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**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 and 17 February 2015. At which a breach of legal requirements was found. This was because legal consent had not been obtained for the use of restraint for one person whilst delivering personal care and staff did not have access to relevant guidance on how and under what specific circumstances they could use this restraint.

After the comprehensive inspection, the provider wrote to us and sent us an action plan detailing what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 6 September 2015 to check that they had followed their plan and to confirm that they now met legal requirements. At our focused inspection on the 6 September 2015, we found that the provider had followed their plan in relation to obtaining consent for the use of restraint which they had told us would be completed by September 2015 and legal requirements had been met.

We had also received concerns that the use of agency staff was high and the staffing levels at the service were not sufficient to meet people's needs. As part of our focused inspection we checked the arrangements for ensuring that sufficient numbers of appropriately skilled and qualified staff were deployed.

This report only covers our findings in relation to these two topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Mill River Lodge' on our website at www.cqc.org.uk'

Summary of findings

Mill River Lodge provides accommodation for 70 older people. It offers nursing and personal care for older people with physical frailty and for older people living with various stages of dementia. There is level access throughout the building and grounds and a passenger lift to provide access to people who have mobility problems. On the day of our inspection 66 people lived at the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The person in day to day charge of the service is referred to as the acting manager throughout the report.

Staff were now aware of under what specific circumstances they could use this restraint and guidance was available to them as to how this should be undertaken. A mental capacity assessment had been completed for the person concerned and an application for a Deprivation of Liberty Safeguards had been made to the local authority. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

Staffing levels were determined by assessing people's dependency needs and staff vacancies and expected leave was planned for. The agreed staffing levels had been maintained the majority of the time. On occasions when agreed staffing levels had not been achieved it was evident that this was due to last minute unforeseen circumstances. One member of staff told us staffing was sometimes an issue due to last minute sickness, they told us, "They seem to do their best to try and get someone else". On these occasions the provider had taken steps to try to cover these shifts but had not always been able to do so. People's needs had been met and no harm had occurred as a result of them operating short staffed. However, we have assessed this as an area of practice that requires on-going improvement.

Cover for staff vacancies and staff expected leave was planned for. The use of agency staff to cover these shifts was high but the same agency staff were used on a regular basis and the use of agency staff had not impacted on the quality of care delivered to people. All agency staff underwent an induction to the service before they worked unsupervised and were aware of people's needs.

People received appropriate support in a timely manner feedback from people and their visitors was positive. One person told us, "Oh they are generally very good I don't remember ever having to wait for help." Another person told us, "Oh it's lovely here I just have to shout and they come and help". A visitor commented, "Staff are always rushed off their feed feet they don't seem to stop, they have some very challenging people to look after, but they do it with such kindness and compassion" and "There seems to be more of the same faces, regular staff Mum seems to know all the staff and they know her so it is such a comfort for us knowing this".

Recruitment continued to be a challenge for the service. The provider was continuing to advertise locally and nationally in order to fill their vacancies.

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?

Mill River Lodge was not consistently safe.

The staffing level set was sufficient to people's needs; however when staff took unplanned leave these levels had not always been maintained.

Cover for staff vacancies and staff expected was planned for and provided

Requires improvement

Is the service effective?

Mill River Lodge was not consistently effective.

Legal consent had been obtained for the use of the restraint of a person who lacked the capacity to make this decision themselves.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for effective at the next comprehensive inspection.

Requires improvement

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.

We undertook a focused inspection of Mill River Lodge on 6 September 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on the 3 and 17 February 2015. It was also to respond to concerns we received that the staffing levels at the service were not sufficient to meet people's needs. We have reported our findings under two of the five questions we ask about services: is the service safe and is the service effective.

The inspection was unannounced and completed by an Inspector and an Inspection Manager.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law.

During our inspection we spoke with twelve people and seven relatives, eight staff, the acting manager and the deputy manager. We reviewed a range of records about people's care and how the service was managed. These included the care records for three people, staff duty rotas and records relating to the management of the service. We observed care and support in the communal lounges during the morning and spent time observing lunchtime in two dining rooms.

Requires improvement

Is the service safe?

Our findings

At our last comprehensive inspection we found there had been a high use of agency staff and some people using the service and some staff had voiced concerns about the level of staffing at the service. This was an area of practice that the provider was asked to improve on. Following that inspection we received further concerns about the level of agency staff at the service and the number of staff vacancies.

At our focused inspection on the 6 September we found that the use of agency staff continued to be high, particularly at weekends. We found that staffing levels had been determined by assessing people's dependency needs and most of the time had been maintained at the level assessed as required to meet people's needs which was; seven care staff and one nurse, on each shift, plus domestic staff and the acting manager who worked five days a week. Management support was available via an on call system at times when the acting manager wasn't working.

Whilst staffing levels had not been consistently maintained, people's needs had been met. One member of staff told us they felt the impact of operating short staffed was that staff felt more pressurised and breaks were difficult to take as there were not enough staff to cover. Another member of staff told us they were not aware of people's personal care not being attended to as a result of being short staffed and told us, "We would always make sure that care is give no matter how short staffed we are". In relation to working when short staffed a third member of staff told us, "It's mentally very draining and non-stop at the moment on these units as we make sure that the residents get what they need, we are the ones who are actually suffering". They told us they were not aware of any accidents or incidents which have may have happened as a result of being short staffed.

Steps were taken to replace staff who took unplanned leave. One member of staff told us told us they felt staffing was sometimes an issue due to last minute sickness, but this was not a regular occurrence and told us, "They seem to do their best to try and get someone else". The service had operated with three less staff than they had been assessed as required on one Sunday in August 2015. The acting manager and staff explained that they had planned for agency staff to cover shifts at the service but that several staff members had phoned in sick at the last minute and some of the agency staff already booked had failed to turn up to work that day. They told us they had managed to cover some of the shifts but not all of them. They told us it had been an extremely stressful day but that no harm had occurred to anyone as a result and this event had been a one off. Whilst it was clear the service had operated on some occasion's with less staff than had been assessed as required, we did not assess this had resulted in any harm occurring to people. Therefore we have not assessed this as a breach of regulation but as an area of practice that needs to improve.

Cover for staff vacancies and expected leave such as maternity leave and holiday was planned for. Shifts were covered by offering permanent staff additional hours or by booking agency staff. Where agency staff were used, the provider had obtained confirmation of the qualifications they held and provided them with an induction to the service before they worked unsupervised. Both permanent staff and agency staff confirmed this.

People needs were met and they received the support they needed when they needed it. We observed that people received appropriate support in a timely manner. Staff responded to requests for assistance from people and call bells were answered promptly. One person said after the staff had answered their call, "Oh they are generally very good I don't remember ever having to wait for help." Another person told us, "Oh it's lovely here I just have to shout and they come and help". A third person told us, "Anything I need I can just ask".

Some visitors commented that staff appeared busy but all were positive about the care their relatives received. One visitor told us, "Staff are always rushed off their feet they don't seem to stop, they have some very challenging people to look after, but they do it with such kindness and compassion" and "There seems to be more of the same faces, regular staff Mum seems to know all the staff and they know her so it is such a comfort for us knowing this". Another commented, "There is always relaxed atmosphere; mum has not mentioned any issues with staff since she moved in."

The same agency staff were used on a regular basis which helped to ensure continuity of care. All staff including agency staff attended a handover at the start of each shift where the senior staff gave the staff coming on duty a summary of how people were and what had happened on the shift before. Agency staff were able to tell us about the

Requires improvement

Is the service safe?

care needs and preferences of the people they were supporting and it was clear from our observations people were relaxed and at ease with them. One person told us they had made it clear to the management they did not want to be supported by agency staff and confirmed their preferences had been taken into consideration and they were always supported by permanent staff. Some other people felt the high use of agency staff was unfair on the permanent staff and felt the provider should do more to recruit permanent staff. The acting manager told us staff recruitment continued to be a challenge for the service particularly the recruitment of nurses. They explained that prospective applicants for vacant posts had not always been suitable to work at the service whilst others that had been invited for interview had not turned always up. They told us they continued to use regular agency staff and were also advertising in the local press and job centre. They explained they had tried various other methods of recruiting staff including using flyers to advertise their vacancies, attending a job fair, holding an open day and advertising on the providers and recruitment agencies web sites.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of this service on the 3 and 17 February 2015 we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the lack of clear guidance on the use of restraint and the omission of relevant best interest decisions. At this inspection we found the provider had taken the action they needed to meet the requirements of the law and the breach had been addressed.

At the last inspection one person, who was living with dementia and lacked capacity to make specific decisions, had a care plan for personal care and challenging behaviour. There was no information in the care plan at that time about what these behaviours were or how staff should support the person. The care plan stated 'two staff to shower and one to use minimal restraint whilst giving personal care' There was no explanation of what 'minimal restraint' was or how restraint should be applied. At that time staff told us the restraint they used was to hold the persons hands whilst they were delivering care. However this person's capacity to consent to this restraint had not been assessed or been agreed as part of a best interest decision.

At this inspection the acting manager informed us that an application had since been made to the local authority for a Deprivation of Liberty Safeguards (DoLS) to be agreed in relation to holding this person's hands whilst they received personal care. The Care Quality Commission (CQC) has a duty to monitor activity under DoLS. DoLS is part of the Mental Capacity Act (2005). The purpose of DoLS is to ensure that a person who lacks the capacity to make their own decisions and, in this case, lives in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

Staff explained the person for whom the DoLs had been applied sometimes refused support with their personal care. They said if the person refused any support they went away and another member of staff would then offer the support. They told us that often the person would change their mind and would accept the care but if they continued to refuse they would offer their hands out to the person for them to hold whilst another member of staff attended to their personal care needs. They said that when they did this the person was happy to take hold if their hands. Staff were aware of the fact that a DoLS had been applied for and that this form of restraint could only be used in these specific circumstances. We saw that a photograph of how staff should hold the persons hands was included in the persons care plan for staff to reference.

The provider had suitable arrangements in place to establish, and act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and this had been applied. People who lacked capacity been assessed regarding their capacity to agree to their care and treatment. The manager and staff understood their responsibility with regard to Deprivation of Liberty Safeguard (DoLS) and they had applied for authorisation for six people under DoLS to ensure people were protected against the risk of being unlawfully deprived of their liberty. Staff were aware of these applications and what it meant for the people they related to.