Pilgrim Homes

Pilgrim Homes - Milward House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Milward House on 15 and 16 November 2016. The inspection was unannounced. 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. At the time of our visit there were 19 people living in the home. The home is located in Tunbridge Wells and is arranged over three floors.

At the time of our inspection there was a registered manager at the home. 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.

At our last inspection on 16 and 23 February 2015, we found five breaches of the Health and social Care Act 2008 (Regulated Activities). These breaches were in relation to unsafe care due to poor moving and handling procedures, staff not following cleaning procedures to reduce the risk of infection, people not being secure in the premises and staff not being trained in safeguarding, staff members not receiving sufficient training, the registered provider had not offered meaningful activities for people living with dementia and that care plans were not individualised. The provider sent us an action plan stating that they had addressed the concerns raised.

At this inspection, we found that the provider had taken action on all these areas and was fully meeting the regulations where breaches were found.

The registered provider had systems in place to protect people against abuse and harm. The registered provider had effective policies and procedures that gave staff guidance on how to report abuse. The registered manager had robust systems in place to record and investigate any concerns.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. The environment was clean and appropriate measures had been taken to reduce the risk of infection. Medicines were managed safely and people had access to their medicines when they needed them.

Staff were well trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly. There were sufficient staff to provide care to people throughout the day and night. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe,

the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met.

The environment was designed and adapted to meet the needs of people who are living with dementia, through sympathetic re-decoration and usage of the building.

The staff were kind and caring and treated people with dignity and respect. Good interactions between people and their support staff were seen throughout the day of our inspection. Staff knew the people they cared for well and treated them with kindness, compassion, dignity and respect.

People could have visitors from family and friends whenever they wanted. People spoke positively about the care and support they received from staff members.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

People felt well cared for and were supported with a variety of activities. However, activities were not always structured meaning that people could potentially become under stimulated. We have made a recommendation about this in our report.

Support plans ensured people received the support they needed in the way they wanted. Peoples health needs were well managed by staff so that they received the treatment and medicines they needed to ensure they remained healthy. Staff responded effectively to people's needs and people were treated with respect.

Staff interacted with people very positively and people responded well to staff. The culture of the service was open and person focused. The registered manager provided clear leadership to the staff team and was an active presence in the home.

Audits to monitor the quality of service were effective and embedded. They identified actions to improve the service and these had been carried out.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from avoidable harm and abuse.

Risk assessments were comprehensive and reduced hazards.

The provider had ensured that there were sufficient numbers of staff in place to safely provide care and support to people.

Medicines were stored and managed safely.

The environment was clean and appropriate measures had been taken to reduce the risk of infection.

Is the service effective?

Good

The service was effective.

Staff received training that gave them the skills and knowledge required to provide care and support to people.

Consent was being sought and the principles of the MCA complied with.

People had access to a range of food options that was nutritious and met their needs. People were supported to maintain their diets when required.

People's healthcare needs were being met with support to routine appointments and appropriate referrals.

The environment had been designed and adapted to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information effectively.

People and their families were involved in their lives.

People were treated with respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs.

Complaints were recorded effectively and responded to appropriately.

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive.

The management team provided clear leadership to the staff team.

Quality monitoring systems had been effective and led to change.

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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 15 and 16 November 2016 and was unannounced. The inspection team consisted of one inspector and one inspection manager..

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people who live at Milward House were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, the deputy manager, four support staff, the chef, one speech and language therapist, nine people, three people's relatives and two people who hold power of attorney for people who live at Milward House. We looked at a range of records about people's care and how the service was managed. We looked at five people's care plans, medication administration records, risk assessments, accident and incident records, complaints records, health and safety checks, fire safety documentation, menus, kitchen cleaning rotas, activities programme and quality audits that had been completed.

Good

Is the service safe?

Our findings

People living at Milward House told us they felt safe. One person told us, "I feel safe here: it's about the only place I do feel safe. Everybody's happy and we enjoy each other's company." Another person commented, "I feel perfectly safe here." A third person told us, "I feel very safe. If the alarm goes off, I know not to worry; it's not anything to do with me, not like at home." A district nurse, who was visiting the service, commented, "It is safe. The staff carry out instructions and work within their limits as they know that district nurses are available."

At our previous inspection on 16 and 23 February 2015, the registered provider was in breach of regulation 13 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that the registered provider had not taken adequate steps to protect people from abuse and the risk of abuse. At this inspection, improvements had been made.

People were protected against the risks of potential abuse. One staff member told us, "We safeguard people from all sorts of things, such as abuse, how people are spoken to, their dignity and respect. We take more care of those living with dementia who can't speak for themselves. Any concerns get reported to the senior or the manager and sent on higher. In this place they deal with problems straightaway." Staff members were able to talk confidently about the reporting procedure and the different types of abuse. They also knew what potential signs to look out for, such as a change in behaviour, in order to be vigilant against potential abuse and to keep people safe.

The service was pro-actively reporting safeguarding concerns. Although the safeguarding folder did not contain recent safeguarding investigations, we saw that the registered manager had made enquiries to the local authority safeguarding adult's board about incidents and these had not met the threshold for safeguarding. This meant that the correct process had been followed and the service had been open in their dealings with other agencies. Staff members had received training in safeguarding people and the building was secure to visitors. A locked door secured the entrance to the independent living scheme and people were not walking freely in to the service without staff knowing and allowing them entry.

At our previous inspection, the registered provider was in breach of regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that people were not protected against the risk of receiving unsafe care as they were not supported to move safely. At this inspection improvements had been made and this requirement was now met.

People received safe care and treatment; their needs were assessed and appropriate care was delivered consistently. During our site visit we observed good practice consistently being followed. People's care plans contained assessments for moving and handling to ensure that people were supported as safely as possible to move from e.g. their bed to their chair. On several occasions we observed staff speaking to people and explaining every step of the moving process when they supported people to change positions. One person had reported that they were feeling a little dizzy. Two members of staff took this in to account when assisting the person to move to a different chair and gave the person extra time to move, as per their care

plan. Some people were supported to move with the aid of a hoist. Staff members consistently followed safe moving and handling procedures and ensured that the person was comfortable on each occasion.

At our previous inspection the registered provider was in breach of regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that staff had not followed cleaning procedures to reduce infection control risk. At this inspection improvements had been made and this requirement was now met.

The service was clean and people were protected against the risk of infection control. One person told us, "The home is always clean." We found the home was clean, odour free and with nice decorations in communal areas, for example, individual cushions in the lounge, flowers in a vase and decals on windows. There were weekly, monthly and quarterly cleaning rotas, which were completed to indicate that tasks were all undertaken as scheduled. The service had appointed an infection control lead to take responsibility for infection control, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

The infection control lead had conducted a yearly audit to ensure that all areas of infection control, such as cleaning or the laundry of soiled clothes, were safe and in line with best practice. The yearly audit had identified areas for improvement and had implemented changes to remedy the shortfalls. For example, it was noted that some incontinence aids had been put directly in to a bin without being safely secured in special bags. An action plan from the audit showed that a note had been left in the communication book for all staff to remind them to use special bags for incontinence aids and that spot checks had been carried out to ensure this was happening. The yearly audit had subsequently been conducted several times in the same month as a teaching exercise to staff members so that all staff members understood their responsibilities around infection control.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. One staff member told us, "We get to understand the resident's needs and we don't put people in danger, we reduce the risk." There was a call bell system in place and all staff carried a pager to alert them if someone needed assistance. People had been assessed to check that they could use the call bell and in cases where they could not use the call bell there were regular checks in place. People's care plans contained relevant risk assessments, e.g. to support people living with a swallowing difficulty and heightened risk of choking. Nutritional risk assessments were in place which provided guidance to staff on how to mitigate the risk of choking, such as providing a soft diet and thickened fluids. Some people were at risk of malnutrition and required their weight to be monitored regularly and the completion of food and fluid charts. The registered manager had consulted national guidance, such as the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. The MUST tool enables provides to monitor people's risk of malnutrition and acts as a baseline assessment.

However not all risk assessments had been kept up to date. For example one person had experienced two falls in two weeks. The service had called a GP to examine the person. The GP had diagnosed an underlying medical condition, discontinued one medicine and advised the person stands slowly and drinks plenty of fluid to reduce the risk of further falls. The falls had been recorded in the accident book and entered in to an electronic system to monitor trends in falls and accidents, but the person's risk assessment had not been updated to include the advice from the GP. The person's care plan had been updated to include information around the falls but did not mention that a medicine had been discontinued or the medical advice to drink plenty of fluids. We reviewed falls management in the service and found that falls were being tracked and responded to. For example, one person had five falls and was referred to the falls clinic, had seen their GP

and were referred to a physiotherapist. The service had taken a positive approach to risk by encouraging people to mobilise freely without restraint, and using risk assessed control measures to keep people safe.

We recommend that the registered manager reviews the procedure for reviewing risk assessments so that information is contemporaneous and accurate.

People told us they felt there was enough staff on duty to meet their needs. One person told us, "There is enough staff here but I don't really think about it. If I want anything I go and ask and I've no problems." The registered provider used a recognised dependency tool to calculate the minimum number of hours that people needed to meet their care and support needs. Our own observations supported that there were enough staff. Staffing rotas indicated that enough care staff were deployed during the day, at night time and at weekends. Staffing levels consisted of six staff in the morning, five staff in the afternoon with three staff members at night time. In addition there was an activities co-ordinator most days and additional 'hummingbird' staff. Hummingbird staff were not employed to carry out care based tasks and instead focused on meaningful interactions with people. One staff told us, "We are working at a reasonable pace and have some empty rooms here. It's really handy having the hummingbird staff as they can fill the gaps and sit to talk with people. Sometimes people just want to sit and chat, or to be read to: it's great for people in their rooms."

There were safe medicines administration systems in place and people received their medicines when required. An administration round was observed and all dispensing was done from a trolley, which was locked between each administration. The staff member administering gave full attention to the task and spent time with each individual, ensuring they understood what was being offered, and why. Where medicines were to be given 'as required', for example to relieve pain or indigestion, there were written protocols with the medicine administration record. These indicated whether people would be asked if they needed the medicine, or whether the staff member would need to use prompts and consider how the person presented. Medicines were delivered in blister packs by the pharmacy and stored in a locked room, in locked cabinets. Creams, liquid medicines and lotions were stored separately and the temperature of the medicines room was checked regularly.

Safe recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal 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. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

The registered manager had ensured that the physical environment was safe for people. There were up to date safety certificates for gas appliances, five year electrical installations, portable appliances testing, and lift and hoist maintenance.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One relative commented, "It appears to me from what I've seen, they [staff] go out of their way to give the help they can." Another relative told us, "I don't feel from my observations that there are any gaps in training; sometimes if there's less experienced staff on it can be stressful for experienced staff but this isn't a usual problem." A third relative commented, "I have over many years found the staff very supportive and any queries I have made, were dealt with immediately."

At our previous inspection on 16 and 23 February 2015, the registered provider was in breach of regulation 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that the registered provider had failed to ensure that all staff had received all the essential training and updates required to enable them to carry out their roles effectively. At this inspection improvements had been made and this requirement was now met.

Staff told us they had the training and skills they needed to meet people's needs. One staff told us, "We have constant training, supervisions and appraisals, and it's nice the newer staff members do training to a high level here in order to keep people safe." Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. A recently recruited member of staff told us, "I've never been asked to do something I'm not trained to do. I've been trained to use the hoists. I've done lots of courses and have studied for the QCF level 2. [Qualifications and Credit Framework (QCF) is a nationally recognised diploma in health and social care]. The induction is going really well and the staff are lovely and helpful. I shadowed for two weeks and worked on the care certificate. [The care certificate is a nationally recognised qualification for care staff who are new to care work.]" The training matrix showed that staff members had completed a comprehensive programme of courses to enable them to carry out their duties. Staff members completed training which included safeguarding, fire safety and moving & handling. In addition to these standard courses there were more specialist courses available, such as in pressure ulcer prevention and angina. We checked the training record for the most recent member of staff and found that they had completed 21 courses via a mixture of face to face training and DVD training.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had ensured that people's freedom had not been restricted unnecessarily and that systems were in place to keep people safe. Care plans contained decision specific capacity assessments for issues such as restraints to keep people safe and for people to consent to their care and treatment. The service followed good practice and thought about the restrictions it had to place on people to maintain their safety. For example, there were DoLS checklists for pre and post authorisation with prompts to check if the restraint was still necessary so that people with

fluctuating capacity would not be unnecessarily restrained.

People were supported to have a meal of their choice by organised and attentive staff. One person told us, "The food here is very good." A relative told us, "I've tried the food and the quality is good it's good old English dinners and it seems well cooked and they put things on the table and people serve themselves." A person who holds power of attorney for one person living at the service commented, "I've had a meal twice there before and it is not only sufficient but also very good." We observed a lunchtime meal and a breakfast. During the lunchtime meal people sat at tables in small groups that were set with placemats, a menu, salt and pepper, a choice of two cold drinks and flowers in a vase. There were two covered serving dishes, containing vegetables and couscous or mashed potato. Everyone in the dining room was served with their meal within 15 minutes of the first lunch arriving so that people could eat together as a social occasion. At the end of the lunch service we saw that people who were bed bound, or had chosen to stay in their rooms, had been served their meals and where appropriate had support to eat. Menu's showed that nutritious and home cooked meals were on offer at every mealtime.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. For example one person was vegetarian but chose to eat fish. This was clearly recorded in their care plan and the cook was aware of this information. Some people required careful support around their nutritional and hydration needs. There was clear individual guidance about how to support people safely and effectively with eating and drinking. Where staff had concerns over people's nutritional intake, food and fluid charts were started to monitor people's nutritional intake and take action where required. Some people were at risk of choking and required their food to be pureed to reduce the risk of choking. Where this was deemed necessary, speech and language therapy guidance had been sought, and was being followed, and the cook and support staff were aware of how to support people. People were encouraged to drink during mealtimes and throughout the day. People who had a poor appetite were gently encouraged to eat more or to try second dishes.

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. People had a health action plan that described the support they needed to stay healthy. One person, who had moved to the service less than a week before we visited had a care plan that contained detailed information from their GP around their recent health appointments, such as recent admissions to hospital and GP appointments. The service had partially completed hospital admission and medical appointment forms for the person so that when they required any medical attention the healthcare professional seeing the person would have the information they required and would be able to capture details of the appointment on the forms.

Other people who had lived at the service for a longer time had been supported to maintain good health and had access to healthcare services. We spoke with a GP who was visiting the service and were told that the service were good at putting action plans in to place. The GP had limited dealings with the service but described a good working experience. We were told that the GP had been called because one person living with dementia was experiencing swallowing difficulties and was struggling with tablets so the service had requested a review of medicines and that another person living with dementia was experiencing anxiety at night times. The GP commented, "The home seem to pick up on health needs quickly and respond to them. The last person I visited had an issue with blood pressure and referrals had been made appropriately." Care plans showed that people regularly saw a range of healthcare professionals as required and people had their health needs met by a responsive staff team.

People's health and social care needs were being met by the adaptation, design and decoration of the

service. The registered provider had redecorated and redesigned the service to take account of the needs of people living with dementia and for people with a strong Christian faith. The registered manager had researched and consulted national guidance on how to make environments more dementia friendly. The entrance lobby had a seating area with a desk and old fashioned typewriter for people who wished to type. The lift had an easy to follow guide on the wall to show which rooms were on which level of the building. Each floor of the service had a different colour scheme to differentiate it. For example, one floor had curtains and flowers that were light pink whilst the next floor had curtains and flowers that were dark purple. This helped people find their way around the building. A shower room that previously contained a cupboard to store towels had been changed to a display cabinet with a traditional water jug and bowl and traditional perfume in old bottles that people could use. These were items that would help people to reminisce or maybe be recognised by people living with dementia. All toilets had been redecorated to be more homely and so that each toilet was different. One toilet was decorated with a beach theme with painted walls and a bowl with seashells and ducks for people living with dementia to pick up and explore. Toilets were fitted with coloured toilet seats. People living with dementia often experience visual impairments and coloured toilet seats help them to see the seat clearly.

There was art on the walls in corridors to give different textures for people to explore as they walk around the home. One corridor had coloured flowers that protruded from the walls and were soft to touch. Another corridor had a board with different locks, door knockers and bells for people with the need for their hands to be busy. Another area of a corridor had an area designed to look like a homes' back door with a clothes peg bag, flat cap, pinafore apron, umbrellas and a children's hoop. The registered manager explained that some people liked to stop and reflect at this space and enjoy the familiarity of engaging with tactile and easily recognised objects. People had memory boxes outside their room doors which contained objects and quotes chosen by people that meant something to them. One person had chosen a picture of their cat, their favourite flower and their favourite religious quote. This would help to orient the person to their room if they were experiencing confusion. There was a small working kitchenette that had been redecorated to look like a pre-war kitchen with old fashioned product boxes and pictures on the wall. Some walls had been decorated with quotes from the bible and psalms. For example, one corridor bore the words, "Be still and know that I am God." The registered manager explained, "It means something to our residents who are all Christians."

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "If you are of a certain age and Christian disposition, I would recommend it. I have been looked after very well." One person with power of attorney for a person living at the service told us, "The way they go about their business there indicates to me that they are caring and their purpose in life is to care for the residents of the home." One relative commented, "Yes they [staff] are very caring and they're very good. They always do what's necessary. For instance X recently had a fellow church member pass away and they recorded the funeral service and I had a DVD of it. The staff helped me to get X in to a chair and watch the DVD which meant a lot to X."

People received care and support from staff members who had got to know them well. During the serving of breakfast one member of staff stayed in the dining room to assist people where needed. The member of staff put their arm gently around people as she spoke to them and knelt down to ensure communication happened at eye level. The staff member smiled and spoke warmly with people, and people clearly enjoyed this natural interaction. One person took an extra cup of tea after this support was given and another person had an extra piece of toast after being supported in this caring manner. When one member of staff was administering medicines they commented, "Ooh you're being looked after X." the person smiled and said, "Yes, she [the staff member supporting her] is lovely," The staff administering medicines replied jokingly, "I've got a rotten job" to which the person commented, "Yes you stuff me with pills and potions." During this humorous repartee, there were natural tactile exchanges with people and staff members, gently placing hands on each other's shoulders and hands, in a comforting and appropriately friendly manner. This type of interaction was typical of the gentle and caring interactions we observed between people and their care staff. Some people preferred a more formal approach from their staff team and this was respected by staff members.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Staff told us, "In a sense we treat residents as a friend: we can't force them to do something they are not comfortable with or that is not at their own speed. People can choose what time they go to bed; some go to bed at seven and some at ten or whenever they are tired. People can choose to have more than one bath if they like." We spoke to one of the hummingbird staff who described that people were not left on their own a lot in the home, but that the staff members respected people's choice if they did not want any intervention, so that support was offered but a person's refusal of support was respected.

People could attend resident's meetings where they were encouraged to have a say in the running of their home. We observed one resident's meeting and reviewed the minutes of two others. In one meeting the food was discussed and one person commented, "We do seem to get a lot of tinned fruit, too frequently; it would be good to have other puddings. The agency cook X is very good, he and [cook] make a good pair and they both are very kind to me, cutting things up. I appreciate that". This comment had generated an action from the meeting to have more varied options for dessert. The manager had followed this up and it was later recorded that, "[person who mentioned tinned fruit] reports more variety now." One relative told us, "They have a residents meeting when they inform residents of changes. Mum now has short term memory

problems so they always tell me about things: they will call or email about any changes or things like that."

The relationships between staff members and people receiving support demonstrated dignity and respect at all times. People's room doors were traditional 'front doors' with brass numbers and door knockers. The registered manager explained that this was to encourage staff members to always knock on people's doors, and where possible gain consent to enter, before walking in to people's rooms. One relative commented, "They [staff] do respect privacy and protect dignity. I have arrived there on occasion and they say they want to go and check with X in her room to make sure she's alright to be seen." One staff told us, "For people who live with dementia, and can't say what they want, we can still see a little smile or a look if you offer the choice of two dresses to wear. We offer choices all day: it's their home and they're free to choose. Some people have a little smile or a signal to say they need the toilet and we discreetly and respectfully help them as we know their little signals." Another staff member told us, "The main thing is to listen. If you're washing and dressing someone we keep them covered up and if we're assisting people to eat we are polite, respectful and we listen and watch people. I personally speak to people the way I spoke to my parents when I cared for them, as the way carers spoke to my parents was so important to my family." Our observations confirmed that staff members uphold people's dignity and respect. People were treated as equals. The registered manager explained that the service refers to people who live at the home as 'family' and the service is aiming to treat people in the way a person would want their own family treated. We observed many caring interactions and did not observe any instances where professional boundaries were not respected.

Staff members respected people's right to privacy and ensured that all information was stored securely in a locked room. People's friends and relatives were free to visit without unreasonable restriction. People were supported to be as independent as they wanted to be. One person had experienced falls but wished to remain mobile independently. This was documented clearly in the person's care plan and risk assessed so that the person could continue walking independently. The person's care plan summary stated, "X likes to keep his independence, even though he is at risk of falling, and does so by using a walker to walk around the building."

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One staff member told us, "Person centred care is getting to know people and their life history. X suffers from [medical condition affecting vision] and likes to hold my hand whilst I read her post to her. It is the little personal things like the particular sweets one lady likes and making sure she has them. Any personal things people want, we can do it." One relative told us, "Yes they personalise care and encourage X to do what she can for herself and they get things ready for her in the mornings so she does more for herself and leave things close to hand so she can see them due to her eyesight." Another relative told us, "When she first moved to the home she was given a room and didn't like the view from the window as the house next door could see in to her room so they gave her a blind. Then she asked if she could move room to look out over the garden and as soon as a vacancy came up they moved her to a room with a view over the garden."

At our previous inspection on 16 and 23 February 2015 the registered provider was in breach of regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that the registered provider had not offered meaningful activities for people living with dementia and that care plans were not individualised. At this inspection some improvements had been made.

Care plans were personalised and each file contained information about the person's likes, dislikes and things that were important to them. For example one person's care plan stated that "X has badges on his suit which are precious to him. X wishes to wear his badges and daughter is in agreement." We observed that this person was dressed smartly in a suit with his badges displayed prominently on the breast pocket of his suit jacket. A person who was living with advanced dementia had a care plan that stated that they found music comforting and that they had a past interest in flowers, horses, and crochet. When we arrived for our inspection, we observed that the person was in their room listening to gentle music and their room was decorated with pictures of animals and flowers. They were in bed with an activity blanket on their lap. An activity blanket is a blanket designed for people living with dementia that keeps their hands occupied and provides useful sensory stimulation. This was especially relevant for the person due to their previous interest in crochet which means they may experience a heightened need for their hands to be kept busy.

People living with dementia also had an additional assessment to address their specific health and social care needs. For example, one assessment contained information for staff to understand how to support a person when they are disorientated to time and place. The assessment also looked at the persons' changing abilities; it noted that the person was rarely able to engage with the activities that they once enjoyed. Instead it directed staff members to complete one to one sessions, for the activities co-ordinator to engage in one to one sessions as well as to provide stimulation when in their room through lights, music and different textiles. We checked the person's room and found the information was being used effectively by staff members. One person was from a Caribbean background and the registered manager told us, "We use different scents in diffusers in people's rooms to remind different people of home; this person has tropical scents like lemon and tropical oils." In the dining room people had personalised placemats with their favourite text and photos of something important to people. One person had a photo of a removal van to reflect their past career. The registered manager told us, "One person living with dementia had doll therapy

and was not eating much. We purchased a high chair for their doll and placed the doll in it at mealtimes and the person's appetite increased."

We found that that staff were responsive to people's needs and demonstrated a good knowledge and understanding of the support people required. We spoke with one of the hummingbird staff and were told that 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. It is distinct from, and separate to, direct care work and the activities programme. However, the hummingbirds and the activities co-ordinator work together and share information for planning. The hummingbird staff described how their role was to focus on one to one work, tailored to meet individual needs and interests based on life story work. For example singing a favourite hymn together, or reading a favourite book. The Hummingbirds also hold small groups, e.g. reading groups, and may do some activities such as using autumn leaves to make a collage. They focused on activities in the afternoon and evening, as these tend to be quieter times, and they can, "tuck people into bed" to give them comfort before they retire for the night. The staff member described how this had given comfort to one family. The staff member had seen one person and read and prayed with them, reading their favourite passages before they went to bed. As the person passed away in the night, the family were comforted to know that there had been a positive interaction in her last moments awake.

Other activities were provided and there was a programme of activities for the week. We spoke to one of the activities co-ordinators who told us that they go through the programme with the registered manager every week and make adjustments. Activities on offer included food decoration, ball games, memory games, exercises and crafts. As a service for people with a strong Christian faith there were also many religious activities for people to engage with. There was a devotional service every weekday morning and an afternoon service every Sunday followed by a Christian Fellowship tea. People gained comfort from their faith and staff members supported people with this. We spoke to a retired visiting pastor who led the devotional service on the day of our inspection, and were told, "I have seen a lot of kindness [in Milward House]. For example, an elderly gentleman was tired so the staff fetched a wheelchair to get him in so he could attend the devotional session without distress." Not all people were happy with the range of activities on offer. One person told us, "We have activities but we don't go outside: I've not been out of the home for a year." The person did say that they get to go into the garden or sit on the patio. We spoke to the registered manager about activities and were told, "We have occasional trips such as earlier in the year to see the lambs. A lot of people find it too much and don't feel secure out of their familiar environment. We don't have a minibus but have hired one in the past. The registered manager commented that there had been a 'friends of Milward' voluntary group who had assisted with outings but this was disbanded due to lack of volunteers.

We recommend that the registered provider reviews activities provision to ensure people who want to go out of the service are able to.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The complaints procedure sets out stages and people who are responsible for responding to complaints at different stages of a complaint. A verbal complaint would receive a verbal response and a written complaint would receive a written response within ten days of the complaint being received. There had been two written complaints and 37 verbal complaints in the past year. Verbal complaints were made around things that were not right on a day to day basis, such as one person's room being found dirty by a relative and housekeeping were sent to clean it and monitor the room in future. All complaints had been handled promptly and the complainant received an answer. One staff member had made a complaint to a member of the management team around their deployment and the support they received from their team mates. The staff member told us, "It was dealt with really well. A manager took them in to a separate room and

explained that other staff needed support. The manager then changed my shifts so I was working with more people and I found it helped me a lot.

Good

Is the service well-led?

Our findings

People and staff members felt supported by the management team. One staff told us, "They [management team] are lovely. When I first started the registered manager was recovering from an injury. Everyone was so lovely and kind. They like to make sure you are OK and not on edge. I know if I had concerns I could go to them and explain myself." A relative told us, "I have every confidence in them and they are very approachable." Another relative commented, "The manager was off sick for several months and things went remarkably well so they must be doing something right and there were no problems. The people who stepped up kept it cheerful and we're glad the manager is back again."

At our previous inspection we found that there were some areas for improvement in relation to the quality monitoring systems. At this inspection we found that improvements had been made. The registered manager had effective systems in place to monitor the quality of care and support that people received. Questionnaires were issued yearly to people, their families, visitors and staff members. Professionals who visited the service regularly completed a questionnaire that prompted them to report any concerns: none were recorded. Ten relatives and advocates completed a questionnaire and did not have any concerns. One person commented, "If I have any concerns I feel I can mention them to the Care Manager who will act to rectify the problem." The registered manager completed a monthly audit utilising the key lines of enquiry used by CQC. For example the audit prompted the registered manager whether the service followed current and relevant guidance about medicines. The audit showed that there was a medicines policy in place with up to date guidance and that regular reviews had been carried out with a GP, pharmacist, and an internal and external auditor.

There was an annual health and safety audit that had been carried out by another manager employed by the registered provider. This audit had led to an action plan with actions such as, wooden shelves in pantry to be replaced by plastic shelves and freezer handles to be repaired. There was an infection control audit carried out yearly which had generated an action plan. The registered manager conducted a daily walk around of the service to check that premises and equipment were safe and that people were being supported with their assessed care needs. The registered provider ensured that a quarterly audit is completed and an overall audit of the entire service is commissioned yearly by an external company. This overall audit had identified faults such as a best interest decision not being signed by one decision maker, and emergency evacuation plans did not identify which people required the use of an evacuation sledge. These faults were rectified quickly. The registered manager informed us that all audits go towards an annual management report. The annual management report was reviewed by the registered provider's audit committee and a development report was produced which was then reviewed by the registered manager and the operations manager.

The service promoted a positive culture. The registered manager told us, "The culture is underpinned by the residents and the senior staff's Christian faith. We seek to be person centred and have as homely atmosphere as possible. We changed the uniform to get rid of tabards to remove an 'us and them' barrier. So now staff are given money to choose something to wear for work. In a family you can't hide behind a uniform and we dress the same as residents here." We saw that staff members were dressed appropriately in

trousers and blouses or shirts, and that there were no unnecessary barriers between people and their staff team. The registered manager added, "We've encouraged staff to be a lot more relaxed with residents. For example so they know that it is OK to sit and chat, to read the paper together and get staff to understand this is as important as personal care." We spoke to relatives and visitors about the culture of the service. One person who held power of attorney for a person living at Milward house commented, "I really feel that it is not only good but it is organised in a way that would satisfy the residents of that particular home." Another relative commented on how friendly the service had become, "They've got the two staff who come in the afternoon and evening and that has been a very good thing as before this a lot of the time people were just sitting there especially people who didn't have visitors. It's working really well and they can read the bible to people at bedtime. Mum has a friend in one of the flats who comes and reads bible passages to her, which is lovely as she was a friend from years ago."

The registered manager and the management team provided strong leadership to the service. One staff member told us, "It [the management] is very, very good actually. The nice thing with [manager] is that she's always there and always available. Everyone knows that if you have any problems you can go to [manager] in confidence and she will address any problems. I like it that things are dealt with immediately." The registered manager explained that they were in the process of completing person centred appraisals with the staff team. The registered manager told us, "We challenge people in the moment if they use task focused language. We've used the probationary period and set targets for people and if they are not the right person we will not continue to employ them." We saw that the registered manager had used the disciplinary policy and performance review to assist staff members to work in the way the registered manager has requested. The registered manager had an open door policy and staff members were comfortable coming to speak to the registered manager about a range of issues.

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.