Milkwood Care Ltd

Milkwood House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 30 June and 1 July 2016 and was unannounced. During our previous inspection on 8 June 2015 we found one continuing regulatory breach in relation to the unsafe management of people's medicines. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements by 21 August 2015. During this inspection we checked whether the provider had completed their action plan to address the concerns we had found. We found the provider had made most of the required improvements, however, at this inspection we identified that further improvements were required to ensure the management of medicines was safe and met the requirements of the regulation.

Milkwood House Care Home provides accommodation and personal care for up to 43 older people, including those who are living with dementia. The home is set in secure grounds near to the town of Petersfield. People are accommodated in either a bedroom with en suite facilities or have the use of a shared bathroom. Other facilities included a dining room and a quiet lounge with a 'pub style' area. At the time of our inspection there were 33 people living in the home.

The home has a registered manager in post. 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.

Robust procedures were not in place to ensure people were not harmed as a result of missed medicines due to problems in the supply of people's medicines. We identified some errors in the recording of people's medicines. Whilst monitoring procedures were in place we were concerned that medicines incidents and errors were not always being identified and acted on to protect people and ensure the safe management of their medicines. Following our inspection the registered manager took action to prevent the risk of a reoccurrence. More time was required for these improvements to be fully embedded into practice.

People told us they were safely cared for at Milkwood House. However, peoples care plans and risk assessments were not always evaluated and updated following a fall to ensure their care plan was appropriate and up to date information and guidance was available to staff to mitigate the risk of further falls. This could leave people at risk from inappropriate care following a fall. A system was not in place to enable the registered manager to effectively monitor risks to people from falls and ensure changes and improvements were made to reduce the risks to people from falls. The registered manager took action following our inspection and implemented a tool to monitor falls and identify where changes and improvements could be made to reduce the risks to people from falls. More time was required for this improvement to be fully embedded into practice.

Staff were aware of their responsibilities to safeguard people and protect them from abuse and the registered manager acted on concerns.

People and their relatives told us there were sufficient staff available to meet people's needs safely. The provider carried out an assessment to identify the levels of staffing required to meet people's needs and the registered manager confirmed additional staff were available when required. The provider had not maintained an improvement they had made following our last inspection to ensure their application form in use required new staff to submit a full employment history to enable the provider to check they were suitable to work with people. During our inspection the provider addressed this shortfall and changed their application form to require new staff to give a full employment history. More time was required for this improvement to be fully embedded into practice.

People were supported by staff who received regular supervision and appraisal in their role. Staff had access to a range of training to ensure they remained competent to meet the needs of the people they supported. Some staff training required updating such as; manual handling, dementia and the Mental Capacity Act (2005) and we were assured this would be addressed following our inspection.

The registered manager had made applications to the relevant authority to legally deprive people of their liberty as required. However, not all applications were made following a recorded best interest process in line with the Mental Capacity Act (2005). The registered manager has taken action following our inspection to ensure decisions would be made and recorded following the best interest checklist to ensure people's rights were upheld. More time was required for this improvement to be fully embedded into practice.

People spoke positively about the quality and variety of the food in the home. People's nutritional needs were assessed and met. People at risk of poor hydration were monitored for their fluid intake. However, this was not always totalled or targeted to enable staff to effectively monitor whether the person was receiving sufficient fluids to prevent the risk of dehydration. This could place people at risk of poor hydration.

People were supported to access a range of healthcare services as required. Staff acted promptly to ensure people's healthcare needs were met.

People told us they were treated with dignity and respect by staff. The registered manager monitored people's experience of the way their care was delivered. People's preferences in the way they were supported were known by staff and people told us they were supported to meet their needs.

People's wishes for their end of life care were discussed with them and recorded. This included people's decisions to refuse treatment, which were made known to staff to ensure they were respected.

People or those that knew them well were involved in developing their care plans. Care plans were personalised and detailed people's needs and choices. However, care plans were not always updated to reflect people's current needs, which could place people at risk of inappropriate care.

People had access to activities that were group based or one to one support if preferred or needed. People told us they enjoyed the activities on offer at the home and were supported to meet their social and spiritual needs and interests.

The provider's complaints process was displayed in the home. People and their relatives told us they were confident the registered manager would listen and respond to complaints. The registered manager used information from complaints to make improvements.

A quality assurance system was in place however, the system was not sufficiently robust to ensure that improvements were always identified, acted on and sustained to drive continuous improvement.

People and their relatives spoke positively about the registered manager and the improvements they had made to the service over the past year. People and their relatives were asked for their feedback on the service and this was acted on.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Improvements had been made in the management of people's medicines. However further improvements were required to meet legislative requirements to ensure people's safety.

It was not evident that the risk management plans in place to minimise the risk of falls for people were reviewed or evaluated to ensure their effectiveness. A post falls monitoring system was not in place to assess and evaluate the measures required to prevent reoccurring falls.

Staff understood how to protect people from abuse. The registered managed acted on concerns but did not always adequately monitor the plans in place to protect people from the further risk of abuse.

There were sufficient staff available to meet people's needs safely. The provider needed to ensure the system in place to protect people from the employment of unsuitable staff was sustained.

Is the service effective?

Requires Improvement

The service was not always effective

People were supported by staff who received regular supervision and appraisal in their role. Some staff needed to update their training in line with the provider's timescales for completion to ensure they remained up to date and competent in their role.

Applications to legally deprive people of their liberty had been made to the relevant authority. However not all decisions had been made in line with the best interest principles of the Mental Capacity Act (2005). The registered manager took action following our inspection to ensure people's best interests were fully explored and recorded prior to making a decision on their behalf. More time was required for this improvement to be fully implemented into practice.

People's nutritional needs were assessed and met. Monitoring of

people who were at risk of poor hydration did not include a personalised target or daily total to ensure this was effective.

People were supported to maintain their health and access healthcare services as required.

Is the service caring?

Good

The service was caring

People were treated with dignity, kindness and respect by caring staff.

People told us they were supported by staff who understood their needs and preferences.

People and their relatives were given support when making decisions about for their end of life care. Staff were aware of people's advance decisions to ensure these were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans were not always evaluated or updated with people's changing needs. This could place people at risk of receiving inappropriate or inconsistent care.

People's care plans were personalised and people told us they received person centred care.

People were supported to participate in activities to meet their interests and needs.

The provider had a complaints process in place and people and their relatives told us they were confident the manager would act on concerns raised. Complaints were used to make improvements to the service people received.

Is the service well-led?

Requires Improvement

The service was not always well-led

A system was in place to enable the provider and registered manager to monitor the quality of people received. However, the system was not sufficiently robust to ensure that improvements were always identified, acted on and sustained to drive

continuous improvement.

The registered manager provided effective leadership and improvements had been made at the service over the past year. People and their relatives spoke positively about the registered manager and their management of the home.

People and their relatives were asked for their feedback and this was acted on.

Milkwood House 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.

This inspection took place on 30 June and 1 July 2016 and was unannounced. During this inspection we checked that improvements planned by the provider had been made to meet the requirements following our inspection of 8 June 2015. The inspection was completed by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service; on this occasion they had experience of family members living with dementia who had received residential care. The expert by experience spoke with people using the service and their relatives.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us of by law. We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the home, what the home does well and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with six people and the relatives of three people. We spoke with the registered manager, the provider and the group operations manager, four care staff, and two members of the domestic team.

Prior to the inspection we received feedback from a member of the Hampshire safeguarding adults' team and a team manager from the West Sussex community team. Following the inspection we spoke with a

social worker from the community learning disability team.

We reviewed records which included five people's care plans and daily notes. We reviewed 12 people's medicine administration records and we observed staff administering people's medicines. During the inspection we spent time observing staff interactions with people which included lunch time sittings. We reviewed six staff recruitment files and four staff supervision and appraisal records and records relating to the management of the service. These included; staff training records, staffing rotas for the period 16 May to 20 June 2016, quality assurance records and the record of complaints.

The previous inspection of this service was on 8 June 2015 when we found one continuing regulatory breach.

Requires Improvement

Is the service safe?

Our findings

Our focused inspection of 8 June 2015 found that people were not adequately protected against the risks associated with medicines. Safe practice was not consistently followed to ensure people's medicines were safely stored or that they were always signed and dated when opened. People's allergy information was not always recorded and there was insufficient guidance for staff on the safe use of some people's medicines.

At this inspection we found improvements had been made in relation to medicine storage and the recording of allergies on MARs. We also found that care plans were in place to support people's specific health and medication needs. However, we identified that further improvements were required to ensure the management of medicines was safe and met legislative requirements. We found two topical medicines (creams) were opened and not dated. This meant that staff could not ensure they remained within their recommended date of usage. This was a continuing concern from our previous inspection.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CDs). Providers are required to have procedures in place to ensure that CDs are safely managed and that staff follow these to keep people safe. Some medicines, whilst not classified as a CD, are recommended to be stored and recorded in the same way. We saw that the provider had followed good practice guidance and stored and recorded a recommended medicine as a CD. However, we found three separate instances of discrepancies between the calculated stock for this medicine and the amount administered. No explanation had been provided for the discrepancies. Although daily checks were in place to monitor the safe management of these medicines it was not evident that these errors had been identified or investigated to establish what had happened and to prevent further errors.

We observed staff administering people's medicines. We noted that one additional tablet was found with a person's medicine that was unexplained. The person's records did not show they had missed a dose of this medicine. Another person had refused their medicines. The staff member was not sure about the action to take in these circumstances. When a person's medicines are not given or are refused, or if an error is identified, it is important to record and investigate the reasons, to ensure the person would not be harmed by this and to prevent a reoccurrence. We could not be assured that medicines incidents and errors were effectively identified and acted on to protect people and ensure the safe management of their medicines.

People's Medicine Administration Records (MARs) showed there was a period of three to four days in June 2016 when some people did not receive some of their medicines because the pharmacy had not delivered them. Whilst the registered manager had repeatedly contacted the pharmacy to request urgent delivery this had not happened. This incident could have caused harm to people because delayed or interrupted treatment could cause deterioration in their health or delay recovery. In these circumstances it is the responsibility of the registered manager to act to ensure people receive the medicines they need or to ensure they have checked it is safe for people to miss their medicines until a supply can be urgently sourced. It was not evident robust procedures were in place or followed to prevent the risk of harm to people from missed medicines. Following our inspection the registered manager met with the pharmacist and confirmed to us that a robust protocol was now in place to ensure this situation did not occur again.

The failure to fully protect people from the risks associated with the unsafe management of medicines was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People at risk of falls had been identified and the severity of the risk calculated. People's falls care plans included some actions taken to protect people and minimise their risks of falls. For example; to ensure people had their call bell in reach at night and to keep the environment 'clutter free'. We could see that some action had been taken following falls such as; reviewing a person's medicines to assess if these were affecting their mobility. However, people's records did not consistently evidence that their risk assessments and care plans had been reviewed following a fall, in order to manage and mitigate their risk of further falls. For example; records showed one person had experienced two falls since their falls care plan had been reviewed. There was no evidence their care plan had been evaluated following these falls to ensure it remained appropriate. One person's risk assessment and care plan had not been updated to reflect that following three falls and a change in medication the severity of the risk to them, according to the providers risk calculation tool, from falls had increased to high from medium. A falls monitoring system was not in place to enable the registered manager to identify patterns and trends for each individual and assess and evaluate the measures required to prevent reoccurring falls. Following our inspection the registered manager confirmed they had introduced a tool to monitor and evaluate falls and identify where changes and improvements could be made to reduce people's risk of falls. More time was required for this improvement to be fully implemented and embedded into practice.

At our previous inspection we found the provider had amended their application form for new staff to ensure candidates were asked for full employment history including any breaks from employment. At this inspection whilst we found the provider had asked their existing staff to record their full employment history to meet the requirements of the regulation we found the application form in use asked candidates to give ten years of employment history only. This had not placed people at risk because new staff did not have over ten years of employment history. However, it is important to establish a full employment history including any gaps in employment to protect people from the employment of unsuitable staff. The provider took immediate action to address this. More time was required for this improvement to be fully implemented and embedded into practice.

People told us they were safely cared for at Milkwood House. A person said "I trust them (staff) absolutely with my safety in every respect. They're all very sensible. I've never been uneasy or unsure at any time and don't expect to." A person's relative said "I would not have said it was safe before (registered manager) came, there have been major improvements since she came and care is more consistent. I feel safer about my relative's care".

Staff we spoke with demonstrated their understanding of safeguarding and their responsibilities. Staff described the concerns that would prompt them to alert the registered manager or other relevant agencies such as the local authority safeguarding team and CQC. Records confirmed that most staff had completed training in safeguarding, with the exception of newly appointed staff who were in the process of completing this training. Staff had access to relevant contact numbers and policies and procedures for guidance should this be needed. People were protected from the risk of abuse. We discussed the management of safeguarding concerns with the registered manager who evidenced they had taken appropriate action to safeguard people from abuse. An incident had occurred during the night which placed people at risk of unsafe care. The registered manager had taken action in line with the provider's disciplinary policy and had plans in place to monitor the effectiveness of these actions.

People and their relatives told us there were enough staff available to meet people's needs promptly. One

person said "If I use my buzzer which is nice & handy, they're there very quickly indeed. They don't hang about I think the longest wait was about two minutes or so". A person's relative said "We turn up here ad hoc and the staff never seem to be stressed out at all."

The registered manager told us the home was fully staffed with no staff vacancies. Agency staff were not being used as existing staff covered gaps in the rota from planned and unplanned staff leave. The registered manager told us this was important to provide a continuity of care for people. Staff we spoke with confirmed there were enough staff to meet people's needs. People's care plans included a dependency needs assessment and the registered manager told us this enabled them to review the number of staff and range of skills required to meet people's needs safely.

Requires Improvement

Is the service effective?

Our findings

Records evidenced that new staff had undertaken the care industry recognised standard induction to their role to ensure they could provide people's care effectively. Staff were required to complete training in areas identified as mandatory by the provider. This included; health and safety, safeguarding, infection control, food hygiene, dementia, the Mental Capacity Act (2005), and equality and diversity. However, records showed that some staff had not updated their training in line with the provider's timescale for completion. For example; areas such as; manual handling, dementia and the Mental Capacity Act (2005) required updating by existing staff and completion by new staff. The registered manager explained the provider had introduced workbook based training for some areas and this was taking some staff a long time to complete. Some staff told us they preferred training to be facilitated by a trainer. The provider said they would review the type of training on offer and take action to ensure training was effective and up to date. Professional development training was available to staff and records showed some staff had completed qualifications in health and social care.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff were receiving an annual appraisal which addressed on-going development needs. Staff we spoke with told us they felt supported and could approach the registered manager for advice and guidance as required. People told us they felt staff were "well trained" and people were confident in and trusted staff to provide effective care to meet their needs. People were cared for by staff who were supported in their role.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (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. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body for authorisation, a number of which were awaiting assessment.

The 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.

Not all decisions made had followed the principles of the MCA. Records showed that a mental capacity assessment had been carried out prior to some decisions being made about people's care and treatment. However, a best interest decision making process was not always in place to evidence whether a specific decision taken on behalf of a person who lacked capacity was in their best interests and as least restrictive as possible, in accordance with the MCA. When we informed the provider they took action and implemented a decision making tool incorporating the MCA checklist for best interest decision making. More time was

required for this improvement to be fully implemented and embedded into practice.

Staff we spoke with were aware of the principles of the MCA and the importance of supporting people to make their own decisions as far as they were able. For example a staff member said "I've had mental capacity act training. We put the training into practice every day. We have to give people choices, for example, asking people if they want tea or coffee and not just assuming that they want what they usually have." Staff gave us examples of when people had refused care and how they had respected their decision. A person told us "If they [staff] want to do something they always explain themselves and then ask for permission to do it and wait for me to say yes." We observed staff offering people choices about whether to have a bath or shower, where they wanted to go and whether they required medication for pain relief. People were supported to make decisions about their day to day care and treatment.

People told us they liked the food and were able to make choices about what they had to eat. People's comments included "Yes, I do like the food, it's very interesting" and "The food here is lovely and there's plenty of it if you want it". People's relatives told us the food was "nice" and "good" and one relative told us how pleased they were their relative was eating well.

We observed lunchtime in the home, people ate where they chose to and this included; the dining room, lounge and their own rooms. People who required assistance to eat were appropriately supported by staff. Some people living with dementia were prompted and encouraged to eat by staff when they noticed the person had stopped eating. A choice of meal was available and we saw that several people who did not like the option given to them were offered an alternative.

People at risk of poor nutrition were assessed using a malnutrition screening tool. Actions such as referral to the GP, food and fluid monitoring and higher calorie foods were provided to support people at risk. We observed people were regularly offered drinks and people told us there was always a drink available to them. However, where people had been identified as at risk and monitoring was in place, their fluid intake was not always totalled and an individualised daily fluid intake target had not been identified. This is important to enable staff to monitor whether the person's fluid intake was sufficient to prevent and reduce the risks from dehydration. This could place people at risk of poor hydration. We brought this to the attention of the registered manager who has assured us this will be addressed.

Records showed people received treatment from a range of healthcare professionals such as; district nurses, GP, physiotherapist, older people's mental health team, community learning disability team and dentists. People told us their health needs were responded to promptly and they saw healthcare professionals as and when needed. The handover information given to staff included information about people's medical history and current care and treatment needs. A staff member said "In handover we are updated and in the evening. If people's needs change we get updates. For example, a lady the other day told me her tooth hurt. I informed the deputy manager. It is obviously bothering her and they are making her an appointment with the dentist. We all work well with GP's, chiropodists, social workers, they all visit." People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

The home had a large terraced garden which people could access via steps or by a lift. The provider was replacing the gravel garden path with concrete to improve the safety and accessibility for people who required support with their mobility. The home included a quiet lounge with a pub themed area 'The Milkwood Arms' for people who enjoyed a pub setting. People's rooms were personalised with their own possessions and included a personalised name plate to assist people with orientation.

Good

Is the service caring?

Our findings

People told us their dignity was respected by staff. People's comments included; "Yes, they're always most respectful and to the best of their ability, they do preserve my dignity" and "The staff are always very respectful to me, I've never had any problems with that. They do what they can to preserve my dignity although they have to do most of that (personal care) for me so it's difficult for them. I don't mind, they're great". The registered manager told us they monitored the approach of staff through "walking the floor and speaking to residents". This was confirmed by people and their relatives and one relative said "The registered manager is very supportive and caring and she does go to see (my relative) and chats to her". We observed staff speaking to people respectfully and people were supported with their personal care needs discretely and in privacy.

We observed that staff treated people with kindness and care, for example we heard a carer telling a person when serving their breakfast "look I've even cut the crusts off for you" which pleased the person. The registered manager explained how they had discussed with a person what would make their life happier and had got them some birds to keep in their room, "Because (the person) told us how they used to keep birds." A person said ""I like the people who are here and I am happy with them. I also know that I am not well and staff will say certain things to help me." We observed staff responding to this person when they became confused in a helpful and caring way.

People's records included information about their personal circumstances and how they wished to be supported. The deputy manager met people with the registered manager prior to admission so they could get to know their needs and preferences and they told us how important this was to developing their care plan. We saw examples of people care plans that included information on their favourite things and 'unforgettable moments' as well as people's spiritual and cultural needs. A person said "I'd give the staff 100% for their caring & considerate attitude. They treat you as a friend really, someone to look after carefully. They're absolutely brilliant!"

Staff we spoke with were aware of people's preferences and personal histories. They told us about people's previous employment histories, likes and dislikes and their interests. People appreciated the caring approach of staff and told us they were 'friendly and fun' and 'considerate'. A person's relative told us how much their relative enjoyed a "natter with the girls" (staff) and a person said " I like to see the birds on my window sill and one of the staff feeds them for me to encourage them." People were supported by staff who demonstrated a caring approach.

People told us the staff respected their decisions and encouraged them to do what they could for themselves which was important to them. For example a person said "The staff encourage me to do as much for myself as I'm able although, to be honest, in my situation I can't do much at all." People who could make decisions told us these were respected and when people lacked the mental capacity to make decisions their relatives confirmed they were consulted about people's care appropriately. A relative said "They do talk to me if they wanted to change anything, they wouldn't just go and do it". This meant people's decisions and what mattered to them were respected.

People's records evidenced their preferences, and decisions about their end of life care were discussed with them or their relatives. We saw people had recorded decisions about the circumstances in which they would prefer to receive resuscitation and hospital treatment and when they had chosen not to. People who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place were identified in the office and discretely on their bedroom door so this would be respected if needed. We saw that prescribed medicines were available when needed to support people at the end of their life. People were supported to make decisions about their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to their admission. A care plan was then developed to meet their needs. People who were able to told us they were involved in developing their care plan. For example a person said "I was involved when my Care Plan was sorted out, I definitely had my say, they (staff) know how I like to be treated." Another person said "I was involved in setting up the care plan; I think the care here is very good." When people were unable to develop their care plan people's relatives were involved. A person's relative said "The care plan for my (relative) was set up with me and they've amended the plan as we've gone along, playing it more or less by ear really." This meant people and their representatives contributed to their care plan as far as they were able.

Care plans included people's needs in relation to nutrition, moving and positioning, falls, continence, medicines, personal care and night-time care. Care planning included the aim and goal of the support provided and how this was to be achieved. For example; it was important for a person to minimise their anxiety and incidents of behaviour that could challenge others. The person's care plan informed staff that this would be achieved by giving reassurance and encouragement and guiding the person away from known 'triggers' that may create anxiety. We observed the person was reassured and encouraged by staff. We spoke with a social worker who confirmed the person was supported to ensure their important needs were met which had resulted in improvements to their quality of life and safety.

People received person-centred care. Care plans were personalised and detailed people's individual needs and choices. For example, whether people preferred a bath or shower, their preferred night time routines; such as a favourite drink and time to get up in the morning, their social or activity preferences and any religious or cultural needs. People's care plans were reviewed monthly by senior care staff. However, we noted that care plans were not always amended to reflect people's current needs or changed needs. For example; a person did not have a care plan to describe the support they required to smoke and a care plan was not in place to address a person's weight loss and nutrition needs. One person had an elimination care plan written on their admission 6 weeks previously which stated staff were not aware of the person's needs at that time. This care plan required updating to reflect the person's assessed needs. Whilst staff understood and provided the support people required to meet these needs, it is important to ensure when people's care needs are assessed and reviewed, their care plan is updated to reflect any changes. This is to prevent the risk of people receiving inconsistent or inappropriate care from new or temporary staff.

People had a range of activities they could be involved in. Activities available included outings and group based activities such as quizzes, crafts and musical events and individual activities such as; massage and puzzles for people who preferred or needed individual support. People we spoke with told us they enjoyed the activities on offer. A person said "I do take part in the activities and the trips out they are quite good. The trip to Southsea with the fish and chips was very good, I enjoyed it very much." The activities provided supported the needs of people living with dementia. For example; activities that focused on reminiscence therapy, such as; singing songs from the past and quizzes based on past events. Outings were arranged to meet people's interests and to stimulate memories such as trips to a local museum, garden centre and the seaside. People were also encouraged to engage in sensory activities which can support people living with

dementia to access memories such as, massage, crafts and gardening. The home had a large garden and part of this was used by people to take part in gardening activities including growing vegetables for use in the kitchen. Individual records were kept of people's involvement in activities and these showed that people participated in a range of activities to meet their social and spiritual needs and their interests. Photos of activities were published every month in the home's 'Milk Round' newsletter. A person's relative said "The activities here are great."

The provider had a complaints procedure and this was displayed in the home. We reviewed the record of complaints which showed they had been responded to. The registered manager told us how they had made an improvement following a complaint to ensure people's belongings were clearly labelled and documented. People and their relatives we spoke to told us that although they had not raised a complaint they knew how to do so and were confident the registered manager would listen and respond. A person said "If I had a complaint to make I'd see the manager. I feel that she would sort it out quickly." A system was in place for people to raise their complaints and concerns and these were acted on.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post since April 2015. People and their relatives spoke positively about the registered manager and the improvements they had made over the past year. One person's relative said "Absolutely I would recommend the home and I have done. The simple thing is my (relative) looks better and that's how you measure it. I think the registered manager has turned it around amazingly." Another relative said "they have just got so much better" and a person said "I believe that the home is well and carefully managed. I have no complaints at all."

Systems were in place to support the registered manager to monitor the quality of the service and identify any risks or areas where the service might not be meeting the requirements of the regulations. The service and the provider had completed a programme of audits and checks. However, this system was not always effective in identifying shortfalls and actions to drive continuous improvements within the service. For example; the dining room experience audit had identified some senior staff were more proactive in completing food and fluid information than others; however no action for improvement had been identified. The provider's audit of April 2016 had identified fluid charts were not fully completed and during our inspection we found fluid charts were not always fully completed, targeted and totalled. Whist audits were carried out in relation to medicines and care plans, the audits had not identified the issues we found on inspection; such as the inaccurate recording of CD medicines and that some people's care plans and risk assessments required updating.

Where audits had identified shortfalls, and actions for improvement it was not always evident these had been completed or sustained. For example; the kitchen inspection audit did not evidence that improvement actions identified had been completed. Following our last inspection the provider had revised their application form to ensure candidates included a full history of employment. This improvement had not been sustained and we found the previous form was in use at the time of our inspection. The quality assurance system was not sufficiently robust to effectively assess, monitor and improve the quality and safety of the home to prevent the quality of care people received being compromised. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had focused on people receiving person centred care and supporting staff to deliver this. The provider promoted the values of person centred care by using the statement 'you alone matter' in their information and with their staff to reinforce these values which staff were aware of. The registered manager told us the value statement applied to people and staff and a staff member said "Values are the motto: 'only you alone matter' everything has been changed. Milkwood is about individuality. It's a lovely company and the home is in a beautiful environment. The values are to respect people and give them dignity." People and their relatives told us the culture in the home had improved and described it as "open and honest". The registered manager said "I am open and honest; I keep an open door to residents and families. I tell them what is going on and give information and updates. I am open with my staff as well". This was consistent with the feedback we received.

We received some feedback from people's relatives and staff that not all members of the management team

were approachable and helpful at times. We have brought this to the attention of the registered manager.

Records showed that residents, staff and relatives meetings were in place to enable people, staff and their relatives to give feedback about the quality of the service delivered and raise suggestions for improvement. Suggestions for improvements had been acted on, for example; people had requested a 'sweet trolley' which could act as a mobile shop and this was being sourced. Relatives had requested regular reviews and a relative confirmed a review had been held following their request and relatives were invited to attend reviews. Staff requests had included visiting another of the provider's homes rated as outstanding to get ideas, team building and a recognition or reward scheme. A staff member said "We have staff meetings and a suggestion box where we can feedback on anything that would help the home improve." The registered manager told us they were following up on these suggestions.

A 'customer care' survey had been completed in January 2016. People and their relatives had been asked to rate elements of the service such as; whether staff are caring and responsive, the laundry service, food, cleanliness, complaints management and activities. The majority of the feedback was positive and some areas had been identified as 'requiring improvement'. An action plan was in place to address these areas and actions had been completed. For example; two new activity staff had been employed, laundry items were labelled and a meeting was held with the domestic team to address malodours.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to fully protect people from the risks associated with the unsafe management of medicines was a continuing breach of Regulation 12 (1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to assess, monitor and improve the quality and safety of the home. Regulation 17(1)(2)(a)(b)