

Care UK Community Partnerships Ltd

Milner House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Milner House is a care home that is registered to provide nursing and residential care for a maximum of 76 people. The provider told us that the service no longer uses its capacity for double rooms and as such they would only accommodate a maximum of 46 people in single rooms. The provider is currently in the process of applying to reduce the maximum of number of people that the service can accommodate. There were 30 people living at Milner House at the time of our inspection, one of whom was in hospital and not available to speak with.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 previous registered manager had not been working in the service for a number of months and their registration has now been cancelled with us. The day to day management of the home was being undertaken by one of the operational support managers for Care UK who had been based at the service since February 2016.

We previously carried out an unannounced comprehensive inspection of this service on 8 and 9 February 2016. At that inspection we found a number of breaches of Regulations in respect of staffing, management, safeguarding, person centred care, nutrition and treating people with dignity and respect. As a result we issued six Requirement Actions for the service to improve. Following that inspection a number of further concerns were received about the way people had been treated by staff at Milner House. As a result we worked with the provider and our partner agencies to ensure people were safe. On 19 June 2016, we undertook a further focussed inspection to talk with people, their relatives and staff about the care people received. This inspection found that people felt happier at the service and that the provider had taken appropriate action to improve the service they received.

Since our comprehensive inspection in February 2016 we have continued to engage with the provider on a very regular basis. We asked the provider to submit regular action plans that updated us about the steps they had taken to improve the service. We also asked the provider to submit us copies of staffing information and provide assurances that safe staffing levels were maintained each week. This inspection confirmed that the provider had taken the action they told us they had. The service now had good systems in place for the monitoring and auditing of quality.

There has been a period of considerable change at Milner House this year. Whilst it was evident that the quality of care had significantly improved, the leadership of the home now needed to be embedded and sustained through the recruitment of a permanent management and staffing team. We identified that the provider lacked a clear vision about the type of service Milner House could provide moving forward. We have therefore recommended that the provider review the Statement of Purpose, taking into account the physical

environment of the service as well as the skills and experience of the staff employed.

The provider had maintained safe staffing levels through the provision of agency staff. Considerable efforts had been made by the management team to ensure wherever possible the same agency staff were used and they were appropriately inducted to the service. Through the use of pen portraits, life stories and summary documents information about how to effectively support people was made available to staff who were less familiar with their needs. Whilst this was helping to provide a more consistent level of support for people, the lack of a permanent team of staff was still impacting on them.

The service had not recruited any new staff since our last inspection, but the management team had taken steps to ensure that appropriate checks were in place for the agency staff supplied. There were now good systems in place to train and support staff. People and their advocates told us that staff were more competent and provided a better care and support.

People were safeguarded from the risk of harm, because staff now understood their roles and responsibilities and knew where to go if they had concerns. The management team had introduced good systems to appropriately assess and manage the risks to people.

People's legal rights were protected and staff ensured that they gained consent before delivering care. Where people lacked capacity to make decisions for themselves, there were processes in place to support people in line with their best interests and ensure care was provided in the least restrictive way.

Medicines were managed safely and the management team now worked in partnership with other healthcare professionals to ensure people's needs were met in a more holistic way. People told us that they now had better access to services such as opticians and dentists. Similarly, relatives highlighted that staff attention to the little things such as nail care and hair styles were now better.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet. Where people had specialist dietary needs, these were known and respected. Assistance at meal times was now provided in a personalised and dignified way.

People had positive relationships with the staff who supported them and were now treated with kindness and in a way that respected their privacy and dignity. People and their advocates were actively involved in making decisions and choices about their care. Both people and their relatives said they now felt confident about expressing their feelings. The management team took appropriate steps to ensure that any concerns or issues raised were listened to, treated seriously and resolved in a timely way.

People received person-centred support and there were now good systems in place to ensure people's needs were continuously reviewed with them and changes responded to. People had better opportunities to spend their time doing things that interested them and had access to a range of activities that were meaningful.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Staffing levels were sufficient, but the lack of permanent staff within the service meant that people's needs were not always met by staff who knew them well.

Appropriate checks were undertaken to ensure only suitable staff were employed.

Medicines were managed safely, but some people experienced a delay in receiving the medicines they were prescribed.

The service now had systems in place to appropriately assess and manage risks to people.

People were now protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in safeguarding them.

Is the service effective?

Requires Improvement ●

The high use of temporary staff provided challenges to the training and supervision of staff.

The design and layout of the service was not wholly suitable for people living with dementia.

There were appropriate systems in place to gain consent from people and care was now provided in a less restrictive way.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

Partnership with other healthcare professionals had improved. People were better supported to access the other healthcare services they required.

Is the service caring?

Good ●

The service was caring.

People now had positive and caring relationships with the staff who supported them.

People were involved in making decisions about their care and staff now understood the importance of respecting people's choices and individual preferences.

Staff now respected people's privacy and took appropriate steps to ensure their dignity was promoted.

Is the service responsive?

Good ●

The service was responsive.

People received person-centred support that was responsive to their needs.

People's personal routines were respected. People had opportunities to engage in activities and outings that were meaningful to them.

People and relatives were now confident about expressing their feelings. The management team ensured that when people raised issues that they were listened to and acted upon quickly.

Is the service well-led?

Requires Improvement ●

The service was not wholly well-led.

The service had recently experienced significant changes to the leadership of the home which needed to be embedded and sustained. The appointment of a new registered manager is crucial to this process.

Systems for monitoring quality and auditing the service had improved and were now being used to develop the service.

The culture within the service was much more positive and placed a much greater emphasis on listening to people's experiences and involving them and other interested parties in the future direction of the service.

Milner House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 20 September 2016. The inspection was unannounced. The inspection team consisted of two inspectors, one of whom was a pharmacist inspector and specialist advisor. Our specialist advisor provided an expert opinion about how people's nursing needs were being met.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We asked the provider to complete a Provider Information Return (PIR) before our inspection. 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 part of our inspection we spoke individually with eight people who lived at the service and met with others and observed their support in the communal areas. We also gained feedback from three visitors. We interviewed two care staff, two nursing staff, the operational support manager and regional clinical lead. We have received on-going feedback from other professionals involved in the service through our partnership safeguarding work with the service. We reviewed a variety of documents which included the care plans for six people. No new staff had been recruited since our last inspection, but we did review the records obtained in respect of the agency staff who worked in the service.

We reviewed seven medicines administration record (MAR) charts. We looked at three people's topical MARs. We saw staff giving some people their morning medicines on the first floor, and inspected the two treatment rooms and two medicines trolleys.

Is the service safe?

Our findings

Our last inspection identified that staffing levels were not sufficient to meet people's needs and a requirement action was set. The provider sent us an action plan which stated that staffing levels across the service had been reviewed and increased. We have continued to monitor the service's rotas on a weekly basis. At this inspection we found that staffing levels had been increased in line with the provider's action plan. The number of staff deployed was appropriate and therefore this requirement action had been met.

People told us that there were now sufficient staff to meet their needs. People said that their calls for help were responded to in a timely way and that they no longer spent long periods of time waiting for support. Due to the high number of agency staff in use in the service, some people made comments about the impact this had on them. For example, one person told us, "I miss the regularity of staff." They went on to tell us, "There is no problem with how my care is delivered, it's just that they don't know my preferred routines as well as regular staff do." A relative echoed the same view commenting, "There's definitely more staff, it's the regularity of staff that is the key issue now."

People were accommodated on the ground and first floors of the service, the top floor was closed off. We found that four care staff and one nurse were allocated to each floor. This was reflected on the rotas as usual staffing numbers. We observed that people were appropriately supported and call bells were answered promptly. Domestic, catering, management and activity staff were in addition to this number. Throughout the day we saw that people's needs were met in a safe and person centred way. Staff described the ratio of staff to people as "Good" and told us that they had sufficient time to do the work expected of them.

Appropriate checks were undertaken before staff began work. No new staff had been employed since we last checked recruitment records in February 2016. At that inspection we saw that criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and character references, job descriptions, evidence of up to date registration with the Nursing and Midwifery Council (NMC) and Home Office Indefinite Leave to Remain forms in staff files to show that staff were suitable to work in the service. A high number of temporary staff were being used to support Milner House. We found that the provider had systems in place to ensure that DBS, NMC and training checks were undertaken on all staff supplied by external agencies.

People told us their medicines were well managed, available for them and that they were happy with how staff looked after them. Suitable arrangements were in place for obtaining medicines at Milner House. People's medicines were ordered and received in a timely manner, so they were available when needed. One person told us that they required regular pain relief and that staff always offered this to them. Staff told us the system for the supply of medicines worked well. We observed that some people experienced a delay in receiving their medicines.

Qualified nurses were responsible for medicines at the home. They gave people their medicines as prescribed by the doctor, and we mostly observed good practice in medicines administration technique. However, during our inspection, we saw that medicines were not always given at the time they were prescribed. Some people did not receive their morning medicines until after 11am; this included certain medicines where timing was important to control people's symptoms. Agency staff who worked temporarily at the home did not always know the people they were looking after, which meant they could take longer to give people their medicines. It also meant they were not aware of which people were prescribed medicines needing to be given at particular times of day, and so did not always ensure these medicines were given at the correct times. Management staff at Milner House agreed to take steps to address this.

The provider had a detailed medicines policy in place and copies were available for staff. A local medication policy specific to Milner House was also available, which reflected local, current processes and practice. The policy at Milner House is that every person should be assumed to have the ability to self-medicate all or part of their medications unless it is assessed otherwise. However, no one was currently self-administering at the home, and we were shown that a self-administration assessment had only been completed for one resident. This meant that people may not in fact be able to administer medicines to themselves, even if they were willing and able to do so. We also noticed that a recent external audit of medicine management within the service had also highlighted that the service did not facilitate the self-administration of medicines. This was fed back to the management team to review.

Medicines were stored and transported around the home in locked medicines trolleys. These were kept within secure treatment rooms on each floor, which prevented unauthorised access to medicines. Staff recorded the temperatures of medicines storage areas, which we found to be within the appropriate temperature range. Items were stored in a fridge where necessary, and fridge temperatures were recorded daily and also found to be within the required temperature range. Suitable arrangements were in place for medicines which needed additional security. Records for these medicines were checked regularly, and showed staff looked after them safely. Waste medicines were separated for disposal and stored securely until they were collected. Records were kept of medicines that had been disposed of, or were waiting for disposal.

Medicines administration record (MAR) charts were in use at Milner House, to show which medicines people had received; staff recorded the medicines they had given and, if they had not given a regular medicine, the reason. The MAR charts we viewed had been appropriately completed. These included information needed to help staff give the right medicines to the right people, such as photographs and allergy information. We saw agency staff referencing these during the inspection.

We saw that monitoring was carried out when needed with some medicines, for example insulin, and that appropriate actions were taken in response to the results. We saw records for two people prescribed a medicine that required regular blood tests to check the correct dose. Staff kept the results of these tests with the people's medicines administration records, so staff were able to check they were giving the correct dose.

Several people had medicines prescribed to be used 'as required'. Information about why, when and how these medicines should be administered to the individual person must be available with the regular MAR chart. Protocols were in place to support staff to know when to offer and administer these medicines to residents at Milner House, in response to their individual needs. This included medicines for use when people's conditions deteriorated, such as seizures in people with epilepsy.

Some people were prescribed creams and ointments; these are referred to as 'topical medicines.' These were kept in people's bedrooms and applied by care staff when they provided personal care. Topical

medicines administration records (tMAR) were in use, to provide information on how to apply the creams and record when they had been applied. We looked at three tMARs, which had been signed to show people had regularly received their topical medicines as prescribed.

There were systems in place to minimise the risk of medicines errors. For example, reminder sheets were used to identify and prompt administration of early morning medicines, and daily 'countdowns' of remaining amount of tablets were performed to help avoid missed doses or running out of medicines. All incidents involving medicines are recorded at the home, and these are reviewed by management to identify actions to take to minimise the risk of repeat incidents.

Our last comprehensive inspection in February 2016 identified that people had been exposed to the risk of legionella. Immediately following that inspection, the provider informed us that urgent action had been taken to rectify the concerns raised. As a result the affected water tank had been removed and all water supplied throughout the service had been transferred to the mains system. At this inspection, we saw records which showed that this work had been completed as advised and that further Legionella testing had showed all outlets were now free from Legionella.

Individual risks to people were identified and managed. Each person had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation. These were accessible to staff and the necessary equipment to aid evacuation was readily available throughout the service. The management team had a good oversight over accidents and incidents within the service. Records contained information about how the incident occurred, witnesses to it and action taken and referrals made as a result of it.

Where people were at risk of pressure wounds they had been appropriately assessed and measures taken to prevent tissue damage. As such, these people had appropriate equipment in place including pressure relieving mattresses and cushions. Such equipment was well maintained and checked regularly. Those people that were nursed in bed had turning charts in place with minimum or two hourly during the day and four hourly at night as per the National Institute for Clinical Excellence (NICE) pressure ulcer prevention and management guidelines (2015). Daily records showed that staff completed a daily skin check which was monitored by the nurses. Both nurses and the clinical lead demonstrated a good understanding of what to do if any skin changes were noted and confidently advised us of the escalation process. For example, when asked what they would do if they noticed skin changes for a person, they told us, "I would ensure the resident is taken off the affected area and I would tell the manager' We would redo all our risk assessments and update the care plan' This would be handed over to anyone looking after the resident."

Risks associated with weight loss were now also better managed. Each person had been appropriately assessed to identify whether their weight was maintained within safe limits. Where people either had a low body mass index (BMI) or experienced a degree of weight loss, they were weighed weekly. All other people were weighed on a monthly basis. Food and fluid intake charts were maintained in accordance with people's care plans and nursing staff had oversight of these documents each day to ensure any issues were immediately identified and responded to. Records also showed that people with swallowing difficulties or weight loss had received speech and language intervention and dietician referrals. Staff spoken with were knowledgeable about the people who were risk of malnutrition and dehydration, the importance of maintaining accurate records and what to do if they had concerns.

People were now protected from the risk of abuse. People told us that they felt safer at Milner House because staff now treated them well. Staff were confident about their role in keeping people safe from avoidable harm. They also demonstrated that they knew what to do if they thought someone was at risk of

abuse. All staff had received on-going refresher training in safeguarding and knew what to do if they suspected abuse and we saw in meeting and handover records, that staff regularly talked about safeguarding. All staff confirmed that the management team operated an 'open door' policy and that they felt able to share any concerns they may have. Permanent staff made comments such as "I'm not worried now." Staff also expressed that they would report abuse to outside agencies such the local authority safeguarding team, the police or CQC if necessary.

Is the service effective?

Our findings

Our last inspection identified that staff had not received appropriate support and supervision to carry out their jobs effectively. A requirement action was set for the service to improve. The provider sent us an action plan which outlined the steps they intended to take to ensure staff were better supported. At this inspection we found that staff had access to a range of appropriate training opportunities and were continuously monitored and supported by the management team in order to develop their skills and improve their practices. This requirement action had therefore been met.

Since the last inspection, the management team had changed the way staff were supported across the service. As such, on a daily basis both the operational support manager and other management staff spent a significant proportion of their time coaching staff and monitoring their practices. People and relatives commented that staff seemed happier in their work and appeared to be, "Less stressed." People repeatedly told us that the new management team were much more supportive of staff and helped them with their work. This view was echoed by staff who told us that they "Couldn't fault the support they now received" from the management team.

There were systems in place to provide clinical supervision to nursing staff. Nursing staff told us that they had regular one to one clinical supervision with the regional clinical lead. Records from these sessions identified areas for development and the support required to meet identified goals. The provider also offered all registered nurses the opportunity to access the Nursing Times learning to support them with revalidation. This demonstrated the provider's commitment to ensuring their registered nurses were updated in their practice and supported them in remaining on the professional nurse register.

Care staff received support on a daily basis through working alongside the management team on a daily basis. Staff told us that whilst they may not have received formal one-to-one supervision yet, they felt well supported by the operational support manager and received lots of guidance and coaching on their roles. One staff member told us, "I feel much more supported and definitely able to raise concerns if I have them and be supported." They went on to tell us, "If I have any problems I can go to the managers. They have been very supportive." The provider identified in their PIR that the re-introduction of formal supervision and appraisals for all staff was an area of development and the management team showed us evidence of the plans in place for these.

Staff were now better trained to meet people's needs. Relatives described staff as being "More competent" and "A lot more professional." Permanently employed staff told us that they now had good access to training and felt they had the necessary skills to meet people's needs. Whilst the provider had offered the same training opportunities to both permanent and agency staff, the latter group had not always accepted the training made available to them. As such, the skills and experience of staff as a whole was varied.

All permanently employed staff had completed core training in areas such as moving and handling, safeguarding, mental capacity, first aid and various health and safety topics. As part of the provider's action plan, staff had also been required to attend specialist training in relation to supporting people with

dementia and diabetes. A new 14-week induction e-learning programme incorporating pressure ulcer prevention and wound care had also been introduced and which staff were required to complete. Bespoke training with the local tissue viability nurse had also been completed.

No new staff had been recruited since our last inspection. The operational support manager informed us however that any new staff would now have to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care.

The design and layout of the service was not wholly suitable for people living with dementia. Whilst the provider had taken steps to improve the skills of staff in supporting people living with dementia, the physical environment presented challenges to effectively supporting people with such needs. For example, the narrow corridors and layout of the service made it difficult to protect people's dignity if they became anxious, confused or distressed. During the inspection we observed one person in a heightened state of emotion. Whilst staff were appropriate in their response, the situation was difficult both for the person and others who witnessed it. In terms of decoration and furnishings, there was little indication that Milner House was a dementia friendly service. The environment had not been adapted to aid orientation for a person living with dementia.

The service currently provides service to people with a wide range of needs, not all of them compatible with one another. With so many vacancies, the operational support manager advised that there were on-going discussions about what support they should offer in the future.

We recommend that the provider review the stated purpose of Milner House, considering both the physical environment and the skill mix of staff.

People's legal rights to consent were upheld. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The operational support manager had made DoLS applications for people when needed and a number had been authorised. As part of this process mental capacity assessments had been completed and best interest meetings held and recorded. These had been arranged and completed by the authority responsible for authorising the DoLS applications.

We checked whether the service was working within the principles of the MCA. Staff had recently accessed training in this area and demonstrated a good understanding of the MCA. Staff talked to us about the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We observed that people were now better involved in their care and that staff routinely asked for their consent before supporting them. We found that where people were deprived of their liberty, staff took ongoing action to provide care in the least restrictive way.

People had enough to eat and drink throughout the day. People were complimentary of the food provided and told us that the chef regularly consulted with them about the food prepared. Relatives were also positive about the meals, which they described as being "Really good." One told us that they regularly joined their family member at mealtimes. Another relative commented that after a period of losing weight, their

family member had recently "Gained weight and was enjoying their food again."

People were offered choice at every meal. For example, at breakfast we saw people eating a range of different options including cereals, toast and full cooked breakfast. At lunchtime, people had a choice of two main meal options and we saw that both were offered to each person. People told us that they could choose when and where to take their meals and we saw these choices being respected.

People's likes and dislikes as well as information on whether they had specific needs were also recorded. This enabled the home to provide people with food they liked and for those who could not tell them verbally what they wanted, with food they were known to enjoy. Staff were aware which people were at risk of dehydration or weight loss and were proactive in the monitoring of people's food and fluid intakes. The chef was fully aware of people's needs and described how they had been experimenting with ways to create the best flavours and textures to improve meals for people with swallowing difficulties.

People who required assistance to eat and drink were supported effectively. One relative was keen to highlight the really good way they had seen their family member being supported with their food and drink. We also noticed that staff spent time with people at mealtimes, encouraging and helping them to enjoy their food.

In comparison to our previous comprehensive inspection we observed that mealtimes were relaxed and social occasions. The management team emphasised their expectation that people enjoyed a positive dining experience. As a result, all staff across the service were required to stop their usual routines and support people at mealtimes. This not only provided a greater level of support to people, but also provided a greater sense of engagement across the service.

Partnership with other healthcare professionals had improved. People were supported to access the other healthcare services they required. Our previous inspection identified that people had not always had regular access to other professionals such as dentists and opticians. At this inspection we found that a system had been introduced to ensure routine check-ups occurred regularly. People spoken with talked about recent appointments with these healthcare professionals. For example, one person told us, "The staff arranged for me to see an optician a couple of weeks ago and before that I saw the dentist." The operational support manager had worked hard to re-establish links with other local health care services such as the district nursing team, physiotherapists and speech and language therapists.

Is the service caring?

Our findings

Our last inspection identified that some staff did not treat people with dignity and respect. A requirement action was set for the service to improve. The provider sent us an action plan which outlined the steps they intended to take to ensure people were better cared for. Our focussed inspection in June 2016, identified improvements in this area and that progress was on-going. At this inspection we found that staff had a much more compassionate attitude towards people and provided support in a caring and sensitive way. This requirement action had therefore been met.

People told us that staff now treated them well and praised the staff that supported them. For example, one person said, "All the staff treat me very well." Similarly, another person told us that, "Staff are always respectful to me and speak nicely to me." Relatives also commented that they felt the way their family members were treated was much better. For example, one relative told us, ""There has been much more effort made to ensure staff know people's needs and care is now provided in a less task based way." Another relative commented that the "Interaction between staff and people has really improved." We observed that people received care in a sensitive and unhurried way.

People had much more positive relationships with the staff who supported them. We saw that staff spent time engaging with people in a meaningful way and interacting with them in a way that was endearing. For example, at lunchtime we noticed that one person fell asleep at the table. A staff member went over to them and gently roused them and supported them to continue with their meal. Once the person had re-engaged with what they were doing, the staff member slowly withdrew their support, enabling the person to continue independently. The person looked up at the staff member and smiled in thanks for what they had done.

Throughout the inspection the home was calm and staff took their lead from people. For example, we overheard one person say that they thought the music in one of the lounges was a bit loud and a staff member immediately turned it down. Staff spoke very calmly and patiently to people and staffs movements were not startling or rushed. All of this helped create a much more relaxed atmosphere and it was apparent that this benefited the people who lived at the home. When people did appear to be anxious staff reacted calmly and sensitively and thereby reducing anxiety levels before incidents of occurred.

The regional operational manager demonstrated an excellent understanding of each of the resident's holistic needs. During her time with us, she was able to talk about backgrounds and preferences of each person. It was evident that people and relatives had a great relationship with her and that staff viewed her as a good role model for their own behaviour and attitudes towards people.

Staff had spent time getting to know people, their histories and their interests. Since our last inspection, life stories had been introduced which we saw had really helped staff see the person behind their needs. Not only did this information help staff provide a more personal level of support, but it also enabled people and their families to be engaged in planning their care. Our conversations with people also identified that they had been encouraged to personalise their room.

People's privacy was respected. Unlike at our last comprehensive inspection, we observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. When people required personal support we saw that this was provided discreetly and in a way that upheld people's dignity.

People's wishes for the end of their life had been discussed with them and recorded where people felt ready to talk about this. Some people had Do Not Resuscitate orders in place following appropriate discussions with them or their representatives. One person told us that they had been given the opportunity to discuss their wishes privately with the doctor. The person's care records reflected the decisions they had made. This meant people's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice.

Is the service responsive?

Our findings

Our last inspection identified that people did not receive person-centred care that met their needs. A requirement action was set for the service to improve. The provider sent us an action plan which outlined the steps they intended to take to ensure people received a more personalised service. At this inspection we found that significant improvements to the way support was provided had been made and people now had opportunities to engage in more meaningful activities. This requirement action had therefore been met.

People's care and support was now planned in partnership with them. The management team had worked hard and alongside the local authority to undertake a complete review of each person's needs. The operational support manager had introduced a 'Resident of the day' system to ensure that care plans were written with people and their advocates. We saw that this process had now been embedded and as such care reviews were personal and meaningful.

People told us that they felt involved in making decisions about their care. Relatives echoed that they too had been involved in the care planning process. Relatives also highlighted that staff were now much more responsive to their family member's needs. For example, one relative said, "There has been a big improvement in the attention to detail, like keeping mum's finger nails nice." Another relative was also keen to highlight that "There is much greater effort with interaction now; staff really do seem to be talking with people about what's going on for them."

Each person had a plan of care that outlined their individual needs and preferences. Key information about people's daily routines was also discreetly available in people's room to help ensure that temporary staff also delivered consistent and appropriate care. Through the development of Life Story books and Pen Portraits across the service, even staff who had never supported a person before had easy access to information that could enable them to deliver personalised support.

Care records looked holistically at people and detailed how their physical, social and emotional needs were to be met. Staff maintained daily records about people's care, including how they were. We saw that support was responsive to people's changing needs and staff recognised how to adjust the care provided dependent on how the person was feeling. For example, by encouraging people to eat independently, but being there to support them if they were struggling.

The management of risks to people's health such as malnutrition, falls or wound care were well documented and continuously reviewed. Staff understood the risks associated with the people they supported. For example, one person had a wound and staff were confident about the care required to manage this effectively. We saw that appropriate steps had been taken to keep this person comfortable and that staff regularly supported the person to reposition in order to relieve the pressure on the wound.

People had opportunities to engage in activities and outings that were meaningful to them. It was evident that the management and staff team had spent a lot of time researching and talking with people about how they would like to spend their time. As a result, both in-house activities and trips out had been arranged in

direct response to the feedback gathered from people and their advocates. One person told us, "We had a really good day trip to Littlehampton that we all really enjoyed." Another person had written an article sharing how much they had enjoyed recent trips out. Relatives were also keen to highlight how much the activities had positively impacted on their family members. For example, one relative told us, ""Dad has really appreciated the increased activities, especially the outings."

People benefitted from activities being coordinated by a staff member who was passionate about meeting their social and emotional needs. The management team had recognised this quality in the staff member and had supported them to develop their skills in this area. The staff member told us, "I have been on training and visited other services to see how activities are run." As a result, a monthly activities plan had been introduced to Milner House which included a wide range of opportunities for people to spend time doing things they enjoy.

The activities available were personal to people. For example, staff talked to us about how during a weekly pet therapy session, a person who rarely spoke was seen interacting with a rabbit. As such, the management team had gone on to purchase house rabbits for the service. Throughout the day, we saw that people engaged with the pets and one person told us, "I really like the rabbits; I like to sit and watch them." We saw that people's birthdays were celebrated in accordance with how the person chose. For example, one person told us "They make as much or as little fuss as you want when it's your birthday, they talk to you and you decide how you want to celebrate."

People, relatives and staff felt better valued because their views were now listened to and any issues raised were handled in an open, transparent and honest way. People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated. The complaints procedure was readily available and people and relatives told us that they felt comfortable to raise any issues with the operational support manager.

All complaints were now well documented with records about the action taken in response. These records demonstrated that complaints had been acknowledged, taken seriously and investigated with people receiving a written response.

Is the service well-led?

Our findings

Our last inspection identified that the service lacked leadership and good governance. A requirement action was set for the service to improve. The provider sent us an action plan which outlined the steps they intended to take to ensure they had effective systems in place to assess, monitor and improve the service. At this inspection we found that the management team, led by the operational support manager had provided strong leadership for the service which focussed on a continual drive for improvement. This requirement action had therefore been met.

People repeatedly told us that things were, "Much better" at Milner House. The feedback we received from people, relatives and staff was that the operational support manager had been effective in taking forward the level of change required in the service and in particular securing a more open and positive culture. One relative told us, "There is a better atmosphere in the home. More positive." Another relative commented that the changes had been really beneficial for their family member who, "Seems much more settled now."

Staff consistently praised the current management arrangements and said that they felt motivated and empowered by the operational support manager. One staff member told us, "I feel really supported now and I don't come to work worried anymore." Team spirit amongst staff was evident and unlike at our last comprehensive inspection, staff were working positively together as a team. Staff told us that they now looked forward to coming to work and it was clear that staff enthusiasm had also improved the morale of people who lived at Milner House. For example, we noticed that people, who had previously presented as withdrawn and disengaged, were now actively interacting with staff and visitors in a really positive way.

The biggest concern for people, visitors and staff alike was the long term plans for the management of the service. With the registered manager position now vacant, the provider has confirmed that they will be recruiting to this position and that there will be a comprehensive induction and transition period before the operational support manager withdraws from the management team. Naturally, this period is unsettling for all concerned and Milner House requires a period of stability for the cultural changes to be embedded and sustained.

People were benefitting from a more open culture. Reflective practice was being used to encourage staff to think about their actions and how their practices could further improve care. For example, we saw that where there had been incidents, such as pressure wounds, a Root Cause Analysis (RCA) had been conducted in which the team involved reflected on how the wound might have been caused and discussed future preventative measures. This way of working contributed to collective learning and responsibility.

Communication of information across the service had improved. We saw that there was a clear management and staffing structure across the service, with staff individually and collectively understanding their roles and responsibilities. Staff reported that effective handovers took place on every shift changeover which allowed information and issues to be shared and taken forward. All staff, including agency staff described communication and team work as being "Very good."

The new management team had introduced better systems to monitor the quality of the services provided. Following our last comprehensive inspection, the operational support manager had devised a detailed action plan which was continuously updated. The action plan covered all the previously identified breaches, in addition to other self-identified areas for improvement. By working systematically against the action plan, significant improvements across all areas of service provision had been made. Alongside the action plan, a range of detailed audits had been undertaken to monitor progress. For example, monthly medicine audits and weekly medicine checks were completed. Action plans to address any identified issues were included in the audit reports. We saw how learning from audits had changed practice and improved care provision at the service. This included the formal allocation of tMARs to care staff as part of the shift handover had led to improved recording of application of people's regular topical medicines.

People and relatives told us that they felt better engaged with and that their views were now being listened to. In the past they had not always seen changes made as a result of their feedback. Regular residents and relatives meetings were now held and had been successful in building a sense of partnership in the way the service was delivered. We saw in the minutes of these meetings that the management team had kept people informed about what was going on at Milner House and consulted with them at every stage about the future direction of the service. As a result of these meetings and the on-going one-to-one engagement with people and their advocates, they had been able to directly influence areas such as activities, outings, menu planning and refurbishment of the service.

Incident and accident reports were completed as necessary and the management team appropriately reported all notifiable incidents to the CQC in accordance with the Health and Social Care Act and without delay.