Mr Anandutt Rucktooa

# New Milton Nursing Home

## Inspection report

Rear 1841 Leek Road
Milton
Stoke On Trent
Staffordshire
ST2 7AD

Tel: 01782542573

Date of inspection visit:
04 October 2016

Date of publication:
27 October 2016

## 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? | Requires Improvement |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

We inspected this service on 4 October 2016. The inspection was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the provider of the service and was supported by a deputy manager.

The service provides accommodation with nursing and personal care for up to 24 older people, some of whom are living with dementia. Twenty-four people were living at the home on the day of our inspection, although one person was in hospital.

People felt safe living at New Milton Nursing Home and with the staff who looked after them. Staff understood their responsibilities to challenge poor practice and to raise any concerns about people's health and wellbeing with the managers. The suitability of staff to deliver personal care was checked during the recruitment process.

There were enough suitably qualified and experienced nurses and care staff to meet the needs of people living in the home. Staff worked well together to make sure people received the care and support they needed and the atmosphere was calm and relaxed.

The provider used a range of assessment tools to identify possible risks associated with people's health and well-being and included clear guidance for staff on how to mitigate the identified risks. The provider had procedures and policies to ensure the safety of the environment and equipment in the home. People's medicines were managed, stored and administered safely.

People were confident in the ability of staff to care for them. Staff received appropriate training and support so they could meet people's needs effectively. Staff were encouraged to develop within their roles and study for nationally recognised care qualifications. New staff shadowed experienced staff until they knew people well and understood how to support them.

The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority. Staff worked within the principles of the MCA. They offered people choices and supported them to make their own decisions where possible.

Risks around people's nutritional intake had been identified and people were offered food and drink that was suitable for their individual dietary needs. External health professionals were contacted when people's needs changed and further health involvement was needed to maintain their health. People and their relatives were confident their healthcare needs were met. Appropriate arrangements were made to support people until the end of their life.

Staff had developed positive, caring relationships with people and demonstrated an easy rapport in their communications and interactions. Staff were patient and understanding and sensitive to people's needs. People were spoken with politely and courteously and told us staff treated them with respect. People's relatives and friends were able to visit when they wanted to and played an important role within the home.

Care was planned to meet people's individual needs and preferences and care plans were regularly reviewed. However, care plans were not always consistently followed. Relatives were kept well informed about their family members' support needs and where appropriate, actively involved in decisions about their relatives care.  People told us that staff were responsive to their requests for assistance.

There was no activities co-ordinator working at the home. Social activities were led by the deputy manager and carried out when staff had finished providing personal care. Following a recent quality assurance questionnaire, the provider had identified that responding to peoples' social needs was an area that required improvement.

People and their relatives were happy with the service provided within the home. People openly complimented staff and spoke well of the home and the care received. The management team were known and visible to people, relatives and staff and had an in-depth understanding of people's medical and emotional needs.

The provider's quality monitoring system included consulting with people, their relatives and reviewing practice within the home to ensure planned improvements were focussed on people's experience.

## 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 felt safe living at the home. There were enough staff to support people safely and ensure they received the care they needed in accordance with their daily routines. Staff understood their responsibilities to protect people from the risk of abuse and report any concerns they had about people's health and wellbeing. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. Medicines were stored, administered and managed safely.

### Is the service effective?

**Good**

The service was effective.

Staff were effective in meeting people's health and social care needs. Staff received regular training in essential areas to keep their skills up to date. Staff worked within the principles of the Mental Capacity Act 2005. They offered people choices and gained consent from people before supporting them with personal care. The provider understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and hydration needs were met. Health professionals were contacted when people's needs changed and further health involvement was needed.

### Is the service caring?

**Good**

The service was caring.

Staff had developed positive, caring relationships with people and demonstrated an easy rapport in their communications and interactions. Staff knew people well and respected their privacy and dignity. Relatives and friends were able to visit when they wished and always made to feel welcome.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People and their families were involved in planning how they were cared for and supported. Care plans were written in an individual and person centred way. They gave staff clear information about people's needs, but this was not always consistently followed by staff. Staff were responsive to people's requests for assistance. Opportunities for people to engage in activities to meet their social needs were limited because staff were busy providing care.

## Is the service well-led?

Good

The service was well-led.

People and their relatives were happy with the service provided within the home. The registered manager and deputy manager were both a visible and known presence to staff, people and relatives. People were asked for their opinions about the service provided. The provider's quality monitoring system included checking people received an effective, responsive, good quality service that met their needs.

# New Milton Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 4 October 2016, was unannounced and consisted of two inspectors and a specialist advisor. The specialist advisor who supported us had experience and knowledge of nursing and end of life care.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Before the inspection visit, 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. We found the PIR reflected the service provided.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people in the communal areas and in their own rooms. This was to see how people spent their time, how staff involved them, and how staff provided care and support to people when required.

During our inspection visit we spoke with four people who lived at New Milton Nursing Home to get their experiences of what it was like living there, as well as eight visiting relatives. We spoke with the registered manager, who was also the provider and the deputy manager. We spoke with seven staff including nursing and care staff.  We also spoke with a visiting healthcare professional.Healthcare professionals are people who have expertise in particular areas of health, such as nurses or consultant doctors.

We looked at three people's care records and other records including quality assurance checks, medicines,

complaints and incident and accident records.

Good

# Our findings

People we spoke with told us they felt safe living at New Milton Nursing Home and with the staff who looked after them. One person told us, "Carers are always around which makes me feel safe." Relatives felt confident that their family members were kept safe by staff who cared. One relative explained, "I think there are enough staff. ...[person] is restless at night and the night staff are really good. They will sit with [person] for company and that reassures me."

People were protected from the risk of abuse because staff knew what to do if they had any concerns about people's health or wellbeing. Staff understood their responsibilities to challenge poor practice and to raise any concerns with the managers. Staff also knew of outside agencies they could contact to raise concerns, for example the local authority or us. Staff told us they would escalate any concerns externally if the managers did not take appropriate action. One member of staff told us, "I would tell the CQC if I was not happy." Another said, "I wouldn't hesitate to report abuse to social services and even the police."

There was information about what constituted abuse in one of the communal corridors. This provided information for people and their visitors so they understood what behaviours were unacceptable and could be regarded as abusive.

There were enough suitably qualified and experienced nurses and care staff to meet the needs of people living in the home. People and their relatives confirmed there were enough staff available to support people and keep them safe. Comments included: "Staff are always there when they are needed" and "I think there are enough staff to care for me." One relative told us, "I think this is the best place in North Staffordshire. I looked at several homes and saw that there was always plenty of staff around here."

Staff felt there were enough staff to support people safely and ensure they received the care they needed in accordance with their daily routines. However, some staff told us they sometimes found it difficult to spend time with people, especially in the morning. They felt it would be helpful to have an extra member of staff in the morning to assist people with eating and giving them drinks. This was confirmed by one person who told us, "Sometimes staff are rushed, but they are good." During our visit we saw that the morning was very busy, but staff worked well together to make sure people received the care and support they needed and the atmosphere was calm and relaxed. During the afternoon staff had more time to have conversations and chat with people.

Many of the staff had different roles in the home at their own request. They worked some shifts as care staff

and other shifts as laundry or domestic staff. The deputy manager explained that this flexibility meant that at times of pressure or in an emergency, laundry and domestic staff could step in to provide additional support because they had the skills and knowledge to provide care. It also meant there were enough staff to fill any gaps on the rota so people received care from a consistent staff team.

The provider checked staff were suitable to support people before they began working in the service, which minimised risks of potential abuse to people. The deputy manager told us the provider's recruitment procedures included obtaining two references and checking staff's identities with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records. Staff only commenced work in the home when all the required recruitment safety checks had been completed. We looked at two staff files. One confirmed all the security checks had been carried out, but the other only contained one reference. The provider assured us they would have followed their own procedures and requested two references.

The provider's policy for managing risks included assessments of people's individual risks. The provider used a range of assessment tools to identify possible risks associated with people's health and well-being that included skin care, falls, weight loss and choking. The assessments included clear guidance for staff on how to mitigate the identified risks. For example, two people were identified as being at high risk of skin breakdown. Plans were in place to reduce the risk of skin damage, which included the use of specialist pressure relieving equipment such as an airflow mattress and two hourly changes of position. One person had bed rails in place. These had been risk assessed and appropriate care plans were in place to manage their immobility and risk of falls. One staff member told us, "The risk assessments are in the care plans, for example, the correct size sling to be used to move them safely." Each risk assessment was reviewed and updated regularly or if a person's support needs changed. This was important to make sure that the information included in the assessment was based on people's current needs.

Staff were knowledgeable about people's risks and how to manage them. Some people could become distressed or anxious which resulted in behaviours that were challenging to themselves or others. One staff member told us, "I pick up signs about changes in behaviour, especially their eyes. I use books or something else to distract that behaviour and reassure the person."

Some people needed staff to use equipment such as a hoist to transfer them from their wheelchair to their lounge chair. During our visit we saw staff used the equipment safely and without rushing. Staff explained to people what they were going to do and provided reassurance throughout the process. One staff member explained, "We always explain what we are going to do and reassure, especially when moving people."

We checked the administration of medicines to see if they were managed safely. We found medicines had been stored safely and in line with manufacturer's guidance. Arrangements were in place to obtain, administer and record people's medicines. Most medicines were dispensed by a local pharmacy in pre-loaded blister packs. These were colour coded to indicate when the medication was due, for example, morning, lunchtime or evening which reduced the risk of errors being made. Medicines were available and Medicine Administration Records (MARs) had been signed to confirm administration, or a reason documented to explain why a medicine had not been given. For medicines prescribed in patches, staff used a body map to show where the patch had been applied. This ensured it was applied to a different area each time, to minimise the risks of making the person's skin sore. However, we observed that syringes used to give medicines were not disposed of in the clinical waste and medicines given directly into the stomach via a percutaneous endoscopic gastrostomy (PEG) tube were signed ahead of the medicine being given. A PEG is a tube which allows nutrition, fluids and/or medications to be put directly into the stomach. Both these actions did not accord with best practice in managing medicines safely.

People we spoke with told us they received their medicines on time and staff were responsive if they were in pain. One person told us, "I ask for paracetamol and they always get it for me. They will also ask if I need any, they are good like that." Another said, "I don't take tablets but if I need pain killers, they will get those for me." During our visit we saw the nurse giving people their medicines. The nurse ensured people had taken their medicines and took time to make sure people were comfortable afterwards, such as helping people put their glasses back on after eye drops had been given.

The provider had procedures and policies in place to ensure the safety of the environment. Safety checks were completed for gas, electricity, equipment and fire safety. Equipment, such as hoists were serviced regularly and staff regularly checked that wheelchairs and slings were safe and fit for use. Records showed fire alarm and fire-fighting equipment were regularly serviced and tested and everyone who lived at the home had a personal emergency evacuation plan. The plans were readily available so that staff and the emergency service would know what equipment and assistance people needed to evacuate the building safely. Staff received training in health and safety, first aid and fire safety, to ensure they knew what actions to take in an emergency. The provider had an emergency folder which contained contact numbers of suppliers to be contacted in the event of an interruption in services to the home.

Good

# Our findings

Staff were effective in meeting people's health and social care needs. People we spoke with felt confident in the ability of staff to care for them. One person told us, "I think they know what they are doing." A relative said, "I would say they are well trained to carry out the job, I think they do everything really well here."

New staff received an induction when they first started working at the home. This included working alongside more experienced staff so they could get to know the individual needs of the people living in the home. The deputy manager explained, "We bring them (new staff) into the home. They have two weeks on the floor shadowing and then we slowly bring them onto the team when we feel they are ready." Induction training included the Care Certificate. The Care Certificate is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker. This demonstrated the provider was acting according to nationally recognised guidance for effective induction procedures.

Care staff told us they received regular training in essential areas to keep their skills up to date and provide effective care to people. One member of staff explained, "I have had lots of training….I have done training on care of PEG site, incontinence and the Mental Capacity Act." Another member of staff said, "We have all the training we need to do the caring." However, some staff felt further training in mental health would support them in managing challenging situations. We shared this with the provider who was a registered mental health nurse. They told us they would ensure staff received the necessary support in this area of their practice.

Staff were encouraged to develop within their roles and study for nationally recognised care qualifications. The deputy manager had recently completed a level 5 diploma in social health care and leadership to support them in their managerial role in the home.

Nurses told us the managers supported them with training to maintain and develop their clinical skills and to support their professional development. One of the nurses explained that the deputy manager resourced clinical training that was available in the local area. Another told us they were booked on to venepuncture (inserting a needle into a vein) training.

Staff told us they felt supported in their role because they had regular supervision meetings and an annual appraisal. Supervision is a meeting between the manager and member of staff to discuss their work performance and areas for development. The deputy manager explained, "Appraisals are about making sure everybody is happy, that they feel competent in the job they are doing, that they have the resources to do

the job and the training they need. Supervisions give them a chance throughout the year to see how they are doing and gives them an opportunity to open up and highlight any problems." Staff told us they found supervisions useful and an opportunity to learn. One member of staff told us, "If we have done something wrong they will do a supervision so we can go through the right way for the benefit of us and the residents."

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. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider understood their responsibility to comply with the requirements of the MCA. The deputy manager told us most people had capacity to make some decisions about how they lived their daily lives. Where people lacked capacity to make a decision, staff made them in people's best interests based on their knowledge of people's likes, dislikes and preferences. For complex decisions, for example treatment for an ongoing medical condition, the deputy manager told us they would involve either a relative or an independent advocate, who could support the person to make a decision in their best interests. An advocate acts on behalf of a person to obtain their views and support them to make decisions.

Some people had lasting powers of attorney to allow other people to make decisions on their behalf. The deputy manager kept a copy of the documents issued by the courts so they could be confident that people's relatives and representatives had the legal right to make decisions on their behalf. They explained how they had recently referred to a document to confirm that a family member had the right to make financial decisions on behalf of their relative but not decisions relating to their health and welfare.

Staff worked within the principles of the MCA. They supported people, as far as possible, to make their own decisions, for example where they wanted to eat their meals. One staff member explained, "Sometimes we have to make simple decisions for people. Any major decisions would have to be made by the doctor and social worker and family." Staff told us they gave people choices about how they spent their day such as if they wanted to remain in bed or be hoisted to sit out in a comfortable chair. People confirmed they were able to make decisions about how they received their care. One person told us, "I prefer being in my bed. It's my choice because I don't like the hoist." Staff understood the requirements of the MCA meant they could only deliver care if a person consented. We saw staff asked people for consent before they provided care. For example at lunch time a member of staff said to a person, "Is it okay if I help put this apron on you?" One person confirmed, "On the whole they ask for my consent." A staff member told us that if people declined support, for example with their personal care, they would respect that decision. They told us, "We will encourage people but if they still refuse, I wouldn't do it without their permission."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities under the legislation. They had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority.

The provider ensured people's nutritional and hydration needs were met. People's care plans had a malnutrition universal screening tool (MUST). A MUST is a tool to identify adults who are at risk of malnutrition or obesity. It allows the staff to manage people's nutrition correctly and identify any risk. Where

risks had been identified around people swallowing, they received a soft diet or their food was pureed. Some people had thickeners added to their fluids because they had been identified as being at risk of choking. Information about each person's dietary needs and allergies was kept in the kitchen so staff preparing meals had the information to hand. People's weight was monitored regularly to identify any weight loss so appropriate action could be taken. One relative told us, "Since [person] has been here they have put on two and a half stone." This was a positive improvement as they had been underweight when they moved to the home.

Some people received their nutrition through a PEG directly into their stomachs. One person could have small amounts of thickened fluids orally as part of their mouth care, but these could only be given by nursing staff because of their risk of choking. When they asked for a cup of tea, this was brought very quickly by the registered manager who was a nurse. The person was supported to take a few sips which they told us they enjoyed.

People were happy with their meals. One person told us, "Food is really good, there is a choice on the menu and you get lots to drink. If I fancy a cup of tea, they get it for me." Another said, "The food is very nice and you get lots of it." At lunch time staff asked people to move to sit at the dining room tables, so they had an opportunity to change position and socialise. However, most people chose to stay in their armchairs and staff brought food to them. People were given a choice of meal each day, but were not involved in planning the menus. However, the cook assured us, "We will give an alternative option if someone wants something different." Where people needed support to eat, staff took their time and gave lots of encouragement to those who were slow to eat. Staff asked people if they wanted assistance rather than just assuming they did. One person declined help because they wanted to carry on eating independently.

People and their relatives were confident that their healthcare needs were met. One person told us, "They will send out for the doctor if I am not well." Another person told us, "They will ring the doctor if I need one, and someone always accompanies me to the hospital." A relative said, "They tell me if [person] isn't well and they have sorted out a chiropodist and they get the doctor in." Another said, "Any problems and they get the doctor out, and [person] has had their eyes and ears tested as well." Most people were registered as patients with a local GP medical practice. One of the GPs visited the home regularly and the Advanced Nurse Practitioner (ANP) visited every Tuesday afternoon. The ANP reviewed patients and was able to prescribe medicines and treatments in response to changes in people's health. The deputy manager told us they contacted other health professionals when there was a need to. We could see in people's care records health professionals were contacted when people's needs changed and further health involvement was needed.

Good

# Our findings

People we spoke with said they found the staff kind and caring. Comments included: "Staff are very caring, we have a good laugh" and "I am well looked after….I was worried at first about settling in but I am much better now, I am very happy." Relatives spoke positively about the caring attitude of staff. One relative told us, "They are all easy going and will do anything for you." Another said, "It is like one big happy family here."

We saw staff had developed positive, caring relationships with people and demonstrated an easy rapport in their communications and interactions. One person told us, "They are very pleasant and we all have lunch together." Staff addressed people in a caring way and in a manner that was appropriate for each individual person. Staff demonstrated patience and understanding and were sensitive to people's needs. For example, one member of staff noticed a person was sat in the lounge with the sun in their eyes. They quietly went over and pulled the curtains for them.

Staff spoke in gentle tones and used a lot of tactile reassurance. One member of staff sat with a person trying to assist them to drink. They had their hand on the person's hand and were gently encouraging them to drink more. Another person who chose to stay in bed frequently called out anxiously. We saw staff responded and went into the person's room to give them verbal reassurance.

Staff enjoyed working at the home and being with the people who lived there. One staff member told us, "It's family orientated here and the residents come first." Another said, "I love it, it's like a home from home, people are really well looked after." Staff told us they took time to develop relationships with people and their families which helped them learn about people's past life. One staff member explained, "There are life stories and I read them. It helps me when I am speaking to people. We learn about their life and that makes them aware that we know about them."

People told us that staff were very respectful, a typical comment being, "Yes I feel the staff are respectful of me." During our visit we observed respectful interactions from staff. People were spoken with politely and courteously and staff knocked on people's doors before they entered. Staff mostly respected people's dignity by closing doors when they carried out personal care and speaking with people quietly about their personal care needs. One person told us, "They knock on my door before coming in and when I am having support they cover me up." We observed a person being transferred with a hoist. They were covered with a blanket to maintain their dignity even though they were fully dressed. However, there was one occasion when a bedroom door was left open when a person was supported with care which was not respectful of

their privacy.

Staff said they always told people what they were going to do to support their dignity and respect. During our visit we observed this in practice. For example, the nurse knelt down to one person who was sitting in a chair so they were at eye level with them. The nurse spoke clearly and explained what they were going to do before carrying out any care which reassured the person.

Most people required a lot of assistance from staff due to their dependency needs. However, where possible they tried to encourage people to be as independent as possible. One person told us, "I try to be independent but they will help me if I ask or need it." We saw one member of staff supporting a person to walk. They asked, "How can I support you, do you want to take my arm?" The person said they would like that and the staff member assisted them to the bathroom and back.

Most people needed support with their personal care needs. We observed that people looked clean and well-presented. They were all wearing slippers and were covered with blankets over their knees. Their hair and nails were clean.

People were encouraged to maintain relationships with those who were important to them. People's relatives and friends played an important role in the home. Throughout our inspection we saw relatives coming to the home to visit their family members. The relatives we spoke with said there were no restrictions on their visits and they were always made to feel welcome. They were able to choose whether to see people in private or sit with them in the communal areas. One relative explained, "I visit every day, except if I am away on holiday and then I call instead…..they are marvellous here."

Requires Improvement

# Our findings

Relatives told us their relations were cared for and supported in the way they had discussed when planning care. They told us staff took time to find out about their relatives likes and dislikes and their past life. One relative told us, "Staff are always discussing about [person's] care and ask me about their life." Another said, "We looked here first and liked that the staff had worked here a long time. We have a good relationship with the staff."

Each person had a range of care plans. These covered all aspects of people's medical and care needs such as drug therapy and symptom control and plans to support breathing, hygiene, mouth care, communication and pain management. Care plans were written in an individual and person centred way and gave clear information about what the person liked and did not like, and how they preferred their support to be provided. Care plans were easy to follow and reviewed monthly to ensure care continued to be responsive to people's needs. We spoke with one person whose care plan we looked at. The care plan accurately reflected the person's own description of their identified care needs. This person told us they were treated as an individual, listened to and enabled to make choices about the care they received.

However, we noted an occasion when care was not delivered in accordance with the requirements of a care plan. Good infection control techniques were not followed when a person's percutaneous endoscopic gastrostomy (PEG) was flushed and the site cleaned. The correct procedure was clearly set out in the person's plan of care and also in an advisory note from the dietician. Failing to follow the care plan meant there was an increased risk of infection spreading.

We looked at a selection of daily records which confirmed that people received the care set out in their care records. However, we identified one person whose care plans stated they preferred to have a bath or shower. Their daily records indicated that since 25 April 2016 they had only ever had washes or bed baths. We saw the person in the lounge. They looked clean and well groomed and their nails were clean, but we could not be sure their preferences for personal care were being met. The deputy manager told us there were issues with the correct type of chair to support the person safely in the bath or shower, but there was nothing about this in their care records or risk assessments.

People had advanced care plans which set out their preferences for their support needs when they reached end of life. The provider worked with the GP and local district nursing team to deliver end of life care that fully supported people and their families if they chose to stay at the home. Symptom management had been considered. Anticipatory medicines were written up for people on palliative care for when they

reached near end of life to keep them comfortable and avoid unnecessary hospital admissions wherever possible.

Care plans also contained "Life Stories" which provided staff with information about people including significant people and events in their life, pets, hobbies and past employment. These built up a good picture of each person and provided staff with information to support them in providing care that was person centred and met people's individual needs.

Although there were no 'formal' care reviews, relatives felt there was very good communication about their relative's care. They told us they could discuss their family members' support needs at any time, were kept well informed and actively involved in decisions about their relatives care. One relative said, "Staff discuss [person's] care with me all the time."

People who were able to use call bells had them within reach when in bed. People told us that staff were responsive to their requests for assistance. One person told us, "I have a buzzer to call and they are quick."

There was no activities co-ordinator working at the home. Social activities were led by the deputy manager and carried out when staff had time, generally in the afternoon between 2.00pm and 3.30pm. One person told us, "Sometimes people come in like singers, but I can get bored." Another person told us not much happened, but went on to say, "I'm not bothered at my age." Relatives felt that staff tried hard to provide activities. Comments included: "Staff do try to do activities like board games and the other day they had someone playing the clarinet come in" and "The staff will sit and put the curling tongs in [person's] hair which is nice for them." Staff felt they would like more time to spend with people and provide activities based on their interests and hobbies. One staff member said, "I don't think there are enough activities. We do try, we play games and do nails but we have to assist with care needs first." Another said, "I would like more time to do activities."

The morning of our visit was very quiet and staff time was generally spent getting people up and dressed. The afternoon was much busier with many visitors in the lounge who moved around and spoke to their own family and other people and their visitors. There was music playing on a vinyl record player and a black and white film was on. Some people enjoyed doing jigsaws and others did some colouring. Some people's chairs were moved around the room to seat them in small groups for activities. For example, one group played a board game led by a member of staff. People appeared to enjoy the general chatter and social feel during this period of the day.

The provider had identified that responding to people's social needs was an area where improvements could be made. The provider information return (PIR) set out the plans to improve this aspect of the service: "We will have a designated member of staff to organise a variety of activities within the home. Relatives will be encouraged and assisted to get together more often and have personal parties and enjoy our new garden."

People and their relatives said they would raise any concerns with the managers. Comments included: "I would make any complaints to the manager" and "I would tell [deputy manager] if I had a complaint, but if I have a problem I can tell anyone." This demonstrated they had confidence in reporting any concerns to them. There was information about how to make a complaint in the communal entrance hall together with our contact details should people wish to share their concerns with us. We asked one member of staff how they would respond if someone raised a concern with them. They told us, "I would inform the management."

We saw the provider recorded complaints but sometimes the details of the investigations were quite limited. The service had received four complaints in the 12 months prior to our visit. Whilst the outcome of each complaint had been recorded, complainants had not been responded to in writing. Therefore, we could not be sure they were satisfied with the actions that had been taken.

The provider also recorded compliments from people's relatives. Recent comments included, "We thank you for the love and dignity you gave [person] and all your support to the family" and, "Nothing was too much in making [person's] last few days comfortable and pain free."

Good

# Our findings

People and their relatives were happy with the service provided within the home. People openly complimented staff and spoke well of the home and the care received. One relative explained, "We chose this home because it looked clean and there were plenty of staff. As a family we made the decision and we are happy." Another relative said, "It's excellent here with the standard of care." A relative of a person who had recently died had refurbished the garden area and provided new tables and chairs. This was done as an acknowledgement of the level of care their family member had received at New Milton.

The management team consisted of the registered manager, who was also the provider, and the deputy manager. The registered manager and deputy manager were both a visible and known presence to staff, people and relatives. They both knew people well and had an in-depth understanding of people's medical and emotional needs.

People and their relatives spoke highly of the registered manager. One person told us "[Registered manager] is always here and I think it's well run and organised." People told us both the registered manager and deputy manager were accessible if they had any concerns. One relative told us, "I know the [registered] manager and we are on good terms and I can speak to them if I need to." Another relative said, "If we have issues we would talk to the deputy manager and they would sort it out."

People felt there was a good atmosphere in the home and that they were asked for their opinions about the service provided. One person told us, "They ask us at resident meetings if we are satisfied with the service." Another person told us they were not interested in attending the meetings because they liked to stay in bed. However, they told us the registered manager went to see them regularly and asked if they were happy with the care they received. They went on to say, "The manager comes in to see me, so if I had a problem I would tell them. If I want anything they sort it out, it's well run." Relatives were aware of 'relatives meetings' but one told us that because they had strong communication with the staff every time they visited the home, they did not feel the need to attend the meetings. Another said, "I feel we have got a good relationship with them here. We have an open relationship which we have built over the last year and it is getting stronger. I know it will continue to grow."

People were encouraged to share their views of the service through an annual quality assurance survey. The results of the survey had been analysed and in conclusion the provider had identified where improvements were required. "Overall the replies were favourable. To improve our service a review is required of the provision of social activities within the home and of our efforts in helping residents keep up with their

personal interests and hobbies."

Staff were happy working at the home and felt supported. They told us they received guidance and advice when they needed it. One staff member explained, "You can go to the managers and they will sort it out." Another said, "There is good support from the management and the staff. We can approach any of the managers and they are ready to do anything for us."

However, although staff told us they felt comfortable talking to the managers and discussing issues, they felt communication could be improved in the home. One staff member told us, "They (managers) can be a bit inconsistent with changes. I think we need better communication." Another said, "The deputy manager is approachable but communication could be better. We don't get staff meetings…We should have time to sit and sort out any issues." All staff mentioned the lack of team meetings with one stating, "We don't have routine meetings and I would like more." We shared this with the management team. They told us that they routinely talked to staff on an informal basis, but acknowledged that more formal meetings had not taken place recently. They assured us they would provide staff with an opportunity to share their views at a meeting as soon as possible.

The provider worked with other healthcare providers to ensure people received the best quality of care. This included nurse specialists, local palliative care services and district nurses. A visiting healthcare professional described good communication and team working with the staff at New Milton.

The provider's quality assurance system included regular checks of people's care plans, medication, the premises, equipment and environment. There were procedures to look at practice within the home to identify where improvements could be made to improve the experience of people and their relatives. For example, the deputy manager completed assessments of the care provided at end of life, to ensure people and their relatives received the best possible support at this time.

The provider assessed the environment to see where improvements could be made for the people who lived there. There was a monthly plan for refurbishment of the home and improvements had been to some of the bathrooms and bedrooms. The plan included further improvements to ensure the environment was suitable for the needs of the people who lived in the home.

The provider was aware of their responsibilities as a registered manager and had provided us with notifications about important events and incidents that occurred at the home. The deputy manager told us they had recently become aware that when Deprivation of Liberty Safeguard applications were approved, they were required to notify us. They told us they would complete the notifications as a matter of urgency. They had notified other relevant professionals about issues where appropriate, such as the local authority. They had completed the provider information return (PIR) which is required by law. We found the information reflected the service well. Our last inspection report was available in the entrance hall of the home which demonstrated the open culture of the service.