Barchester Healthcare Homes Limited

Milford 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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Milford House is registered to provide accommodation, nursing or personal care for up to 80 people. On the day of the inspection there were 67 people living at the service. The registered manager informed us they consider the home to be full with 72 people and five rooms were currently closed to admissions due to building works and refurbishments.

The service provides care for people with dementia, learning disabilities, autistic spectrum disorder and older people.

Milford House consists of two floors with access to the upper floor by a lift or stairs. There are some shared bathrooms, other shower facilities and toilets. Communal areas include lounges on both floors, other smaller seating areas, two dining rooms and gardens to the outside.

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

The inspection took place on 19th and 20th July 2016 and was unannounced.

Most people and their relatives told us they felt safe when receiving care. Staff were able to tell us about people's needs and how to care for them however, it was difficult to locate staff when people sought and required assistance. Safe recruitment practices were followed before new staff members started working at the home. People and their relatives were positive about the care they received and said staff had sufficient knowledge to provide support and keep them safe.

Administration and medicines management systems required improvement in order to fully protect people. For example, some medicines were not stored in line with storage requirements and medicines were left unattended during medicines rounds which meant they were not being managed in line with current regulations.

People's risk assessments had been made and recorded in people's care records however; guidance provided in people's care plans in line with the risk was not always available.

Arrangements were in place for keeping the home clean and help reduce the risk and spread of infection. People's rooms and sanitary ware in bath and shower rooms was kept clean however, some areas of the home had not been cleaned and required attention.

Staff received regular training in relation to their role and the people they supported. Staff received regular supervisions and an appraisal where they could discuss personal development plans. This meant staff

received the appropriate support to enable them to provide care to people who used the service.

People were not always supported to have enough to eat and drink. Food and fluid charts were not always used where required or completed in order to determine whether people had received sufficient diet and fluids. Support was not always given where people required support with their meals or to drink. The weather was very hot during the two days of our inspection and not all people were offered additional fluids in response to this to help keep them hydrated.

People and their relatives told us they had access to health services and there was a GP performed weekly visits to the home with additional visits according to any changing healthcare requirements.

Most people were treated in a kind and caring way and staff were friendly, polite and respectful when providing care and support to people however, this was not consistent throughout the inspection.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The registered manager and staff had a good understanding of supporting people to make decisions and choices.

Staff understood the needs of the people they were providing care for. Care plans were individualised and contained information on people's preferred routines, likes, dislikes and medical histories.

Quality assurance systems were in place but trends were not always identified. However, when trends had been identified, they had not always been investigated effectively.

People, their relatives and staff were encouraged to share their views on the quality of the service they received.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

At times people were left without assistance due to their being no staff available. However the duty rota's reflected the staffing numbers as determined by the services staffing dependency tool.

Medicines were not always managed in line with current regulations.

Risk assessments were in place but the necessary guidance to mitigate those risks was not always available.

Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to have sufficient diet and fluids and people were not offered or supported to have additional fluids during hot weather.

Staff did not receive sufficient information and guidance during shift handover to inform them how to care for people's changing needs.

People who needed support with making decisions were assessed to ensure their best interests were protected in a lawful way.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect.

Most staff were caring in their approach and had a good understanding of people's needs and how best to support them however, this was not consistently observed throughout the

inspection.

People spoke positively about staff and the support they received.

Is the service responsive?

Good

The service was responsive.

People's care plans were provided information on their preferences likes and dislikes and were person centred.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously.

People were supported to follow their interests and take part in social activities although people who chose to remain in their room or were nursed in bed were not provided the same degree of support and were at risk from social isolation.

Is the service well-led?

Requires Improvement

The service was not always well led.

Actions in response to quality audits were not always implemented.

Staff said management were approachable, they felt supported and that there was an open door culture.

Staff said they felt valued and supported by the management team and enjoyed working at the home.

The registered manager interacted positively with people who lived at the home and knew them well.

Milford House

Detailed findings

Background to this inspection

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

We carried out this inspection over two days on the 19th and 20th July 2016. The first day of the inspection was unannounced. Two inspectors, two experts by experience and a specialist advisor carried out this inspection on day one and on the second day; one of the inspectors and the same specialist advisor. The specialist advisor was trained in the care and nursing older people, people with dementia and also in end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the last inspection in February 2014 we found the provider met with the legal requirements in the areas that we looked at.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the 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 used a number of different methods to help us understand the experiences of people who use the service. This included talking with 17 people who use the service and five visiting relatives about their views on the quality of care and support being provided. During the two days of our inspection we observed interactions between people using the service and the staff. We looked around the premises and observed care practices.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included the care records of 11 people, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents.

We spoke with the registered manager, nine care staff, the activities coordinator, one member of the housekeeping staff, one member of the maintenance staff, one member of staff from the catering department and one volunteer.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us they felt safe when receiving care and told us they were encouraged to raise issues with staff and the manager. However, during the inspection it was difficult to locate staff when people sought and required assistance and there were occasions when people asked for assistance and it was not possible to locate staff to assist them. For example, although staff responded to some call bells promptly on one occasion it took 19 minutes for a call bell to be answered. When we asked staff why there had been a delay in answering this request for help, they said they had assumed this person had only wanted their plate cleared. The person had called to request a drink which was given however, there had been no indication this person had not fallen or was at risk when they had called for help to cause staff to respond in this way.

Throughout the inspection, people asked us for help as we walked past, it was very difficult to locate staff to support them. On one occasion, we heard a person was coughing and required re-positioning as they were on their back with their head tilted back. We were able to locate one member of staff but they were unable to re-position this person on their own. They said there was no other staff available to help them at this time. We asked this member of staff how many staff were currently working on the floor with them. They told us they were on their own as all the other staff had gone on their break. We asked if the nurse in charge could help them but the care staff was unable to locate them despite calling them on the internal radio. When there was no response to this call, the care staff said they thought the nurse in charge may be on their break too. We asked the care staff whether the nurse in charge usually informed them when they go for their break to which the care staff replied "I usually do get told but I was probably on my break when they left for theirs so I wouldn't really know". After the care staff tried to make contact with the nurse in charge a second time, it took five minutes for them to respond. This meant there was an increased risk that staff would not be available to promptly deal with an emergency situation where people may require urgent care or treatment.

People told us they had concerns about the availability of staff which had a negative effect on their care. When we asked one person what they would do if they were worried about anything they told us "I don't want to bother them (staff) as they are busy". Some people said staff were busy and although able to meet basic care, felt they had no real time to spend with them because of their workload. One person told us "Carers never have any time. They have more than they can do but it's not their fault" and another told us "Staff are around but always very busy". Another person told us "The carers are very nice. The night care is not as good as they are short staff sometimes". .

We raised these concerns about staff availability with the registered manager. They said they believed there was enough staff on duty to meet people's needs. They said "In fact we are generally over staffed". Some of our observations during the inspection did not reflect this.

Some people told us they were unable to call for help as their call bell was out of reach. One person was in bed and their call bell was on the television unit. When we passed this to them they struggled to press the button. Another person told us they were unable to press their call bell. When we looked at their care records; it stated they were able to do this. One person wore a call button around their neck as a pendant.

They told us it was too heavy and hard for them to press. One person called out "help me please, help me" and was quite agitated. Their call bell and spectacles were on the floor. When we pressed the call bell to raise assistance, staff came quickly to offer assistance. They offered reassurance and offered help as appropriate. One person told us "Staff are very good but they do get very tired. There is not enough time for them to do what they want to do". One staff member told us they could do with more staff but this was not allowed due to the provider's policy on allocation of staff.

These findings were a breach of Regulation 18(1): Staffing of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to report safeguarding concerns. One staff member told us "Staff really try to do a good job. I would raise a concern without hesitation, there's a range of staff to go to, it doesn't matter as long as you report it". Another staff member told us "I would report any concerns and tell staff if someone appeared to be different than usual".

The registered manager was in the process of recruiting a new deputy manager as they previous deputy manager had recently left. Safe recruitment practices were followed before new staff members started working at the home. Checks were made to ensure staff were of good character and suitable for the role. People who use the service and their relatives were positive about the care they received and said staff had sufficient knowledge to provide support and keep them safe.

Although people's risk assessments were completed, up to date sufficient guidance in response to some of these risks was not always provided. We looked at care records which did not provide sufficient guidance following assessments which identified that people were at risk. For example where people had sustained skin damage due to pressure and/or injuries, we noted there was inconsistent information recorded on body maps and wound assessment forms. In addition photographs relating to wounds were not always available, were of poor quality or not labelled which made it difficult to see what they related to. For example, one person had a break in their skin which had been photographed and filed in their care records. However, there was no follow-up information about this in their skin integrity care plan. We asked the manager and staff to see whether they were able to locate this information which they were unable to do. This meant this information was not useful to aid the assessment in any deterioration or healing of a wound. Another example of this was where people required emotional or behavioural support. For example, in one person's care plan it stated they were not always compliant due to having dementia and pain. However, there was no description of what 'compliant' meant and there was no guidance about how staff should support the person in these circumstances. When we spoke to staff about how they supported people who exhibited behaviours which may challenge, they were able to tell us how they do this. However, people's care records did not demonstrate how best to provide care and support for people who may be distressed.

Where care records did provide guidance on how to address identified risks, this guidance was followed. For example, in response to one person's risk assessment, guidance had been written to manage their weight loss and there was evidence from their care records this had been followed. In response to this, their weight had been monitored until the risk decreased and new guidance had been written in response to this.

The monitoring of incidents was not managed effectively. For example, during a medicines audit, it had been identified there were unexplained gaps on the Medicines Administration Records (MAR) where a few entries had not been dated. In addition, the audit noted that not all topical creams had been recorded on the corresponding topical creams chart to indicate they had been applied as directed. The provider's medicines policy regarding management of medicines errors stated errors should be documented on an accident/incident form and forwarded for investigation at local level. As there was lack of appropriate

recording of these errors, there was a risk that any recurrent trends may not be identified and the opportunity for learning from these events was lost.

Medicines were not always managed safely. For example, on four separate occasions, we saw medicines unattended which meant there was a risk these may be removed and/or taken in error. During a medicines round where an agency member of staff was administering medicines, we found as we were passing, the medicines trolley had been left unattended. The door to the trolley was open and anyone passing by could have had access to the contents. We approached the agency staff about this however, when we passed the medicines trolley a second time, although the door to the trolley was closed, it was not locked. On another occasion, during a separate medicines round this time carried out by a regular member of staff, we passed the medicines trolley to find this unattended with medicines in a pot at the top of the trolley. We approached the member of staff about this who said they had been assisting someone to take their medicines and they were not far away. However, as they were assisting someone else at the time, it would not have been possible for them to ensure these medicines were secure at all times. A thickener powder had been prescribed for one person who had difficulty swallowing. This thickener had been left on the top of their bedside cabinet with the lid not secured. Thickener powders are to be used as directed and if these directions are not followed i.e. the wrong quantity used, or is taken incorrectly, there is a risk of choking. As this thickener had not been stored securely, there was the risk this may be taken by someone who is not aware of the potential risks.

Topical creams were not always dated upon opening and therefore it was not clear when these medicines were due for disposal according to local labelling. Where dates of opening other medicines had been recorded there was no guidance available to state how long they could be used for and when the member of staff was asked they were unable to tell us this.

During review and discussion of the MAR following a medicines round, it was identified that a medicine was being crushed for a person who was having difficulty swallowing. This was not in line with current medicines administration guidelines or with the home's policy which state input should be sought from a pharmacist when any medicines are crushed to determine whether this is safe practice. As this guidance had not been sought from a pharmacist there was a risk that the effectiveness of this medicine may have been altered by giving it in this way.

Medicines were not always stored safely. The temperature of medicines which required storage at no more than 25 degrees were being stored in an area which exceeded this. The temperature recorded was 27 degrees. When we asked how long these medicines had been stored at this temperature, a staff member told us this had been noted yesterday and they had reported it to the maintenance manager who had said it was due to an issue with the air conditioning. There had been no advice sought from a pharmacist to determine whether these medicines were being affected by this rise in temperature and no medicines had been moved to an alternative place of storage. This meant there was a risk that people's medicines could be less effective or act in a different way as a result of not being stored as required. We informed the staff member to seek further advice on this.

These findings were a breach of Regulation 12(2)(g) Safe care and treatment of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Although medicines were not always managed appropriately, during the medicines round, staff explained to people what medicines they were taking and completed the MAR according to the completion requirements. If people refused medicines a code was correctly indicated on the MAR with the reason for

these being refused.

Although cleaning schedules were in place and people's rooms and most communal areas were clean and tidy there were areas of the home that had not been cleaned and required attention. For example, the light pull chords to a downstairs shower room and upstairs toilet were stained brown and a small balcony leading from a communal lounge on the first floor was covered in bird excrement. Some of the call bell buttons given to people to call for assistance were dirty and required cleaning. A food trolley with waste food on plates and half empty jugs of gravy and custard were left outside a kitchen area for up to two hours creating an unpleasant smell on what was a very hot afternoon and a strong smell of sour milk was noticeable in the kitchen area. There was also debris on the wheels of the same trolley and part of a seal joining the floor to the wall in the kitchen area was torn creating a risk of debris gathering a due to it not being possible to wipe clean. The two sluice areas, had coded entry and only staff were able to access these areas however, they were very untidy with full clinical waste bags on the floor and empty medicine bottles on the floor and shelves. During a recent quality assurance visit, areas of the home were highlighted as requiring cleaning. However, despite the action plan stating monthly deep cleaning should be implemented this did not appear to have been carried out in these areas of the home. Despite this, cleaning schedules were in place and people's rooms and sanitary ware in bath and shower rooms was clean. Staff were provided with sufficient personal protective equipment (including gloves and aprons) which we saw being used as appropriate during the inspection.

Requires Improvement

Is the service effective?

Our findings

Staff were not always given up to date or detailed information regarding people's care needs. For example, during a staff handover meeting, although some information was given regarding changes in people's health and in the care they required, other information was not concise or detailed. During the handover staff were told one person was "feeling down" however, no guidance was given to staff on the signs that led them to think this was the case, what they could do about this and how to monitor this person. Staff were also told about another person who was "sleepy and not as interactive as usual" but no guidance was given to staff on how to monitor their condition, whether a doctor had been informed or whether any assessments had been done or planned to investigate and monitor this further. As it was a hot day, some people required additional support to meet their hydration needs. However, the only mention of this during the staff handover was that a few people were "hot" but no advice was given to staff on ensuring people had additional fluids. This meant people were not being supported or assessed in order for staff to adequately meet their needs and were at risk of dehydration.

On the second day of the inspection, we observed a nurse spend a considerable amount of time explaining routines and details about people's specific needs to an agency nurse who had not previously worked at the service. The registered manager told us staff were deployed to care for the same people where possible to ensure consistency of care and said there was good communication between the nursing staff who shared up to date care issues and changes in people's health at the start of each day.

People who remained in their rooms were not always supported to meet their nutritional and hydration needs and where people were on fluid charts or required closer monitoring of their fluid intake, these had either not been fully completed or were not in place. For example, although staff were able to tell us how to support people during hot weather and some people sitting in communal areas and participating in activities were offered ice lollies and drinks, other people who were in bed or in their rooms had drinks out of reach and were not supported to have additional fluids in response to a spell of hot weather. One relative we spoke with told us "(X relative) was so thirsty today; when I came in she drank three beakers of juice". One person who was being nursed in bed had a jug of water which was three quarters full and was on their bedside cabinet out of their reach. No drink had been poured for them. When we asked them at 11am when they had last had a drink they told us they had not yet had a drink that day. When we saw them an hour later, the jug was at the same level and no drink had been poured for them. When we looked at the nutritional risk assessment for this person it stated they were at high risk of malnutrition as their intake was low. On day one of the inspection, there was nothing in place to monitor their fluid intake. We raised this with the registered manager at the end of day one. When we visited on day two we saw the nutrition and hydration plan had been re-written and a fluid monitoring chart had been commenced. Another person was semi reclined in bed. They had a meal on their table but despite efforts to try to pick up the food from their plate due to their position in bed they could not see the food clearly and had difficulty reaching it. They also had no drink with their meal. The care records for another person indicated they had lost almost 11kg of weight in the last six months. The nutrition and hydration care plan for this person stated this was due to a loss of appetite which it said, could be due to several medical reasons. The records also stated they had lost up to 8kg in one month alone. When we asked a staff member about this they told us they did not know the

cause of this person's weight loss but would put a note in the diary for their weight to be taken again and a referral made to their GP. No referral for appropriate assessment had been arranged which meant this person's nutritional needs had not been met. Minutes from a recent staff meeting addressed concerns regarding the accurate completion of food and fluid charts. The guidance in the home's policies and procedures on what to do in the event of a heatwave were not followed. These stated individual protocols of care should be written in order to monitor and provide additional care and support for people and that people's fluid intake should be closely monitored. There was no evidence during the inspection that this guidance had been followed and meant there was a risk people could become dehydrated.

This was a breach of Regulation 12(2)(a) Safe care and treatment.

Staff told us they received sufficient training to enable them to support people's needs. One staff member told us about when they first started working at the service. They said they had a good induction where they were given training which included manual handling, food hygiene, dementia care, safeguarding and health and safety. They also told us they had shadowed experienced members of staff prior to working under supervision before working independently and continued to receive ongoing support following this. Staff said they were able to agree when they were confident to work on their own following a period of shadowing then working under supervision. Staff records also confirmed this and we saw documentation of staff supervisions and mandatory training that staff had completed including safeguarding, moving and handling, first aid and fire safety.

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 legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff acted in accordance with the requirements of the Mental Capacity Act 2005. Where people did not have the capacity to make decisions themselves, mental capacity assessments were in place and records showed that decisions been made in line with the person's best interests. Where required, Deprivation of Liberty Safeguarding applications had been submitted to the appropriate authority by the registered manager. Staff we spoke with were able to explain what the Act meant to people they provided care for. They were all able to describe the importance of DoLS and what their responsibilities were in this respect and said they gave people the opportunity to express their wishes and encouraged them to make choices.

People told us they liked the food. A varied menu was available and people's individual preferences were catered for. The chef was knowledgeable about people's individual dietary requirements and offered people alternatives if required depending on choice. Comments from people about the food included "The food is good here. It is hot and tasty and I have meals that I would do for myself" and "The food is very good, no complaints whatsoever. There is a choice of meals. The menu is brought round and I get to choose what I would like each day". There were drinks available to people in the communal areas with a drinks dispenser also available in the dining room for people to help themselves should they wish to do so.

People's care plans demonstrated that a wide range of external professionals were providing services to people on a routine and regular basis and the majority of people had access to these services as they needed them.

Requires Improvement

Is the service caring?

Our findings

During the inspection, we saw examples of good care and staff treated people as individuals. However this was not consistent throughout the inspection. Most staff were respectful and caring towards people and seemed to know them well, treating them as individuals. Staff generally showed an interest in people and asked their opinions about events in the news and other topical issues.

People told us staff were caring. One person told us "The staff treat me with respect. They are always kind" and one person's relative told us "This is a marvellous place. The staff never complain about anything and are never inpatient".

The care given did not always fulfil people's requirements. For example, some people had not been supported with their oral hygiene. When we asked the registered manager about one person with a low fluid intake and whose mouth was dry and their teeth and gums smeared with plaque whether they were receiving additional oral care to refresh their mouth, they told us although they were given support for their oral care additional care was not currently being offered. They agreed this should be implemented and on the second day of the inspection, additional oral care had been planned for this person. Another person's relative told us "The cleaning of dentures is poor. They asked me to bring in denture cleaner but often they haven't used it and the teeth have not been put in and still on the table".

The privacy and dignity of most people was respected. Staff knocked on their door before entering their room and closed it before carrying our personal care. When staff entered their room they asked permission from the person before undertaking any tasks such as cleaning or providing any care or support. However, there were occasions during the inspection when people's privacy and dignity was not respected and the care provided did not always meet people's needs. During a lunchtime observation there were times when people were not being supported in a dignified way. For example, a member of staff who was supporting a person with their meal did not interact with them and on one occasion, placed food into their mouth before they had finished the previous mouthful. At lunchtime people who were being taken to the dining area in wheelchairs by members of staff, were not always given a choice of where they would like to sit. In one of the corridors, boxes of incontinence pads had also been stacked up which detailed people's names. A staff member walked straight into a person's room without knocking and stood at their bedside table. They spoke abruptly to the person and said "What do you want?" During a conversation with someone else, a member of staff picked up a person's hat and placed it and adjusted it on their head. At no time did the member of staff ask this person whether they wished to wear their hat. Another person was being transferred in a wheelchair down the corridor towards the dining room by a member of staff. The member of staff did not speak with this person and without alerting them, turned the chair around and started to push them backwards in the chair down the corridor. This person could not see where they were going until they were spun around in the chair again towards a dining room table. A clothes protector was then placed around their neck. The member of staff did not ask this person whether they would like to have a clothes protector on and had not explained at any time what they were doing. This meant people's dignity was not respected.

This was a breach of Regulation 10(1) Dignity and respect of the Health and Social care Act 2008 (regulated Activities) regulations 2014.

Staff were knowledgeable about people's past history and knew their likes, dislikes and preferences. One example was when the activities coordinator told us about a person who wanted to play a game which used disks and how they had adapted the rules to enable the person to take part in a way they were able to. Another person had chosen to stay in bed as they were tired. This choice had been respected by staff who had supported them with this decision and had assisted them to do this. This demonstrated staff were thoughtful and adaptable to people's needs. There was some kind interaction from staff with people and conversations were sometimes meaningful rather than task focussed. One staff member told us "This is a lovely home to work in. The staff get on well and work together to provide the best for people. We remember it's their home and respect this". Another staff member said "I love it here. Everyone is so friendly. We work well as a team and the residents are lovely".

People told us staff were caring. Comments from people included "The carers are very good. I have no worries living here, it is much better than I thought it would be" and "Carers, you couldn't find a better bunch of people. They are all good and I know all their names" and "They look after me well. I am quite happy".

Good

Is the service responsive?

Our findings

We reviewed the care records of 11 people. People's needs were assessed prior to them moving into the service and care and support plans were developed as appropriate to this. Care plans were person centred and detailed people's likes, dislikes and preferred routines. Care plans provided staff with clear and detailed guidance in order to deliver care in the way people preferred and included details of their life histories, hobbies and interests.

People and their relatives were consulted about their ongoing care in the input and review of their care plans and care plans were regularly reviewed and updated according to changing needs. The relative of one person told us "We have been asked about care and what (X- relative) would like. We are due to meet again shortly to review the care plan".

Staff were knowledgeable about people's preferences, likes and dislikes and told us they always aimed to deliver care in response to this.

During the inspection, a range of activities were provided to people using the service. The activities co-ordinator knew people well and had established a warm rapport with them. The activities coordinator was engaging in their approach and they were kind and caring. A programme of activities was provided to people each week based on their preferences. Activities included singing, current affairs – looking through the daily newspaper, physical exercises, a sherry morning and shop trolley which was taken to each person's room. People told us they have the opportunity to suggest activities which they would like to do. For example, one relative suggested boat trips in the Solent could be an activity people would enjoy and this was added to the current programme of events. Trained volunteers also work at the Milford House. Activities provided by volunteers included massage, pampering sessions and Pets as Therapy Dog. The activities coordinator told us "(X) has had dogs all his life so when the dog comes in he can relate to it and it reminds him of his past dog owning days and he really comes alive". One person told us about a volunteer who helps at the service "She's amazing. She goes around the rooms with the shop trolley, also has a chat, very popular". The activities coordinator told us "This is the best job ever. It is a privilege to work with older people, share their experiences, learn such a lot, like hearing about people's stories".

Although there was a varied activities program, during the inspection we observed people who were in their rooms or nursed in bed not receiving the same degree of support and it was difficult to locate staff to attend to these people when they required attention. One staff member told us they tried to spend time one to one with people as much as possible when time allowed. Although carers responded to people's needs during the inspection, they did not have time to spend with vulnerable people who were confined to bed and therefore these people were at risk of social isolation. When we asked the registered manager how they address this, they told us they have a group of volunteers who regularly visit the home and assist with helping to provide stimulation, activities and company for all people using the service and with a particular focus on people who are nursed in bed or who wish to remain in their room.

A number of people using the service spoke about the importance of their spiritual life and what it meant to

their wellbeing. One person told us "I've been involved with the church all my life and it is very important to me. The vicar comes in to take communion services and we have a new church group who come in to hold a prayer meeting and we sing hymns".

Both people and their relatives said they had been consulted about their/relative's care and their suggestions had been listened to and reflected in their care plans. Staff took time to find out what people wanted and spoke kindly to them. People were able to make choices about their preferences. One person told us "I can go to bed when I like and get up when I want to".

People had the opportunity to give feedback on their experiences, concerns and complaints.
Relatives we spoke with told us they were listened to and kept informed of any changes. Some relatives told us they had attended resident/relative meetings. People and their relatives said they had no complaints however, said they would feel confident in raising a concern and would be sure that any issues would be dealt with appropriately. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. The manager ensured that all complaints had been resolved to people's satisfaction and where corrective action was required, for example the requirement of additional staff training or supervision, this had been implemented. A copy of the service's complaints procedure was clearly displayed in the entrance to the home.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of the service being delivered and the running of the home however, improvements and actions in response to findings had not always been implemented. Audits were carried out periodically throughout the year. These audits included assessments of incidents, accidents, complaints, training, staff supervision and the environment. These audits were used to address any shortfalls and plan improvements to the service. The registered manager was able to tell us how they would identify and escalate any trends and when identified some of these had been investigated effectively. However, some items that had been raised during a recent quality audit had not been corrected. For example, it had been identified that people's fluid charts lacked guidance on people's total daily fluid intake targets and there was a lack of clarity between some people's risk assessments and their care plans. Corrective action to these findings had not been implemented at the time of the inspection.

People, their relatives and staff were encouraged to give their views about the service they received. Comments and suggestions cards were available in the front entrance of the home and questionnaires on the service were sent out annually people and their relatives.
Following review of complaints, actions had been implemented to correct and prevent issues recurring. For example, following a complaint regarding the moving and handling technique of a staff member, further training and supervision was given to support them with this. Following a complaint regarding the level of cleaning of a person's room, weekly cleaning schedules were implemented to ensure all items were regularly cleaned and all work completed.

There was a registered manager in post who was available throughout the inspection. There were many positive comments about the registered manager and staff team. People and their relatives told us the registered manager was approachable and would be sure any concerns would be addressed appropriately. One person's relative told us "(X – the registered manager) – her door is always open and she is happy to talk to you even about the most mundane things". When we spoke to a person about the management of the service, they told us "If there is anything untoward it gets dealt with straight away".
Staff spoke highly of the registered manager. One staff member told us there were very happy working at the service. They told us they have good team who work together well with a manager who was very approachable. Another staff member said "X (registered manager) is lovely, fair and gets to the point and if you're not sure she'll take you back to the beginning which is really helpful. She cares about the residents and staff".

The registered manager interacted positively with people who lived at the home and knew the staff well. All the staff said they had regular one to one time with the management team. They said this was helpful in their development and they had the opportunity to take further vocational qualifications. Staff told us the registered manager was approachable and there was an open door policy.

At the time of the inspection the home was undergoing a major refurbishment. The registered manager explained that this was due to being selected by the Provider; Barchester Homes as part of their initiative to improve the appearance and layout of their homes which had been built some time ago to bring them in

line with the comforts and décor of some new builds. This included having new ensuite showers installed and developing the conservatory area to make it more usable and dedicated for activities. During our visit, the building work was managed in a way that had a minimal impact on people who used the service.

The registered manager told us their main challenges included the current building work and their aim was to limit any negative impact this may have on the people living in the home. In addition, the registered manager had been without a deputy for the previous five weeks who had been an asset to the home so this added to the complexity of their role. They were currently trying to recruit but had been finding it difficult to find the right calibre of staff. The registered manager said they were looking for a "Special kind of person as it was not an easy job". The registered manager said they were lucky to have a staff team who were very caring, committed and wanted to do their best for people. They said the majority of the team had worked at the home for many years and were very familiar with their work and what was required of them. They said the team was very stable but also had some new staff with those newly recruited.

The registered manager said they sometimes deployed additional staffing in order to support and value their staff. They said this was always done if staff had experienced a particularly difficult shift. The registered manager said they had started using agency staff due to only recently experiencing problems with staffing. These problems were due to staff leaving; three who recently retired another who had recently relocated and other staff had been asked to leave due to being unreliable. Previous to this, their use of agency staff was more than 15 years ago. We were told that they always aimed to deploy the same agency staff to ensure consistency but also made sure they had the right skills and attitude to do the job. We saw evidence of this during the inspection when we saw an agency nurse who had not previously worked at the home being given a comprehensive handover and instructions at the start of their shift. The registered manager said staff worked well as a team and "Did everything" rather than saying "that's not my job". We were told that a meeting was held with nurses at 10am each day to talk about key aspects of the day including any admissions, clinical tasks such as wound dressings and any changing health needs of people using the service.

The registered manager told us they networked with external services and organisations. They also had contacts of advocacy services and although we were told people were offered these services none were currently being used. There were regular staff meetings, which were used to give the opportunity for staff feedback, share best practice and keep staff up to date and actions raised and documented accordingly. The manager welcomed volunteers into the service to enhance the care for people. This included volunteers to provide companionship, group and one to one activities and emotional support.
Throughout our inspection, we discussed findings with the registered manager. They were open to our comments and addressed some of these during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect when receiving care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g) People were not supported to meet their needs to sustain good health and did not always receive the necessary support to eat or drink when required. Regulation 12(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not being supported by sufficient numbers of staff to keep them safe and meet their needs. Regulation 18(1)