Pilgrims' Friend Society

# Milward House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Milward House is a residential care home registered to provide accommodation and personal care for a maximum of 28 people. The home specialises in providing care to older people, with a strong Christian faith. Some people at Milward house were living with dementia. At the time of our inspection there were 26 people living in the service. Milward House is located in Tunbridge Wells and is arranged over three floors.

Milward House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager at the service. 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.

People were kept safe from abuse and harm and staff knew how to report suspicions around abuse. Risks were minimised through the use of effective control measures. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety. People received their medicines when they needed them from staff who had been trained and had their competency checked. Staff understood the best practice procedures for reducing the risk of infection and audits were carried out to ensure the environment was clean and safe. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to a service being offered. This meant that care outcomes were planned and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. People were supported to receive enough to eat and drink; staff used food and fluid charts to record intake for people at risk of malnourishment or dehydration.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

The service worked in collaboration with other professionals such as district nurses and people's GP's to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe in their homes and staff could work without the risk of danger.

Staff treated people with kindness and compassion in their day to day care. Staff knew people's needs well and people told us they valued and liked their care staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form and complaints were used to improve the service offered to people.

Staff were open to any complaints and understood that responding to people's concerns was a part of good care. End of life care had been planned for people who wished to do so. The service had end of life care plans but these did not make it clear how people would be supported to prepare for the end of life phase.

There was an open and inclusive culture that was implemented by effective leadership from the registered manager. People and staff spoke of a 'family' culture that was caring. The registered manager had ensured that audits of quality were effective in highlighting and remedying shortfalls and the registered manager understood their regulatory responsibilities.

People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

Milward House was safe.

People felt safe and were protected from the risk of potential harm or abuse.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were consistently met. Safe recruitment procedures were followed in practice.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated and learning fed back to staff.

### Is the service effective?

Good

Milward House was effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

Staff received effective training to meet people's needs. An induction and training programme was in place for all staff.

People were supported to eat and drink enough to maintain good health and this was monitored where needed by staff.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they delivered any care.

## Is the service caring?

Good

Milward House was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

## Is the service responsive?

Good

Milward House was responsive.

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Where people received end of life care this was planned and provided sensitively.

## Is the service well-led?

Good

Milward House was well led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked in partnership with other agencies.

# Milward House

**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 14 and 18 December 2017 and was unannounced. Inspection site visit activity started on 14 December and ended on 18 December 2017. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, and review of care records and policies and procedures.

Before the inspection we looked at information we held about the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury. 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.

The inspection team consisted of two inspectors. We spoke with the registered manager, care manager, two senior carers, seven care staff, nine people and four people's relatives. We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This is the first time the service had been inspected under the new registration.

Good

# Is the service safe?

## Our findings

People living at Milward House, and their relatives, told us that they felt safe at the service. One person told us, "I feel safe and feel blessed to live here." Another person commented, "Yes I feel safe: it's the care that makes me feel safe. They [staff] are always busy but are very caring." A third person said, "I feel safe but it's hard to say why. I think it's the atmosphere; my visitors say the same: the atmosphere is as near to home as it can be." One relative told us, "She is safe here without a question. They bend over backwards to make sure she knows where she's going and even put white tape on the floor to stop her going one way: it's an amazing place."

People were protected against the risks of abuse by staff who understood their role in safeguarding people. There had been no recent safeguarding or whistleblowing referrals made but the staff we spoke with were aware of the different types of abuse, including newer definitions of abuse such as modern slavery. One staff told us, "Everyone here is a vulnerable adult and there are so many forms of abuse. We have to keep an eye out and be vigilant together." Staff members were aware of who investigated potential safeguarding incidents and the correct procedures for reporting concerns. There was a copy of the local authority safeguarding adult's multi-agency policy displayed in the staff duty room. The registered provider had their own safeguarding policy and this document, along with the staff induction and training programme, ensured that people were protected from discrimination and that principles of diversity and inclusion were understood by staff. The registered manager was aware of the importance of notifying CQC of safeguarding incidents when they occurred.

Risk assessments were effective in keeping people safe from harm and control measures reduced potential hazards. Risk assessments provided staff with clear information on what action to take. For example, one person had suffered a fracture to a limb and the assessment clearly stated the person was to be transferred with a full body hoist using a specific sling and for staff to ensure that the person did not weight bear. Care plans contained a range of risk assessments to keep people safe. For example, risk assessments documented mobility and risk of falls, risk of developing pressure ulcers using the established Waterlow Score and risks associated with choking. The Waterlow Scale is a nationally recognised tool that gives a score for an estimated risk for the development of a pressure sore in a given patient. We saw guidance had been provided to staff for example how to manage people's skin integrity and pain management. A risk summary was in place which gave staff key 'at a glance' information. For example, to state whether a specialist air pressure mattress was in use or whether a person was dependent on their carers to eat and drink and was on a soft diet.

There were up to date safety certificates for gas appliances, electrical installations, portable appliances and hoist maintenance. The registered manager ensured that general risks such as slips, and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening regularly and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire.

There were sufficient staff deployed to meet people's needs and to keep them safe. We checked the services duty rota and saw that the levels of staffing identified by the registered manager as being required to operate the service safely had been provided. The registered manager used a dependency tool to determine the number of staff required to work each shift. The dependency tool gave the registered manager a base level of staff which they had then supplemented to meet people's specific needs. Activities staff had been increased in the morning and the times that housekeeping staff worked had been altered to meet the needs of people living at the service.

Recruitment systems were robust and safe recruitment procedures were followed. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible.

There were safe medicines administration systems in place and people received their medicines when required. The service used a monitored dosage system where tablets arrived from the pharmacy pre-packed and in a separate compartment for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly, meaning that audits of medicines were being conducted accurately and regularly. MAR charts had been signed correctly to indicate that people had received their medicines. Medicines were stored safely in lockable cabinets, within a locked room, including medicines that required additional security. We observed an administration round with one staff member dispensing medicines to people from a locked trolley which was secured between each administration. The staff member gave their full attention to each person and was not rushed. This ensured that each person understood as best as possible what medicines were being offered, and why. Some people had been prescribed as when required (PRN) medicines and there were written protocols for these medicines with the MAR charts. People's medicines were reviewed regularly with their GP and the registered manager was tracking this to ensure that people had the correct medicines as their needs changed.

People were being kept safe against the risk of infection by the prevention and control of infection hazards. Infection control training had been evidenced for staff and had been competency checked. An annual infection control audit surveyed different areas such as waste disposal, linen and clinical practices amongst other areas. The audit created an action plan with tasks that were time limited and responsibilities for completing these tasks were clearly defined. Hand washes and alcohol gels were available and used by staff. Staff used personal protective equipment such as aprons and gloves appropriately. There was an infection control champion in the service in line with The Health and Social Care Act 2008: code of practice on the prevention and control of infections. This is a national guidance document to ensure health and care providers comply with legislation around infection control. The service was clean and hygienic during our inspection. There was a well organised laundry that enabled staff to keep clean and dirty linen separate to reduce infection and cross contamination risks. The service used the 'Safer Food Better Business' scheme. Safer Food Better Business is a food safety pack produced by the Food Standards Agency to help small catering businesses comply with food hygiene regulations. Daily temperature checks had been carried out for the fridge and freezer and the temperature of food served to people. There were cleaning charts completed for the kitchen and dry stores area and these were clean.

Staff understood their responsibilities to raise concerns and report incidents. Accidents and incidents had been recorded on an electronic care planning system. Where accidents or incidents relate to people there is a 'managers' report' that is generated. We saw one report where a person had fallen and it had been identified that 'dizziness' was a factor when raising themselves from their armchair. As a result a medicines review was held and the staff were instructed to encourage the person to keep a safety alarm by their side as the person was frustrated at losing independence and having to ask for help. The registered manager had signed up with national bodies such as NHS England in order to receive safety alerts relating to updates, investigations and reviews.

Good

# Is the service effective?

## Our findings

People told us that they felt the service was effective in meeting their needs and providing a good quality of life. They told us staff had the necessary skills to provide the care they needed and that they supported them to access health services as needed. One person said, "The staff know what they're doing and are very reassuring. They hoist people and know what they are doing alright." Another person commented, "When there's new staff they shadow the others but they're very good: I get on well with them all." One relative told us, "There's always enough staff around and they know what they're doing. They always hold mum's hand when they help her to walk. I know they are competent because she lets the staff help her and she won't let me."

People's needs were assessed and their care planned in line with evidence based guidance. There were assessments of people's needs prior to a service being provided. The assessments identified a range of people's needs from which support plans were drawn up and worked to accordingly. For example, the assessment covered practical areas such as personal care continence, pain management, medicines, memory, communication and sleep. Where needs were identified, such as with skin integrity, care plans were put in place following national guidance with reference to Waterlow charts. Assessments looked at people's spiritual needs and identified how their faith was important to them and which services they would like to attend. People were given the opportunity in their care plans to discuss their sexuality or to discuss gender preferences in terms of which carers they would like supporting them.

Staff had the training and skills they needed to meet people's needs. One staff member told us, "We have plenty of training, we have monthly on line training and the manager does overview training on top. I deliver one course and I went for a two day course to learn how to give the training and have been back for a refresher course as well." We checked the training matrix and saw that staff had access to a variety of courses to assist them to carry out their roles. Some courses such as medicines were competency checked to ensure that staff members had understood their training. Staff members had received effective supervision and appraisal and staff told us that they could speak to a manager if they needed guidance or had concerns. Staff received an annual appraisal and were given targets to achieve for the coming year and asked to rate their own performance. Newly recruited staff were given an effective induction using the Care Certificate. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. One recently recruited member of staff told us about their induction, "I shadowed four of each shifts and also shadowed in the kitchen and laundry and was offered more which was good: I never felt left alone."

People received enough food and drink to meet their needs and maintain good health. One person told us, "I get lovely healthy meals." A relative commented, "It's the right type of food and everyone says it's good. It's all the old favourites like roasts, sausage and mash and cottage pie, and there's always cake in the afternoon." Care plans included a nutrition and hydration plan. One care plan stated the need for a soft diet and for the person to be fed by staff. We tracked this at lunch time and found the person being supported to eat with a soft mashed diet. We observed that people had a choice of food at meal times: one person requested some tea and toast as they were not feeling well enough to eat a meal, and this was swiftly provided. Another person did not want the puddings on offer and specifically requested a yogurt which staff swiftly sourced from the kitchens. People were offered choice of a vegetarian option at each mealtime and menus were a healthy and balanced selection of meals that reflected people's preferences.

Staff worked together to ensure that people received a consistent and person-centred support when they were referred to, or moved between, different services. We reviewed one care plan for someone who had recently moved to the service from another care provider. A member of the management team had visited the care provider four times and had held informal conversations with the person and their staff team. These had been recorded and a copy of the person's care plan had been received. The initial care plan for Milward House was then compiled from notes taken from the conversations recorded and the previous provider's care plan and the details were checked with the previous provider to ensure that no changes had occurred and that the information was consistent. We spoke to the member of the management team who conducted the assessments and visits and were told, "I spent time alone with the person, with their family and with staff doing different things like during a harvest festival or going for a meal and discussed all their needs." This process ensured that the person's needs and wishes were fully known and included in their care plan.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. Care plans clearly demonstrated that a wide range of professionals were involved in people's care. For example, we saw specialist doctors, district nursing, hospices and dieticians were all involved in people's care. People were involved in regularly monitoring their health and had goals or outcomes in their care plans. One person had severe arthritis and problems with their thyroid. They had set a goal for their medicines regime to be maintained as this was helping with the symptoms of these diagnoses. The same person also reported that they were experiencing issues swallowing pain relief tablets so the staff assisted them to obtain liquid pain relief medicines from their GP. People were monitored effectively and where there had been changes in people's presentation or diagnosis healthcare services had been contacted and people were swiftly seen by professionals.

People's individual needs were met by the design of the premises and they were able to have their say on the environment in which they lived. The registered manager had researched how environments can be decorated to aid and enrich the experiences of people living with dementia. Each floor of the building was decorated in different colours and art had been installed on the walls to give different textures for people to explore as they walk around the home. There were other installations such as a 'back door' area designed to look like a traditional home with a clothes peg bag, pinafore apron, umbrellas and selection of keys. The registered manager explained that one person who was living with dementia and was disoriented to time and place frequently felt distressed that they had lost their door keys, and they feel relieved when they can come and collect their keys from this area. There had recently been a large refurbishment of the building and people were involved in choosing colour schemes. A sensory path had been created in the garden and one person in particular enjoyed doing their daily walk there.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care plans included a mental capacity assessment and one plan clearly stated a DoLS authorisation was in place. The plan also recorded the date that the DOL's was due to expire. 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. People's right to make decisions was promoted and the principles of the MCA were adhered to. MCA assessments had been used appropriately and best interest decisions were made in line with the MCA code of practice. One best interest discussion had taken place to help professionals make a decision on whether to continue to provide a medicine following a fall and fractured bone. The decision to continue with the medicine was clearly documented including who was part of the decision making process. The decision had been made with the family, care home manager, GP and hospital consultant.

Good

# Is the service caring?

## Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "The staff are very caring without a doubt. I can hear them coming and I think 'which lovely face am I going to see'. They've all got such lovely smiles when they come in." Another person commented, "For me it helps being a Christian home. I think that makes all the difference; they [staff] are always so very good." One relative said, "The staff are really caring and they show genuine affection to the residents. They always call people by their name and the way they help people just seems right."

People were treated with kindness and compassion in their day to day care. Care workers had built up positive and caring relationships with people they were supporting. Staff knew how to communicate with different people and where people had a communication need this was explained in their care plan. Peoples care plans described the best way for staff to communicate with them. The care plans set out the spiritual needs of each person as the home is Christian based. A church service was held each morning and people can chose whether the wanted to attend or not. The registered manager told us that there was nobody who currently had the need for an advocate or for an interpreter. However, if this need arose the registered manager would access services without delay and had details of organisations to contact. There was a calm supportive atmosphere in the home. We saw from the care plans that each resident had been allocated a staff member as their key worker. Staff members showed respect for people and knew their backgrounds and preferences. Some staff members spoke to us about how they would spend quality time with people in their rooms reading passages from the bible and talking about their faith. We spoke to people about staff members discussing their own views on religion and whether this was ever a problem and were told it was not. One person told us, "The word of God is all that matters so it doesn't matter if it's another opinion." Staff members showed concern for people's wellbeing and responded quickly to people's needs. We observed staff offering drinks, biscuits and blankets to people and interacting in a caring and thoughtful manner that people responded positively to. During mealtimes staff members did not wear 'uniforms' but instead had old fashioned homely aprons to support people with their meals.

People were supported to express their views and be actively involved in making decisions about their care and support. One staff member told us, "People with capacity read through their care plans with their relatives. For people without capacity we discuss their plans with their family as they know their likes and dislikes and some people have their life histories." We spoke to another member of staff about how people living with dementia are offered choices. The staff member commented, "We give people choices what to wear, or whether to stay in their room or come down. We constantly ask as we're in their home. Whether it's TV, radio, books or singing we give people a choice of what they want to do." Staff encouraged independence at meal times but gave support and verbal prompts. Staff members encouraged people's independence by prompting them to take a few steps down the corridor before sitting in their wheelchair or cutting up their own food. One staff told us, "Some people dry mugs up or hand out biscuits to people to feel part of the community here. We saw staff using a body hoist and standing hoist within the lounge area. Staff communicated to the resident what actions they were taking and ensure their dignity was protected during the procedure.

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. We observed staff respected people's choice for privacy as some people preferred to spend time in their own room. We saw those that were bed bound doors were left open when care was not being provided. One staff member told us, "We don't do any personal care without having the door shut and the curtains pulled. If we're washing someone we put the towel on their lap and not leave them exposed. We all knock on the door and wait for a reply." Some room doors contained a note from the resident stating their preference for the door to be shut when they were not in their room. Staff members respected people's right to privacy and ensured that all personal information was stored securely in a locked room in line with the Data Protection Act 1998. People's friends and relatives were free to visit without unreasonable restriction.

Good

# Is the service responsive?

## Our findings

People and their relatives told us that the staff were responsive to their needs and requests. One person said, "There's always something going on. There's hymns every Monday and we've got a carol service coming up. I attend the morning service and they are very good." Another person commented, "I've got a lovely room with a TV and phone and make myself at home up there. My family decorated the room and brought my furniture and it's like a little home." One relative told us, "I was involved in the care plan review it took us a good hour to go through everything." Another relative commented, "There's so much going on and if you don't want to take part you don't have to. Mum really enjoys the spiritual element. Due to her Christian faith it's the ideal place for her."

People received an individualised care service that was tailored to their needs. During meal services people were seated at tables with personalised table displays. Placemats had been personalised so that there was a meaningful photo of the person, such as a depiction of them at their old place of work, as well as information about them and a quote from their favourite psalm or bible extract. Wax fruit, cakes and rolls had been put in an eye catching display to help people living with dementia orientate to place and help their appetite. There was a small kitchenette area decorated in a 1940's style with adverts and appliances from that era. One person liked to put milk down for the house cat but this had caused the cat to be unwell. To relive the person's anxiety about the cat not being fed staff had painted the bottom of the bowl white so the person could see that the bowl had milk in it. One staff member told us, "We personalise care for people by being aware of the way they like to do things and responding [to their preferences]. People have their life histories and we know them so we treat people as individuals and know their likes and dislikes."

People were involved in writing their care plans. We reviewed six care plans in detail and information was recorded clearly about people's wishes, routines and preferences. For example, one person's profile document detailed to staff what time they liked to wake up, where they liked to take their breakfast, and how they watched TV in the morning before being supported with personal care. The care plan set out in detail what level of support the person required with personal care, exactly how they liked to be supported and by whom. This meant that staff would be able to provide a consistent level of care to the person in the manner that they preferred. At the time of our inspection there were two close relatives living at the service. The registered manager had ensured that they had rooms next to each other as both people had wanted to be close to each other.

People had 'my life story' folders in their bedrooms with childhood memories, memories of Christmases past, information about children, grandchildren and important relatives and detailed information about their Christian life, such as which churches they attended and any jobs they did within their local parish. People's bedrooms were decorated with family photos and cards from friends and family were displayed. People were encouraged to have their own furniture to make their rooms homely and reflect their tastes. We observed that people's beds were made with care with blankets folded neatly and cushions and soft toys placed on beds or pillows. This made bedrooms a comforting and familiar place for people.

People were supported to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them. The service had monthly activities rota in place which included a daily morning church service, bowling, pampering sessions and games such as Ludo, snakes and ladders, ball games and reminiscing. On the first day of our visit the activities coordinator was not working and staff were covering the planned activities. In the afternoon we observed the manager and a member of staff delivering a memory game with the residents in the main lounge area. People were engaged in the various activities on offer and appeared to enjoy joining in and talking amongst themselves about what was going on. The service also employs two part time staff to cover a seven day 'hummingbird' service for residents. The theory behind using 'hummingbird' staff was based on the benefits of having short, stimulating interventions with people to maintain mental stimulation and social engagement, distinct from, and separate to, direct care work and the activities programme. We found that staff worked together to provide unified and co-ordinated support to people. The hummingbird staff focused on activities in the afternoon and evening, as these tend to be quieter times, and they can, spend dedicated one to one time with people.

The provider had a complaints policy in place. The complaints file had a log of 15 complaints received during 2017 and eight in 2016. The registered manager informed us that the complaints had all been received verbally and had been resolved at an early stage which did not necessitate a formal written response. One complaint had been from the neighbour, five from relatives; one from a care manager and eight from residents. All of the complaints and been investigated and statements from staff taken where relevant. None of the complaints had a written response which means it was difficult to measure whether the complaints were fully resolved in a timely manner and complainants may not have been given information on how to escalate if they were not satisfied. The complaints log recorded the outcome and learning for the organisation. For example to inform neighbours in future before any building work starts, to relieve carers so activities can be delivered, and to ask relatives about arrangements for the provision of a birthday cake.

People were supported in a sensitive and compassionate way at the end of their life to ensure they experienced a comfortable, dignified and pain free death. We reviewed one end of life care plan and found the wishes of the resident and their family had been recorded. A recent change in their health had led to a review with the family who asked that the care be provided within the home rather than transfer to hospital care if possible. DNACPR were documented in the care plan and were clearly stated in the care summary. The service responds swiftly to people's needs as they may change towards the end of their life. Specialist services such as hospice nurses were called in to ensure people had access to specialist equipment and medicines. People's families were supported sensitively by staff who were trained to know how to respond to people in times of grief. We spoke to one member of staff who told us, "The hospice nurses get involved and come in to make sure people are comfortable. We tell relatives every day what updates there are, even if there are none. Good end of life care is about making people comfortable: giving them a sip of drink and involving relatives and making it a friendly environment for people to visit."

Good

# Is the service well-led?

## Our findings

People and their relatives told us they felt the service was well led. One person told us, "[Manager] is very, very good. I don't go often but if there is something I don't like I see the manager and we talk it over. She says a word of prayer with me and I feel at ease." Another person commented, "The management of this home is very efficient and the manager is good. I know I can talk to her." One relative told us, "The management is great. It's always spotless here and they're very friendly too. The manager approaches me if there's anything to do with mum's welfare. As we speak someone is putting pictures up in mum's room, which is lovely."

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs. There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. The culture promoted within Milward House was a family culture. The registered manager told us, "We are part of the resident's family and they are ours as well. This is their home and we are open to visitors and they join us for meals, come and make tea just as they would in their relative's home, and we have a guest room where people can stay." The registered manager ensured that staff were able to approach the office freely and without prior appointment and staff were observed to walk in to the manager's office and talk about day to day issues and get them resolved.

The management team were seeking new ways to enrich people's lives. The registered manager explained a new initiative being implemented at Milward House called 'Fulfilled Lives' which has been adopted by the registered provider. 'Fulfilled lives' was described as a way for staff to think about how to help people get the most out of life. There had been a recent meeting with people and staff to discuss the scheme and it was discussed about how staff can always question and seek to strive to do more and show people that coming in to a care home can be a positive experience. Inclusion and diversity was being promoted by the organisation and was an important part of staff induction. New staff worked through the Care Certificate Equality, Diversity, Inclusion and Discrimination module. The service had built up a team of volunteers who visit people and take them for a walk or support special activities, such as baking. There were also students on the Duke of Edinburgh Award scheme where they visit later in the day: the registered manager explained, "This is to echo the rhythms of family life where grandchildren or young people would visit after school and it offers a new dimension to resident's lives."

There was an effective governance framework in place to ensure that quality monitoring was reviewed and regulatory requirements were managed correctly. The registered manager was monitoring the quality of service delivered with a wide range of regular audits and spot checks. Quality control audits took the form of a daily walk-around which recorded people spoken with, and any positive observations as well as issues to be addressed, such as a socket in the dining room that had fused and required repairing. There were housekeeping audits which identified any issues with keeping the service clean, such as two pictures that needed to be dusted. There was an additional medication audit that looked at one person in detail every month. There is also a dignity audit completed by the service's dignity champion who interviews different people on a monthly basis to discuss any improvements the service could make to uphold people's dignity.

One person had requested they were left by staff when supported to use the commode and this was implemented. There were also external audits, for example, by a specialist organisation to check health and safety and produce a risk rated action plan. The registered provider also conducts regular operations audits to ensure there is oversight of the management of the service and to support the registered manager in their role.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour. The registered manager was given good support from an operations manager who supervises and appraises their performance and oversees quality monitoring with the registered manager.

People, their families and staff members were involved in the service and regular feedback was sought through questionnaires. There were regular residents, relatives and staff meetings and there were actions plans produced from these meetings to ensure that people's views resulted in changes where possible. We reviewed several action plans and saw that people had requested a bigger bed, different films to be available and for more dementia friendly questionnaires to be made available for people. These action points were allocated to the registered manager to oversee. Questionnaires were sent out twice a year and these are returned to the registered provider's central office where they are collated and scored. The registered manager showed us how the outcomes of the questionnaires were returned with comments on and how they are acted upon to improve the service.

The service was continuously learning and improving and learning was shared with staff members. We discussed with the registered manager how learning was identified and cascaded to staff members and were shown case studies of how learning was cascaded to staff members. Near misses were being recorded and reviewed effectively. We reviewed one case where a person returning from hospital did not have clear instructions of their prescription. This lead to learning whereby staff double check all prescriptions and call the hospital and peoples' families to ask specific questions about medicines when people are discharged from hospital. Other learning had occurred when the registered manager had observed poor practice in relation to moving and handling people. To stop a delay in retraining the staff members involved, the registered provider arranged for one staff member to be trained at a 'train the trainer' level so they could deliver up to date training to people.

The registered manager had a good working relationship with the local health and social services. The service works closely with people's GP and where necessary the local hospice. The service has good working relationships with the district nursing team who visit to provide services to people who require it. The registered manager showed evidence of the local clinical commissioning group audit of the service as well as documents showing how the local authority had attended reviews and conducted a contracts inspection. The registered manager demonstrated the close working relationship the service had with the local pharmacy, who conducted an annual audit and train staff in medicines. The service had been sharing information appropriately with relevant agencies for the benefit of people who use the service. There had been partnership working with the local speech and language therapy department, with local physiotherapists and the continence team. These services had been accessed through referrals via people's GP.