Care UK Community Partnerships Limited

Mill View

Inspection report

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Date of inspection visit: 29 November and 2 December 2014
Date of publication: 12/03/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 29 November and was unannounced. We returned on 2 December 2014 to complete the visit.

Mill View is a purpose built home that provides residential and nursing care for up to 70 people, including people who live with dementia, mental health conditions and have general nursing needs. The service provides long term and respite placements. At the time of our visit there were 67 people in residence.

The service has 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.

There were not always sufficient numbers of staff to meet people's needs or to keep them safe. People were at risk of receiving care that was inappropriate or unsafe

Summary of findings

because their needs were not always regularly reviewed or updated when changes occurred. Where people had particular needs that required monitoring, such as fluid intake, records contained significant gaps.

We found that people who required a pureed diet did not always receive food that was appropriate for their needs. They were also limited by the choice of food available, particularly dessert options.

The registered manager and provider had a system for monitoring the quality of the service provided but identified improvements or changes were not consistently implemented or sustained.

Morale amongst staff was low, they told us because they were too rushed to provide a high standard of care. Suitable arrangements were not in place to monitor the status of staff training and to ensure that staff received refresher training in accordance with the provider's policy. While staff told us that they had supervision meetings, we found that records were missing and that they had not had appraisals. This meant that staff may not have been supported to care for people safely and to an appropriate standard.

Some people and many relatives were concerned that the standard of care was in decline. They told us that the staff were excellent but they were increasingly busy and did not have time to chat with them. They told us, and we observed, that communal areas were not always supervised. Others shared a most positive experience. One said, "I hear negative things but that's not my experience. I'm really happy with the home".

Staff were caring. People, or their relatives, had been involved in planning the care they needed. They were able to make suggestions and felt that they were treated with dignity and respect.

Risks to people's safety were assessed and generally reviewed. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Medicines were managed safely.

People were able to access healthcare professionals, including their GP, dieticians and chiropodists.

The registered manager held meetings with residents, relatives and staff. In the main, people told us that they were listened to and that the registered manager responded to their concerns. There had been positive changes, such as activity provision at the weekend in response to feedback.

The concern over staffing was, however, unresolved in the eyes of some people, relatives and most staff. Staff and relatives did not feel listened to when raising concerns over staffing. This was having an impact on the atmosphere at the home and had created a culture of mistrust. There were also issues with the maintenance of the building, including a lack of hot water, which were taking too long for the provider to put right.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were not enough staff to keep people safe and meet their needs at all times.

Risk assessments were in place and generally reviewed to help protect people from harm.

People said they felt safe. Staff understood safeguarding including the signs of abuse and what action to take.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service was not effective.

People's care plans did not always reflect their current support needs which put them at risk of receiving inappropriate or unsafe care. People who required a pureed diet were not always provided with a choice of suitable food. Where people were at risk of dehydration their fluid intake was not monitored appropriately.

Staff had not had appraisals and some staff had not received refresher training to support them in their responsibilities.

Where people lacked capacity to consent to certain decisions, the registered manager had followed best interest decision making procedures.

People had access to health care professionals to maintain good health.

The premises were purpose built to cater for people's mobility and support. needs.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff. They appeared to enjoy their company and told us that they wished staff had more time to spend with them.

Staff involved people in planning their care and supported them in decisions relating to their daily needs and how they wished to spend their time.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The majority of staff knew people well and understood their wishes and needs. They responded to changes in people's needs.

Summary of findings

Maintenance issues were not always addressed promptly and impacted on the service people received.

People were able to make suggestions and the staff team took action. There had been improvements in activity provision at weekends in response to feedback.

People understood how to complain. Formal complaints had been investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider and registered manager used a series of audits to monitor the delivery of care that people received. The system had failed to bring consistent improvements.

The home was going through a period of change. Staff and some relatives were anxious. This was having an impact on their relationship with the registered manager and affecting the atmosphere in the home.

Mill View

Detailed findings

Background to this inspection

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

This inspection took place on 29 November 2014 and was unannounced. We returned on 2 December 2014 to complete the visit.

One inspector, a nurse specialist advisor and an expert by experience in older people's services undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed two previous inspection reports and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We also considered the details of recent concerns that had been shared with us by relatives. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. We 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 looked at nine care records, two staff files, staff training and supervision records, medication administration records (MAR), weight charts, monitoring records for food, fluid and wound care, quality feedback surveys, accident and incident records, activity records, minutes of meetings and staff rotas.

During our inspection, we spoke with 16 people using the service, 13 relatives, the registered manager, the clinical lead, four nurses, three team leaders, nine care staff, the chef on duty, the maintenance manager, three administrators, and two housekeeping staff. After the inspection, we contacted a Speech and Language Therapist (SALT) who had involvement with the service to ask for their views. They consented to having their feedback published in this report.

Mill View was last inspected in July 2014 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

People shared concerns with us over the staffing level in the home. They told us that staff were very busy and did not spend time with them outside of delivering their basic care. One said, "They run round like scolded rats". Another told us, "It would be nice if staff had time to chat". People also shared examples of when the staffing level had impacted on their care. One said, "I have to be fed, sometimes by the time someone comes the food gets cold". Another told us, "It's often difficult to find someone". We observed that one person who asked for assistance to use the toilet was asked to wait while staff supported another person. After twenty minutes when the staff member had not returned the person asked another member of staff and was assisted.

Staff expressed concerns over the staffing level. They told us that they sometimes struggled to get people up at the time they wished. One explained that sometimes people had their lunch in bed because they had been unable to assist everyone in time. A nurse told us, "I can't leave the meds but I can't tell them (the care staff) that I can't help". We noted from repositioning records that people were not always assisted to change position at the recommended frequency. A member of staff told us, "If we haven't got enough staff, then the two hourly gap doesn't happen. We try to get them turned as much as possible". Another said, "Sometimes we have to leave behind the paperwork because the residents are the first priority".

The registered manager had implemented the provider's dependency tool to calculate the number and skills mix of staff required to meet people's needs. This was reviewed on a weekly basis to determine the staffing hours. The registered manager explained that they tried to staff above this 'benchmark'. For a two week period in November 2014, we calculated that 56% of shifts were over the benchmark, 34% were at the benchmark and 9.5% were under the benchmark by up to one member of staff. However the levels of staff still did not appear safe at all times. On the two days that we visited, the staffing level was above the benchmark. We observed that communal areas were not always supervised. As some people were assessed as at risk of falling, this meant that they were at increased risk. We noted in the incident records that a fall resulting in injury had occurred in the lounge during the evening when it was unsupervised. Staff told us that monitoring communal areas in the evening was not always feasible as they were busy assisting people to bed.

We found that there were not always a sufficient number of staff to keep people safe and meet their needs. The information used to inform the dependency calculation did not always accurately reflect people's needs. The system in place relied upon staff updating people's care needs in the electronic records, which was generally carried out on a monthly basis. One person had returned from hospital and required the support of two staff rather than one. Their dependency score had increased from low to high. This was not picked up on the system until a week after the person returned to the service and was therefore not reflected in the staffing calculation. The registered manager said, "It looks as though we missed her coming back". Nursing staff were not able to influence how decisions about staffing were made and flexibility to take account of their professional experience and knowledge was not built into the process.

The above demonstrated that the provider had not taken steps to ensure that, at all times, there were sufficient staff to provide safe care to people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people had accidents or sustained injuries, staff maintained accurate records. Where there were known risks to people's safety these had been assessed and had usually been reviewed on a monthly basis, or sooner if people's needs changed. A Waterlow risk assessment was carried out for each person. The score from this assessment gave an indication as to the person's risk of developing pressure areas. It took account of risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. It allowed staff to assess the risks and then plan how to alleviate them, for example by ensuring that the correct mattress was made available to support pressure area care. We found examples of action staff had taken to keep people safe, such as seeking advice from the dietician or speech and language therapist when people were at risk of malnutrition and had lost weight. We noted positive examples of people gaining weight following such intervention.

People received their medicines safely. Medicines were administered by nurses or, for people requiring residential

Requires Improvement

Is the service safe?

care, by team leaders who had been trained to do so. We observed part of the medicines round at lunchtime. Staff provided clear information for people regarding their medicines and administered them in accordance with the instructions from the prescribing GP. Where medicines were prescribed on an 'as required' basis, protocols were in place. These described the circumstances in which the medicine should be given, the dose and the expected outcome. Medicines, including controlled drugs (controlled drugs are drugs which are liable to abuse and misuse and are controlled by legislation), were stored safely, within the recommended temperature range and accurately recorded. Records for the administration and disposal of medicines were complete and up-to-date.

People told us that they felt safe. Staff were able to describe what they would do if they had concerns and how they would escalate this to protect people if they suspected they had been harmed or were at risk of harm. They confirmed that they had attended safeguarding training and understood issues that related to bullying, harassment and abuse. Staff were confident concerns they raised with their line managers would be acted upon. Posters encouraged staff to raise concerns and included details of the provider's whistleblowing line were displayed in the home and staff room. We noted that the information displayed did not include contact details of the local safeguarding authority and discussed this with the registered manager during our visit.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers and their qualifications were checked in line with information supplied on the application form. This helped to ensure that new staff were safe to work with adults who may be at risk.

Requires Improvement

Is the service effective?

Our findings

Effective care could not be assured because monitoring of people's care needs was inconsistent. Some people had been identified as at risk of developing pressure areas. Support plans were in place which directed staff to ensure that they were supported to change position. We found that the records contained significant gaps. One person required assistance to change position on a two hourly frequency. In the record for one week, we found five instances where the records indicated gaps of four, five or six hours between turns. Another person had been identified as at risk of constipation and staff were directed to monitor and record bowel movements. We found that the monitoring records were incomplete. The chart contained one entry in May, three in August, one in October and one in November 2014. Whilst there were some entries in the daily notes, the system in place did not provide a clear record for staff to refer to. The lack of accurate records meant that people may not have received the support they required and were at risk of not having their needs met.

People's care had been planned but had not always been reviewed to reflect their current needs. The home used an electronic system to manage their care records. The system triggered a review on a monthly basis. In our sample of care plans, review dates were overdue for four of the nine care plans. In addition, some had not been updated to reflect changes in a person's needs. One person's mobility had changed significantly after they suffered a fall. As a result they were no longer able to transfer using a stand-aid and required a full body hoist. We asked a member of staff about this person. They told us that the change had occurred approximately two weeks previously and that, "The care plan all needs changing". Staff understood how to assist the person but the care plan did not reflect their current support needs. This put them at risk of receiving care that was inappropriate or unsafe.

The above was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people that we spoke with were satisfied with the choice of food on offer. One person told us,

"We have a menu every day and there are options". People who required a pureed diet did not have a choice of meal and the food served was not always in keeping with their needs. The chef on duty told us that the dessert option for those requiring a pureed diet were pureed fruit or angel delight. In the comments book one relative had written, 'Surely if you offered people on normal diets the same dessert four days running they would be up in arms. It is not on'. A speech and language therapist that we contacted told us, 'A number of patients on very soft, pre-mashed diets were repeatedly given high risk vegetables'. We noted recurring feedback raising concerns over the pureed meals and variety over the four months prior to our visit. Comments from November 2014 included, 'The evening pureed meal was a complete disaster. Finely chopped mushrooms and long grain rice (which does not puree) is not an acceptable evening meal' and, 'Peas full of husks and no pureed dessert – disappointing lunch and dinner'. People who required a soft or pureed diet were not provided with a choice of suitable and nutritious food that protected them from the risk of choking.

Where people had been assessed as at risk of dehydration, fluid charts were in place but had not always been completed. In one person's record for the period from 1 to 18 November 2014, just three days had been totalled. The registered manager was unable to demonstrate that staff were ensuring people received sufficient fluid to meet their needs.

The above was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they had confidence in the staff and their abilities. One person said, "They know precisely what to do". Staff were satisfied with the training opportunities available to them and told us that they were supported to pursue additional training. They explained that they had a mix of face to face training and e-learning. One said, "The training is good". Another told us, "We can also do extra courses from universities, such as recognising mental illness and nutrition. The company pays". We found however, that the registered manager had not ensured staff received refresher training in accordance with the provider's policy. Moving and handling was listed as an essential training course to be followed by all staff on an annual basis. We noted almost half of the staff had not attended an update within the last 12 months. The

Is the service effective?

completion rate for this training was 54 percent, fire training was at 67 percent and safeguarding at 70 percent. This meant that staff may not have been trained to care for people safely and to an appropriate standard.

The provider had a system of staff supervision. Most staff told us that they received regular supervision. We noted that two members of staff did not have any supervisions recorded, although one confirmed that they had taken place. There were, however, no recorded appraisal meetings for staff in 2013 or 2014. Staff may not have received appropriate support and supervision in relation to their responsibilities which could impact on the care that people received. A system of appraisal is important in monitoring staff skills and knowledge to enable them to deliver safe care.

New staff followed the provider's induction programme which included shadow shifts, alongside a nationally recognised programme of induction. This helped them to get to know people and to understand what was expected of them. One new member of staff said, "I did my moving and handling and then I did shadowing for four long days. After that I worked on doubles so they could keep an eye on me". New staff told us that their competency had been checked in tasks such as moving and handling, supporting people to eat and drink and providing personal care. One said, "The nurse always checked how I was working and made sure I felt comfortable". We found, however, that competency checks were not routinely recorded as part of the induction paperwork. This could mean that some new staff were providing care to people before they had been assessed as having the necessary skills.

The above demonstrated that the registered manager had not ensured that suitable arrangements were in place for staff training and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were involved in decisions relating to their care and treatment and staff understood how consent should be considered. Care plans included guidance on people's preferences, such as if a person preferred not to wear their false teeth. There were also details on the action staff should take if a person refused support. For example, we read 'Has the right to refuse to take her daily medication… the trained staff should go back every 15 minutes for up to one hour. After one hour the medication must be destroyed as per Care UK policy and procedure'. Where people lacked the capacity to consent, staff followed the Mental Capacity Act 2005 (MCA). Assessments concerning people's capacity to make specific decisions reflected the principles of the MCA. The two-stage functional test was applied to ascertain if people could understand and retain the information they needed to in order to make informed decisions. Where people did not have capacity to make a particular decision, such as on whether to use bed rails, best interest meetings had taken place. Best interest meetings should be convened where a person lacks capacity to make a particular decision, relevant professionals and relatives invited and a best interest decision taken on a person's behalf.

The registered manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. Deprivation of Liberty Safeguards (DoLS) protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

There were good examples in people's care plans of detailed information relating to their specific needs, such as seizure or diabetes management. Where people presented with behaviour that could be described as challenging, behaviour monitoring was in place. Incidents had been clearly documented and included detail of the situation surrounding the event. This information had been used effectively to establish causation and develop appropriate behaviour care plans to reduce such occurrences. Staff used a tool to assess people's pain. This included observations of body language such as facial expression and response when touched. This helped staff to make decisions about whether pain relief was required when the person had difficulty communicating. It helped to manage pain consistently and to ensure that people's needs in this area were met.

People were able to access healthcare professionals, including their GP, dieticians and chiropodists. A relative told us, "The Doctor is called if needed". A healthcare professional told us that staff provided them with good information about people's health and made appropriate decisions as to when to contact them for further advice.

The home was purpose built and offered a variety of spaces for people to relax or socialise. In addition to a number of lounge and dining areas, there was a cinema room, coffee

Requires Improvement

Is the service effective?

shop and hair salon. Doors opened into an enclosed garden space which was landscaped with a level pathway for people to walk. One relative told us how they found the café to be a very relaxing environment and how useful their relative had found the hairdressing service. Another person told us, “It’s a beautiful building”. We observed that people’s needs in relation to the design and decoration of the service had been considered. Bathrooms were spacious and well equipped. Bedroom doors had pictures of people and their names with objects of reference that were individual to them.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the staff team. One person told us, “We’ve got some very nice staff here”. Another said, “They’re very friendly”. We observed that people addressed staff by their first names. Their communication appeared relaxed and cheerful. One person told us, “They remember that I like this spoon for soup”. A relative said, “Staff treat people like their own”.

People and relatives told us that the staff were wonderful but expressed concern about the changes in the staffing level. One person said, “I used to be very happy here but now I’m not. We’re always short staffed”. They told us that they would like staff to spend more time with them. One said, “I would have thought it was part of care to sit and talk to us but they don’t seem to have time for that”.

People and, if appropriate, their relatives were involved in making decisions about their care. Relatives confirmed that they had been involved in setting up and reviewing the care provided. One said, “We sit down and go through everything”. Another told us they had a, “Big review” and were routinely informed of any changes, such as if a new medicine was prescribed. People had been engaged in discussions regarding their future care wishes. Decisions with regard to appointing a power of attorney (legal authority to act on behalf of the person in matters relating to their health and welfare or finances) and preferences with regard to resuscitation were discussed and documented. This meant that people’s wishes were recorded in the event that they were unable to make or communicate a decision regarding their treatment at a later date.

Where people had limited or no verbal communication, care plans included a good level of detail to help staff to understand their wishes. We read that one person put their hands above their chest when they felt anxious. Other care plans included specific details such where a person preferred to be supported by male or female staff, their spiritual views and particular preferences, including that one person liked half a spoon of sugar in their tea. We observed that staff supported people in their decisions. One member of staff rushed to catch up with a person who was going out for the day and had forgotten their coat. They also spoke with kitchen staff to ensure that supper would be kept for them. A relative said, “I can’t fault the care she is given”.

People told us that staff respected their privacy and dignity. One said, “I keep my door shut and there’s always a tap. That’s no problem”. We observed that staff spoke with people and explained the care they intended to deliver. They did this consistently, including when people were not able to respond verbally. One member of staff apologised for interrupting a person’s lunch to give them their medication. They asked if they were enjoying their lunch and thanked them as they left.

We noted that staff had taken care to make the environment pleasant for people. There were flowers in the bathroom which made it more inviting and the lunch tables were decked with festive napkins. We noted that a recent newspaper clipping celebrating achievements in the life of one of the people living there was prominently displayed. The registered manager had also introduced a colourful newsletter full of photographs detailing activities and special events, including birthdays, at the home. One relative told us, “They arranged a party with music for Dad’s Birthday”.

Requires Improvement

Is the service responsive?

Our findings

Staff were knowledgeable about people's care needs and interests. People told us that most of the staff knew them well and that they noticed if they were not feeling at their best. When staff arrived for work they received a handover. We looked at the handover notes compiled by the nurse. This included written notes identifying relevant changes and updates to people's care. Staff explained that they had training in how to recognise changes in behaviour, how to respond and how to escalate any concerns. There were regular GP visits to the home. We noted examples of staff logging their concerns in advance of the GP visit. For example, we saw that they had requested a medication review for one person who staff felt was 'very sleepy'. This demonstrated that staff responded to changes in people's needs by seeking advice or adapting the care delivered.

People told us that they were involved in determining the programme of activities. One said, "If they are planning something, usually a few of us are involved in the conversation". Another told us, "We didn't used to have activities at the weekends until just recently". They explained that this had been raised with the registered manager who had reviewed the activity staff rota. When we visited in July 2014, one person told us that they would enjoy visits from children. We saw in the home's newsletter that this had been arranged. We found that people were able to make suggestions and that the registered manager responded.

People spoke positively about the entertainments on offer. One said, "They've always got something organised if you feel like it". Another told us, "They're quite good the trips we have". Relatives were also pleased with the programme. One told us, "Yes, Mum goes to cinema and hairdressers in the home, she walks in the garden. The activities are brilliant". We saw that the monthly programme was available for people to take a copy. There was a range of activities available including pub visits, outings, gardening, art, music, visiting dogs and ponies. The first day of our visit was on a Saturday and the home was holding their Christmas fair. There was a good atmosphere in the home with people and visitors enjoying time in the café, the stalls and activities provided.

People had an opportunity to express their views at residents' meetings, which were chaired by residents. In the minutes of the most recent meeting, in October 2014, we saw that people wished to be informed on a daily basis about activities taking place. During our visit we observed activities staff inviting people to join a visit to a local garden centre which suggested that this feedback had been acted upon.

The manager took steps to respond to feedback. In response to suggestions from relatives there was now a photo board of staff displayed in the main entrance. Where there were maintenance faults, such as a broken tumble drier, there was a notice in reception. The provider carried out an annual survey of relatives which were compared to the previous year and ranked against other homes run by the provider. We saw that Mill View had demonstrated an improvement in several areas, such as the level of privacy given at the home and organised activities outside the home. The registered manager was aware of the areas where satisfaction had fallen and was able to describe the action they were taking. One area of concern was availability of the registered manager. The registered manager explained that they were spending more time with people and relatives in the home in response to this feedback. One relative told us, "The manager's attitude has changed. She's out and about, she talks to people".

A relative said, "We are listened to in most respects, the home does respond". There were, however, two particular areas of concern that people, their relatives and staff shared with us where they felt the response had been insufficient. The first related to the change in staffing levels and their worries about the impact on the care staff were able to deliver. Staff told us that they had attended a meeting to voice these concerns but that they had not received feedback. They told us that they felt disempowered and that morale was low. The second area related to maintenance issues with the building. One relative told us, "The lift has broken down six times in the last year, it's always Mañana". Another said, "They say they'll address it but nothing seems to get done. There's more false promise than action".

At the time of our visit the water was not heating up effectively, reaching temperatures of 35-36 degrees centigrade rather than the minimum of 39 degrees stipulated in the provider's policy. This meant that people were unable to have a bath or shower, or if they did it was in cool water. One person told us, "We used to have hot water, it was lovely" and said, "It's appalling for the amount we pay". We found the problem had been ongoing for ten

Requires Improvement

Is the service responsive?

days. Following our visit we received confirmation that the problem had been rectified, over two weeks after the onset. The manager explained that they had to go through the provider's maintenance team to remedy issues with the building. The maintenance manager said, "My hands are tied, there is only a certain distance I can go". We reported this concern to the Health and Safety Executive due to the impact it was having on people living at the home and the delay in finding a solution.

People and their relatives understood how to complain. The complaints procedure was displayed and we saw in the minutes of the residents' meeting that the procedure had been explained. Where formal complaints had been received, these had been thoroughly investigated and responded to. The records included a summary of the complaint and the action taken. One relative told us, "We are getting things improved".

Requires Improvement

Is the service well-led?

Our findings

The provider had a system for monitoring the quality of services delivered. There was good evidence that this system identified areas of concern and highlighted possible improvements. We found however, that the registered manager had not been effective in ensuring that improvements were consistently delivered. Action had been taken to improve the quality of pureed meals but it was evident from the comments book that there were still concerns over the choice and suitability of the pureed food available. As one relative told us, "The chef has done a lot of work but it goes off the rails with bank staff or agency". The registered manager had not ensured that food was delivered to a consistently high standard. At our inspection in July 2014 we noted that fluid monitoring was not always well documented. We discussed this with the registered manager and they quickly introduced a monitoring tool for nurses to complete. We found, however, that there were still significant gaps in the records and whilst the monitoring tool was ticked, the checks were not effective. Maintenance issues had not been addressed promptly and impacted on the service people received. The manager did not have an effective system to regularly assess and monitor the quality of the services provided.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was going through a period of change and the culture at the time of our visit was one of mistrust and unease. The registered manager had been in post since June 2014 and, using the provider's tool, had made changes to the way that staff numbers were calculated. This had resulted in fewer care staff on most shifts. Some people, relatives and most staff were frustrated by the introduction of a staffing benchmark and recent maintenance issues. This had an impact on the atmosphere in the home. One member of staff said, "It's not the same Mill View". Relatives shared that it had been a flagship home but that they would no longer recommend it. One person said, "When I first came here the staff were happy. Now all we hear is they're looking for new jobs. They're obviously unhappy." In staff recruitment material we read, 'You will still be able to spend genuine quality time with residents, which is why you do what you do after all'. Staff told us that the lack of time to spend with people meant they did not feel fulfilled and were not able to help people lead, 'fulfilling lives' as per the vision of the provider. It seemed difficult for staff to look beyond current staffing concerns and discuss a vision for the service. They explained that they had no time for innovative practice as they were too involved with day to day tasks. They told us that they did not feel valued.

The registered manager did not have the full support of the staff team. Staff told us that they felt disempowered. The nursing staff appeared to lack the confidence to raise concerns. One said, "There's something about communication that isn't good". Another told us, "The manager doesn't listen, she just tells you what she wants". We noted that requests from the manager, such as for copies of staff supervision documentation had not been complied with, despite repeated requests. The manager told us, "It's about chasing them all the time".

The manager was working hard to make improvements and to engage with people, relatives and staff. There had been resident, relative and staff meetings to discuss and explain the changes. Some of these meetings had involved representatives from the provider. Some staff and relatives felt that there were signs of progress. One said, "I think the manager is beginning to turn it around".

There were examples of positive action, for example a repeat medicines audit by the pharmacy recorded an improvement in the records concerning topical creams. Visits from a representative of the provider had noted the delays in refresher training for staff and had set a target for completion which was to be monitored on a monthly basis. There was also evidence that the manager and provider were investigating the concerns around staffing levels and an independent internal audit in this area had been requested.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff in order to safeguard the health, safety and welfare of service users.** Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment because an accurate record, information and documents in relation to the care and treatment provided had not been maintained.** **The registered person had not maintained accurate staff records.** Regulation 20 (1)(a)(b)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration by means of the provision of a choice of suitable and nutritious food and support, where necessary, to enable service users to eat and drink sufficient amounts for their needs.** Regulation 14 (a)(c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person had not ensured that suitable arrangements were in place for staff training and appraisal.** Regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have an effective system to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.** Regulation 10 (1)(a)