purpose.

There was an up to date safeguarding policy in place and staff were aware of how to recognise and report any safeguarding issues. Safeguarding issues were followed up appropriately by the home. We saw the home's medication systems which helped ensure medicines were safely ordered, administered, stored and disposed of.

Staff had appropriate skills and training to ensure they were able to administer care effectively. Supervisions were undertaken regularly but recording needed to be more consistent.

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

People's nutritional and hydration requirements needs were assessed and documented appropriately. Special diets were adhered to by the chef and people were given choice with regard to meals. Food and drink were plentiful throughout the day.

People told us they were treated with respect and kindness and we observed good interactions between staff and people who used the service. Visiting times were unrestricted and visitors told us they were made to feel welcome at all times.

People who used the service and their families were involved in care planning where appropriate. People's wishes for when they were nearing the end of their lives were documented and their preferences adhered to if possible.

Care plans were person centred and included a range of health and personal information. This included people's likes, dislikes and care needs. There was a varied programme of activities at the home and people's preferences for how they liked to spend the day were supported.

Complaints were dealt with appropriately by the service and there were a number of forums for people to put forward suggestions and raise concerns.

The new manager at the home had not yet had time to become established. We were therefore unable to assess her leadership skills. People who used the service, visitors and staff reported that the management team were approachable. Staff meetings took place regularly.

A number of audits and checks were carried out by the home. Some were followed up appropriately but others lacked analysis and follow up actions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe at the home. Appropriate risk assessments were in place and these were reviewed and updated on a regular basis. Staffing levels were appropriate to meet the needs of the people who used the service and recruitment procedures were robust.

The premises and equipment were maintained and serviced regularly to help ensure they remained fit for purpose.

There was an up to date safeguarding policy in place and staff were aware of how to recognise and report any safeguarding issues.

We saw the home's medication systems which helped ensure medicines were safely ordered, administered, stored and disposed of.

Is the service effective?

Good

The service was effective. Staff had appropriate skills and training to ensure they were able to administer care effectively. Induction was thorough and supervisions were undertaken regularly but recording of supervisions needed to be more consistent.

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

People's nutritional and hydration requirements needs were assessed and documented appropriately. Food and drink were plentiful throughout the day.

Is the service caring?

Good

The service was caring. People told us they were treated with respect and kindness and we observed good interactions between staff and people who used the service. Visiting times were unrestricted and visitors told us they were made to feel welcome at all times.

People who used the service and their families were involved in care planning where appropriate. People's wishes for when they were nearing the end of their lives were documented and their preferences adhered to if possible.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and included a range of health and personal information.

There was a varied programme of activities at the home and people's preferences for how they liked to spend the day were supported.

Complaints were dealt with appropriately by the service and there were a number of forums for people to put forward suggestions and raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. There was a new manager at the home, who had not yet had time to become established so we were unable to assess her leadership skills. There were two clinical service managers and a manager for each of the houses.

People who used the service, visitors and staff reported that the management team were approachable. Staff meetings took place regularly.

A number of audits and checks were carried out by the home. Some were followed up appropriately but others lacked analysis and follow up actions.

Mill View Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 28 and 29 November 2016 and was unannounced. The inspection consisted of three adult care inspectors, a specialist professional advisor (SPA) who was a registered nurse and a pharmacy inspector.

Before the inspection the provider completed 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. We also reviewed information we held about the home in the form of notifications received from the service and concerns raised by HM Coroner with regard to training around assisting people with swallowing difficulties to eat.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care.

During the inspection we spoke with thirteen people who used the service, nine relatives, and nine staff members, including five carers, two house managers and two clinical service managers. We looked around the home and spent time observing care including the lunch time period in one of the houses. We reviewed records at the home including fifteen care files, nine staff personnel files, meeting minutes, training matrix and audits held by the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe at the service. One person, who had limited verbal abilities, gave the thumbs up when asked. Another person said, "I feel safe here, well looked after".

Care plans included individual risk assessments for areas such as moving and handling, falls, nutrition and skin care. These were regularly reviewed and the ones we looked at were complete and up to date.

We looked at staff rotas which evidenced how many staff were on duty on each house. We observed that staffing levels were adequate to meet the needs of the people who used the service in each of the houses. We looked at information supplied prior to the inspection which set out how staff were deployed to meet the dependency of the people who used the service and found this concurred with our observations on the day. We asked a staff member if there were adequate staffing levels. They said, "Always enough staff on". Another agreed, "Always enough staff". One relative told us, "There are always lots of staff around". On one of the houses staff told us that 17 of their 30 people in that house required the use of a hoist or stand aid for transfer and two staff to assist. Another stand aid was required to help with this, which the manager told us was on order.

We saw that accidents and incidents were logged within people's care files and accompanied by a body map where injuries had occurred. There was an accident and incident log with copies of notifications sent to appropriate bodies, such as CQC. Accidents and incidents were audited and analysed in each House to look at the time, location and person's diagnosis. This helped the service look at patterns and trends and address any recurrent themes. Similarly there was a falls analysis to help ensure all falls were monitored, trends and patterns addressed and appropriate responses made, such as updating individual risk assessments, referring to the falls team if needed and/or implementing monitoring/sensor equipment to help minimise the risk.

There was appropriate fire signage around the premises and fire equipment was in evidence around the home. Each House kept a fire log book which included a list of people's personal emergency evacuation plans (PEEPs), which set out the support each person would need in the event of an emergency. There was also a log of weekly checks of fire alarms, detectors, call points and equipment, occasional fire drills and follow up actions and bi-annual maintenance and testing of equipment.

We looked at the recruitment procedures, which were robust. Within the nine staff personnel files we looked at we found evidence of appropriate applications, interview questions, production of references and proof of identity. There were also terms and conditions of employment and an asylum and immigration form if required. Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks had been undertaken for all employees, to help ensure their suitability to work with vulnerable people and pin numbers (registration) for all qualified nurses were held by the service.

We walked around the premises and found them to be clean and warm in all areas, with no evidence of malodours. We looked at bedrooms in different houses and all were clean, tidy and were personalised with

people's photographs, ornaments and belongings. We looked in depth at mattresses and bedding in five of the bedrooms and these were clean. We also looked at bathrooms and found them to be clean and clutter free. There were domestic staff on site using appropriate cleaning fluids and equipment in line with infection control guidelines. We saw that new flooring was in the process of being installed in two of the houses.

There was an up to date safeguarding policy and staff had undertaken training in safeguarding. They were confident in how to recognise and report a safeguarding issue. The service referred appropriately to the local safeguarding team.

Medicines management was looked at on all six houses. We examined a sample of Medicines Administration Record (MAR) sheets and the relevant sections of the care plans. We also looked at the systems in use for medicines procurement, storage, administration, disposal and record keeping. We saw that these procedures were safe and medicines were managed well by the service.

We saw examples of medicines audit carried out by staff. Records showed that any incidents and errors were recorded appropriately and action plans were prepared to ensure that lessons were learnt and measures put in place to help prevent reoccurrence. A comprehensive range of policies and procedures were seen. These covered all aspects of medicines management.

We observed that training had been given to hostesses and care assistants on all units on how to correctly prepare, administer and record prescribed dietary thickening agents. We were shown the records for basic medicines management training given to all care home staff on induction and more detailed specialist training given to clinical staff. We saw evidence that competency assessments were undertaken on all care staff at their annual performance review.

Controlled drugs were found to be stored appropriately, in locked cupboards, and records were correct. Fridge temperatures were recorded in a daily log and showed that the temperatures were within the manufacturers' recommended limits. Staff were aware of procedures to follow if temperatures were outside these limits.

Covert medicines, that is medicines given in food or drink, were given according to best interests procedures. We did not see evidence of these decisions being regularly reviewed, which would be good practice.

Good

Is the service effective?

Our findings

We spoke with nine staff members who all said they were happy in their work and understood their roles and responsibilities. One staff member told us, "I love working here. It can be challenging but I like it".

Staff completed a full induction programme on commencing work at the home, which included mandatory training. Staff also completed work books on infection control and medication awareness, capacity /incapacity and decision making.

One staff member had transferred from another BUPA home and told us they had met with the previous manager prior to working alone, to familiarise themselves with people who used the service and their care needs. They had also been orientated around the building and asked to read the policies.
We saw that staff supervision sessions were undertaken regularly, some themed and others general. Supervisions provide a forum where work issues can be discussed and personal development needs updated. Recording of supervisions was a little inconsistent, but staff we spoke with said they had regular supervision sessions.
Staff training was undertaken regularly and staff knowledge was good. However, some training was overdue for renewal and this needed to be addressed so that staff knowledge and skills remained current. For example, renewal of training in behaviour that challenges was overdue for a number of staff. This course is important for staff working with people living with dementia.

Concerns had been received from HM Coroner around an incident that had happened at the home. The concerns were around the lack of appropriate training in relation to assisting people with swallowing difficulties to eat. Information received from the provider and evidence gathered at the inspection demonstrated that the service had responded to the concerns appropriately. They had produced an action plan, updated staff guidance around assisting people to eat and included more specific instruction and guidance within the nutritional training for all staff.

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 so that they can 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. We saw that each care file included mental capacity assessments where appropriate. Where people were unable to make a decision there was clear documentation around why they were unable to participate in the decision making. There was also

evidence that decisions had been made in people's best interests, in line with the principles of the MCA. Staff members we spoke with had an understanding of the MCA and DoLS and the training matrix confirmed that staff had undertaken training. One staff member told us, "MCA is about decisions being made in someone's best interest by an advocate if needed. DoLS are needed to keep people safe as they are not able to leave the building due to no capacity".

There was documentation within people's files with regard to DoLS and a DoLS tracker was in place to ensure authorisations were renewed in a timely manner. We saw records of best interests decisions with regard to DoLS applications and authorisations. There was an information leaflet for family and friends to help ensure understanding of the process.
We saw that consent forms for agreement to care and support, the use of photographs and the sharing of information were signed by the person who used the service or their representative. If the person who used the service had not signed the forms it was clear why this was from the mental capacity assessments within the file. If a person who used the service had declined to have their photograph taken, this was recorded.

We looked at documentation with regard to people's nutritional and hydration requirements. These were clearly recorded within people's care files and people were weighed on a weekly basis where this was deemed necessary. Where there was weight loss or nutritional issues, we saw that food and fluid charts were completed and appropriate referrals to GPs, dieticians or speech and language therapy (SALT) teams. Advice from these professionals was recorded and followed and we saw that communication was on-going between the home and relevant professionals. We only saw one instance where it was unclear whether a referral to a dietician had been followed up. We brought this to the attention of the clinical service manager who agreed to address this immediately.

We saw there were a number of options offered at each meal time. There were menu boards so that people could see the choice on offer and for those who required it; staff explained the choices to them. Breakfast consisted of porridge, cereals, poached or scrambled eggs, sausage tomatoes, bacon, toast and a choice of drink. We observed a significant number of people who used the service opting for a cooked breakfast. One visitor who was sat with their relative told, "Breakfast is like this every day, they can have what they want". A person who did not want the breakfast asked for cake. We saw that a cake was brought to them by staff.

Dining tables were nicely set in most of the houses. We discussed with management that in one house the dining experience could have been enhanced, with the use of tablecloths, napkins and condiments. They agreed to look at this. There were pictorial menus on the wall to help people make choices.

We observed the lunch time meal on one of the houses. People who used the service were offered clothes protectors, but their choice was respected if they refused to wear one. We saw that staff used people's first names and there was lots of chatter during the meal. This made it a pleasant social experience for people. There was a choice of hot or cold drinks and meals were served efficiently. Some people dined in their rooms, but had been given the choice to come into the dining area. There was a choice of meal, soup and a sandwich or sausage lattice. Some people required assistance with their meal and this was offered in a discreet and sensitive manner. Staff were seen sat down with people chatting and offering encouragement with their meal.

One person who used the service said, "Food is alright", another told us, "The food is nice and you are treated well by staff". Other comments included; "Staff are very nice, very friendly, fetch us our meals. Food's good, if we didn't like it we would send it back and they will send us something else"; "I am a small eater but the food is nice"; "Food's grand". We saw there were lots of fluids offered throughout the day, including milk, juice and hot drinks.

We saw there was a satellite kitchen for drinks and refreshments in each house. There were also snacks available during the night. The options offered were displayed on a menu board entitled 'Night Bites'.

The design of the dementia houses was not ideal for people living with dementia as the corridors led to dead ends and were T shaped, so people were unable to walk around without turning back at some stage. However, staff had made the best use of the space. The walls had tactile objects for people to look and touch, pictures were appropriate and aided with reminiscence and there were 'rummage chests' with lots of different objects in for people to explore. There was seating on corridors for people to move away from the main hub of the home.

There was clear signage around the home to help with orientation to bedrooms and communal areas. Some bedrooms had name plaques, but not all and some had memory boxes, but not all were filled. This meant that some people may experience difficulty in finding their rooms.

Good

Is the service caring?

Our findings

We asked people who used the service how they felt about the home. One person said, "Staff are kind, I like it here, bedroom's mine and I like it". Another told us, "I like pleasing myself what I do and it's now very difficult as I am not very mobile you see, but staff help me with things. Staff are kind to me". A third person commented, "I like it here, it's nice. I like the wide open space; you can wander around and make friends, no concerns at all". Other comments included; "I am being looked after, the nurses are OK. They don't offer choices, just do things for me. I would rather be at home but I suppose this is the next best thing"; "I am happy, I have my friends"; "I am happy here. Everyone is nice"; 80% of staff are nice, 20% are not"; "The experience is very good. They (staff) are gentle with me, the staff will help with anything, bedrooms are always clean, and it's a very clean place".

A relative said, "Staff are good here, they look after (relative) well. I am always made to feel welcome". Another said, "The staff are very good, I have no worries or concerns about the care. My [relative] is always clean and is dressed as how he would have dressed if he was living at home".

There were no restrictions on visiting times. One visitor told us, "I can visit at any time, I fit it around work. I have no problems with the care [relative] receives. I know he is happy here". Their relative who used the service also confirmed they were happy living at the home. Another visitor told us, "(Relative) has been in for one week and it's great. Came from a residential home and this is far better. We happened to be here when she arrived and the way she was received was excellent. We have been in every day and are very happy with (relative's) care. We feel she is well looked after, staff are friendly and offer hot drinks and we are free to come and go whenever we wish".

People told us staff treated them with respect. We observed staff interactions throughout the inspection days and saw that these were respectful. Staff were calm and unruffled when delivering care to people. Staff we spoke with demonstrated a good understanding of people's likes, dislikes and care needs.

We saw evidence of involvement of people's family members, where appropriate, in care planning. One relative told us, "(Other relative) deals with (relative's) reviews, I know she is always invited to them". Where people who used the service had capacity we saw that they were fully involved with the care planning process.

There were some people at the home who were on end of life care. On the nursing houses the service cared for people with the support of the GP when they were nearing the end of their lives. On the other houses the staff were supported by the local district nurses with regard to end of life medicines and pain relief. This helped ensure people were comfortable and pain free at this difficult time. If people had expressed their wishes for the end of their lives, these were clearly documented within their care plans.

Good

Is the service responsive?

Our findings

One relative said, "There are always activities going on when I visit". We observed care throughout the two days we were there. We saw that people were free to move around the houses and could open the door and go outside to walk around the enclosed outside areas. One person wanted to go to their room for a lie down and they were supported with this. Another was on their own mobile phone, chatting away in their bedroom.

Care plans were person centred and included documents such as, 'My Day, My Life, My Portrait', which contained personal information about people who used the service. Information such as what was important to people, important dates, background history, likes and dislikes were all recorded. People's preferences, such as wanting two pillows at night, wishing to have a light on or the door open, were documented. We saw that if people were unable to use the nurse call bell this was recorded as well as the way they accessed staff or whether staff needed to regularly check on the person. A relative told us, "The amount of information they wanted to form (relative's) care files was very impressive. They even wanted to know about her work experiences and what was important to her. We have been kept up to date with how (relative) has settled".

Care plans outlined how and where people liked to spend their time. We saw that some people liked to return to their rooms during the day whilst others liked to socialise with others in communal areas. When we walked around the home we saw that some people were in their bedrooms, others walking around the premises and some in general lounge areas. We saw a programme of activities and these were outlined on posters around the home. There was evidence in the care plans of varied activities, including reminiscence sessions and one to one chats, games, massage, reading, hymn singing, bingo, exercise and entertainment. We saw there were plans for activities over the Christmas period. People's preferred activities were recorded within their care plans.

The home had a hairdressing salon which was in use on the day of the inspection. The salon was located away from the houses which provided the opportunity for people to leave their house and visit the salon. It provided a social setting for people to chat and interact as they would have done before moving into Mill View. The home also had a café which was well used by people who used the service and relatives. This also provided an opportunity for an 'outing' to a different place and to interact with other people.

Relatives and residents meetings were held on each house and we saw minutes of some of these. Items discussed included activities, Christmas programme, DoLS and related issues, concerns, environmental issues and care reviews.

The complaints procedure was displayed in each of the houses as well as in the main foyer. Complaints and concerns were logged and we saw that they had been followed up appropriately.

We saw customer feedback forms were collected regularly by the service. The last ones were dated July 2016 and there was one comment about new carpets being needed in one of the houses. We saw that action had

been taken and the flooring had been replaced. There were two separate comments concerning financial issues and these had been addressed with actions.

Compliments the service had received over the year included; 09/03/16 'I would like to thank the staff team in Albion for the care and support they gave to my dad and to me'; 'To all the staff that cared for my dad, you did a good job. I know you really cared for [relative] it made all the difference'; 16/06/16, 'My daughter and I wanted you to know how much we appreciate all the love and care shown to us by each member of staff in Victoria House. They helped us tremendously in steering us through a very difficult time'.

We saw there was a suggestion box in the foyer of the home. This provided another forum for people to have their say, raise issues and make comments.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager in place at the home, who was in the process of registering with the Care Quality Commission. The manager had only been in place for a matter of days when the inspection took place, and this was her first full day managing alone. We were unable to assess the new manager's leadership skills due to her being so new to the service. There were two clinical services managers, however, who were each responsible for three of the houses, as well as a house manager for each separate house. They were able to help facilitate the inspection and supply relevant information as requested.

We asked people if the management team were approachable. One relative said, "I have no concerns, if I did I would speak with the House manager. I know things would be dealt with".

We asked staff if they felt supported. One staff member said, "I have worked in health and social care all my life and feel supported in my role". Another staff member said, "You can approach all management with anything".

Staff were supported via supervision sessions and regular training. We saw that there was a board in one of the corridors which contained messages of congratulation and thanks to individual staff members who had exceeded expectations. Staff said they found this encouraging and rewarding.

There were minutes of staff meetings available. Issues discussed included Quality Review Report, mealtime experience, personalised rooms, infection control, staffing, privacy and dignity, cleanliness, safety, activities, care plans and documentation. There were daily walk rounds by clinical service managers and actions from this were recorded and discussions held around what was observed on these walk rounds. We also saw a night visit log which demonstrated that the management team carried out unannounced night visits and documented their findings. These were discussed with staff as required.

We looked at care plan audits for the last month and saw that some actions had been followed up. We saw a number of other audits, such as falls and accidents. These had been analysed for any patterns or trends to help minimise the risk of further incidents. However, other audits lacked analysis and follow up actions, for example, a 'First Impressions' audit completed on 17 November 2016 required recording of issues identified and follow up actions. A home quality assurance audit, dated 11 October 2016 was incomplete regarding health and safety and a quality infection control audit featured comments made but no record of actions taken. This was the same for each of the houses. We found that the home's internal audits were better in terms of recording actions than those undertaken by head office.

Notifications were submitted to CQC in a timely way. If follow up information was requested, this was supplied promptly by the clinical service managers.