The Orders Of St. John Care Trust

OSJCT Millbrook Lodge

Inspection report

Moorfield Road
Brockworth
Gloucester
Gloucestershire
GL3 4EX

Tel: 01452863783
Website: www.osjct.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 10 and 11 January 2017. At our last inspection in June 2014, the care home was meeting the legal requirements.

The inspection was unannounced. Millbrook Lodge provides nursing and personal care for up to 80 people. At the time of our inspection there were 76 people living in the home.

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

People told us they felt safe in the home. They were cared for by staff that had been trained and understood their responsibilities with regard to keeping people safe from avoidable harm and abuse. Risk assessments were completed and risk management plans were in place. However, we found some bed rails and a pressure relieving mattress that were not used in a safe way or as intended.

People's healthcare needs were met. People were supported to make decisions. Staff identified when people's needs changed and they obtained support and guidance from external health care professionals. The home received regular visits several times each week from the local GP practice.

Staff demonstrated a kind and caring approach and they treated people with dignity and respect. Staff knew people well and were able to tell us about people's likes, dislikes and preferred routines which were reflected in their care records.

There was a range of activities that people could participate in and people were enjoying group activities on the days of our inspection. The registered manager had developed links within the local community and groups such as the local 'Mother and Baby' group were held in the home on a regular basis.

People, staff and relatives told us the home was well-managed. People and relatives told us the registered manager was readily accessible and available to them. Staff told us they were well-supported and that the home was a "Good place to work." Quality assurance systems were in place however their effectiveness at identifying areas of concern or risk needed further improvement.

We found a breach of one of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the 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.

Equipment was not always safely or correctly used.

Staff were deployed in sufficient numbers to meet people's needs.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Arrangements were in place to ensure people received their medicines safely.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to carry out their roles. Staff felt supported and their performance was monitored on a regular basis.

The home was meeting the requirements of the Deprivations of Liberty Safeguards (DoLS) authorisations.

Staff ensured people's health care needs were met and that they had access to health care professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind, caring and respectful and we saw people being treated with compassion and dignity.

Staff provided care in accordance with people's individual needs, wishes preferences and choices.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and reflected people's changing and current needs.

People had opportunities to participate in social activities and events, in and out of the home.

There were well developed links between the care home and community groups and projects that were mutually rewarding and beneficial.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Systems were in place for monitoring quality and safety. Action plans were implemented and monitored for progress. However, the audits had not identified the shortfalls we found with regard to the safe and correct use of equipment.

People and staff spoke positively about the registered manager, and told us the home was well-managed.

The registered manager was aware of their responsibilities with regard to notifications and information they were required to send to the Commission.

OSJCT Millbrook Lodge

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.

We undertook a comprehensive inspection of Millbrook Lodge on 10 and 11 January 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an Expert by Experience on each day. An expert by experience is a person who has personal experience of the type of service inspected. A specialist advisor supported the inspection for one day. This is a person who has professional experience of the type of service being inspected. On this occasion the specialist advisor was a registered nurse.

Before carrying out the inspection we reviewed the information we held about the care home. 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 also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with 18 people who lived at the home and 12 visitors. We observed the way staff interacted and engaged with people. We spoke with the registered manager, two senior managers, a visiting health professional and 16 staff that included registered nurses, care staff, activity, catering, housekeeping and laundry staff. We observed how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at eight people's care records. We looked at medicine records, staff recruitment files, staff training and competency records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, the registered manager sent us further information that we had requested.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe because risks associated with use of equipment were not always identified or safely managed. For example risk assessments and risk management plans were in place for the use of bed rails. We checked six bed rails at random and found two sets of bed rails were not compliant with the Health and Safety Executive (HSE) guidance for Care Homes. The guidance states the height that bed rails should be a minimum of 220mm above the mattress to reduce the risk of a person falling or rolling over the top of the bed rails. One set of bed rails was 70mm above the mattress. The completed bed rail risk assessment had been incorrectly completed and confirmed the bed rails were safely fitted. We found another set of bed rails in use where the risk of entrapment between the bed rail and the side of the mattress had been identified but was not being safely managed. The gap between the mattress and the bed rail contained foam padding. This was not secure, therefore the risk of the person's face becoming entrapped had not been mitigated. We brought our findings to the attention of the registered manager who took immediate action to rectify the shortfalls.

Some people used pressure relieving mattresses. This equipment, of which there is a wide range, is used to reduce the risk of the development or deterioration of pressure ulcers. The types of mattresses in use had pumps that required setting according to people's weight. A system was in place to inform staff of the setting required for each person. We checked five at random and found one person's pressure relieving mattress had been set incorrectly at 15kg more than the person's weight. This meant the person was at risk of not receiving the support and protection they needed because the equipment was not being used correctly. We brought this to the attention of a senior member of staff. They agreed with our finding and immediately corrected the setting. The senior member of staff told us later that day, that all pressure relieving mattresses in use had been checked and they were correctly set.

People were not always protected from potential risks caused by unsafe use of equipment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. One person told us, "Absolutely, I really do [feel safe], it's like coming home safely when you've been out" and another person said, "Yes, I do feel safe here." We also spoke with relatives who told us, "We're happy she's safe here, she says it herself: 'It's like my home here, nice and safe.'"

There were sufficient staff on duty to ensure people's needs were met and to make sure people were safe. People told us that staff responded promptly to calls for support and assistance. One person told us, "They've [staff] always got an eye out for you. They look in, sometimes they stop for a chat." The registered manager used a dependency assessment tool as a guide to determine the staffing levels needed. They also completed frequent observational checks when they walked around the home. Comments from staff included, "We have enough staff, and the management of the home are great, if there's [staff] sickness we get help if we're running short," and "It's [staffing levels] so much better than it was."

Staff had a good understanding of their responsibilities with regard to safeguarding people from avoidable

harm and abuse. They were able to describe how they would recognise abuse, and how they would act on concerns. Staff told us how they would report concerns immediately to senior staff or to the registered manager. Comments from staff included, "I would report any worries straight away to the senior or the manager. If I needed to report further I would contact CQC or the local authority" and "I know what we need to look out for and we get training refresher's every year." All the staff we spoke with were aware of the contact details for the local safeguarding teams. The details were displayed on a notice board alongside other information and guidance about safeguarding people.

People received their medicines safely, when they needed and them and when they were prescribed. Medicines received into the home were checked and the amounts confirmed on the medicine administration record sheets (MARs). Medicines were suitably stored in locked cabinets and cupboards in designated rooms. Arrangements were in place for medicines that required cool storage or additional security. Records were maintained for medicines no longer required.

We observed medicines being given to people and this was completed in a kind, caring and unrushed manner by the senior care staff and registered nurses. For example we heard people being asked, "Is it ok now, are you ready for your tablets?" We heard staff explaining to people what their medicines were for. Some people were prescribed medicines to be taken when needed, for example, for pain relief. Protocols were in place to describe the types of pain the medicines were prescribed for and we heard people being reminded and asked if they had any pain and if they needed their medicines. We saw that staff signed the MARs after they had made sure people had taken their medicines.

We looked at the records for a person who self-administered their medicines. A risk assessment had been completed with the involvement of the GP. The person had lockable facilities in their room and had agreed they would keep their medicines safely and securely stored.

A homely remedies policy was in place. A small range of medicines to treat minor ailments for short periods of time had been agreed with the GP. Accurate records were maintained of when these medicines were given to people and the stock amounts were regularly checked.

Where people were prescribed creams, arrangements were in place to confirm the application instructions. Body maps were completed that identified the specific areas of the person's body the creams were to be applied to.

Risk assessments were completed and risk management plans were in place for risks such as eating and drinking, weight loss, communication, moving and handling, bathing and falls. The risk assessments and management plans were reviewed monthly.

Accidents and incidents were reported and recorded on an electronic system. There was a full description of the accidents or incidents, immediate actions taken and steps required to minimise the risk of recurrence. The registered manager told us how the system helped identify any trends in the types or frequency of accidents. They told us how the number of falls for one person had been reduced when it was identified they were susceptible to falls at certain times of the day. Extra staff had been deployed at the identified times to provide the additional support the person needed. Another person who had fallen had their medicine reviewed and changed. They also had a sensor mat installed in their room, to alert staff when they moved from bed during the night.

Safe recruitment processes were completed. Staff completed an application form prior to employment and provided information about their employment history. Previous employment or character references had

been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella checks, electrical safety, lift maintenance and hoist checks had been completed.

Systems were in place to ensure that fire safety was adhered to. There was a fire risk assessment in place and records showed that regular tests of the fire alarm were completed. In addition to this, the emergency lighting was tested periodically and maintenance completed on firefighting equipment such as extinguishers. At the entrance of the home there was an overview of each floor, showing what level of assistance each person individually required to support them during an evacuation.

Staff told us they worked hard to keep the home clean and free from odours. A member of staff told us, "It's hard work but worth it." We saw records of the cleaning programmes and schedules in place. An audit, completed on 3 January 2017 identified that improvements were needed for in depth cleaning, referred to as 'high-low' cleaning of people's bedrooms, and an action plan was being implemented. A notice board, prominently displayed in the home, contained information and best practice guidelines for the 'Prevention and Control of Infection'.

The laundry area was organised and people's personal clothing was well presented. One senior member of staff told us, "If your mother wouldn't wear it [the clothes that have been laundered] don't send it out."

Good

Is the service effective?

Our findings

People and their relatives spoke positively about the staff that supported them. They told us they were well cared for and that staff met their needs. Comments included, "They're [staff] very well trained, no problems at all," and "[Name of person] is back on his feet within a month of arriving-from the care here."

The registered manager and the training co-ordinator told us about the range of training provided for staff. This included training they described as mandatory that included health and safety, first aid, moving and handling, food safety, mental capacity and safeguarding. Staff told us they were given reminders when mandatory updates and refresher training was due. One member of staff said, "It's flagged in your payslip what you need to attend, it will say your e-learning has expired, find time to attend." The training coordinator told us they provided additional support for staff that experienced difficulties with e-learning. They told us some staff were not confident and appreciated support when using a computer.

Staff were provided with further training, designed to help them meet the individual needs of the people they were providing personal and nursing care for. This included specific illnesses and end of life training. The registered nurses received clinical procedure updates such as catheterisation and venepuncture. Staff spoke positively about the training they had received and we received the following comments, "Our training is really good here, and the head of training visits and explains what is available for us" and "I'm so impressed with the training we get."

One member of staff described how they had improved their skills following a training session that included guidance on communicating with people who could not speak. The member of staff told us, "It was so simple, even small things like making sure I ask the residents' who can understand, but can't speak, a question they can just answer by a shake or a nod of their head."

Staff completed an induction programme when they started in post. The programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff are suitably trained to provide a high standard of care and support. The training coordinator told us the induction programme started with staff undertaking five days of classroom based training. Staff were allocated mentors, experienced members of staff they 'shadowed' until they were confident to work unsupervised.

Staff received individual performance supervisions and annual appraisals. The registered manager told us they had reviewed the supervision programme and were launching a new programme, aiming to make the process more meaningful for staff. We saw information about the new programme was displayed and available for staff. Staff we spoke with told us they felt supported and told us they received supervision on a regular basis.

Care staff in designated senior roles administered medicines within the home. We saw that staff had completed training and their competency to practice was assessed before they were able to administer medicines to people. Refresher and update training was provided each year to make sure staff knowledge and skills were kept up to date.

Educational boards with up to date and current guidance were on display in one of the main corridors in the care home. Topics on display included prevention and control of infection and falls awareness. A lead member of staff had been identified for each of these topics and their role was to ensure other members of staff were aware of care developments and best practice, and to provide guidance and support for other members of staff.

The registered manager told us they were one of five care homes selected and participating in a national teaching care home project. The registered manager spoke positively about the aim of the project which was to highlight and develop further good practice and create centres of learning and excellence within the care home sector.

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.

In the records we looked at, consent had been obtained and consent forms were signed for the taking of photographs, use of sensor mats and bed rails. There was confirmation of the care and treatment people had consented to. Where people were noted as not being able to communicate their needs and wishes verbally, the records confirmed how consent to care was obtained. The staff we spoke with told us they were aware that people needed to agree before care was provided. One member of staff told us, "We always ask people, and if they don't want to get up, go to bed or have the care we do try and persuade them, but it's their choice."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

The registered manager had met their responsibilities with regards to DoLS and 18 applications for people living at the home had been made and were awaiting assessment by the local authority. Two people at the home had current authorised DoLS in place.The registered manager understood the requirement to notify the Commission when a DoLS was authorised.

We spoke with people who were positive about the quality and choice of food available. One person told us, "Very good food here. I like breakfast best. I have cereal, egg on toast, toast and marmalade and a pot of coffee" Another person commented, "The food is jolly nice" as they were eating their meal.

The catering team were informed of people's specific dietary needs. These were recorded in a folder in the main kitchen. We spoke with catering staff about how they became familiar with people's likes, dislikes, choices and preferences. We observed meals served to people in their rooms and in the communal areas. Staff offered people choices of drinks and provided support and encouragement to them. Menus were displayed in the dining rooms and in communal areas of the home. Where people needed assistance, this was done sensitively and people were not rushed.

Some people with an identified choking risk were prescribed thickening agents for their drinks. The staff we spoke with were able to tell us the amount of thickening agent each person needed, to make their drink the right consistency for them. However, the records did not always confirm the amount of thickening required.

A senior member of staff told us that speech and language therapist (SALT) assessments had been completed, but they were unable to locate the records during our visit. They told us the records may have been archived.

People's weights were recorded and significant weight loss or gains were noted. There was also a nationally recognised tool used to calculate people's risk of malnutrition or obesity. When a person had been identified as having a significant weight loss or gain, additional actions were recorded if required. For example, if a person had suffered a weight loss, staff were required to monitor and record the person's food and fluid intake for a specified period of time. We saw that people had been referred to the GP when there were concerns about their fluid and dietary intake or their weight. Some people had been prescribed food supplements. People had access to drinks when in their rooms. Jugs of water/juice were readily available. A registered nurse commented there was "Always a jug of drink in peoples' rooms."

Staff recognised and responded to people's changing needs. They took appropriate action when people were unwell. One relative told us, "It happened last week..the nurse noticed a decline in Mum and called the out of hours service. They know, because they know and understand my Mum. She had a stroke [some time ago] and staff take time to learn her [ways of] communication."

People were referred and had access to external healthcare professionals. Specialist health care practitioners were accessed when people needed particular support to manage their health needs. During our visit a community mental health nurse had a telephone conversation with a registered nurse to confirm a visit would be undertaken the following day for one person to receive a mental health assessment.

The registered manager and senior staff told us they received an excellent service from the local GP practice. GP's visited the care home four times a week to see people who needed a review. We spoke with one GP who spoke positively and told us the service provided from the care home team was, "Excellent, very responsive to patients' need and very responsive to our instructions" and the staff were, "Very helpful." People could therefore be confident they received the health care support or treatment they needed at the time they needed it.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with told us that staff were kind and caring. Feedback included, "I wouldn't fault them [the staff] on anything, and the manager's very kind" "[Name of person] is back on his feet within a month of arriving-from the care here" and "I don't sleep very well and the carers stick their head around the door to see if I need anything."

We watched interactions with staff, and people looked relaxed and comfortable in their presence. Staff were attentive and sensitive to people's individual needs. The care staff we spoke with told us how they got to know people well. One member of staff told us how they supported people that were not always able to remember what was important to them and said, "Just because she has dementia, doesn't mean she can't wear makeup."

Staff were knowledgeable about people's preferred routines. A member of staff told us, "We get to know people so well and sometimes we can tell, just by looking at them, how they are feeling, or if they are tired and need a little rest." Another member of staff told us how important one person's early evening routine was to them. The member of staff told us the person liked to be in bed by a certain time so when their grandson visited, he could kiss them goodnight when they were in bed.

Staff were able to describe how they made sure people's privacy and dignity were maintained. For example, one member of staff told us, "It's so important that we knock on residents' doors, it's their room," and another member of staff said, "Things like closing curtains and covering people with towels when being washed, and I'd soon speak with staff who weren't doing that." We saw people's clothing was protected, if needed, when they were being supported with food and drink.

People were encouraged to be independent. However, staff also recognised when people could not be as independent as they would like. One person explained that recently they hadn't been able to walk, and required the use of a hoist to get out of bed. They told us the staff always checked how they were on the day and asked, "I think we will have to use the hoist today, is that ok?"

People's rooms were personalised and people were supported to make choices about the decoration of their room. The registered manager told us they actively encouraged people to make decisions such as this. One person had recently had their room painted with the colours they had chosen and was very happy with the result.

On arrival people were given key information about the home, which included the management structure. Copies were kept in people's bedrooms. There was information on fire procedures, the catering facilities, the care standards people should expect and how to make a complaint. In addition to this, people were provided with telephone numbers for a range of organisations, including the Care Quality Commission, the local authority and the local safeguarding teams. This ensured that key information was communicated to people. This allowed them to understand more about the care home and contacts they could make within it or with external agencies. In addition, relatives were asked if they wanted to receive information and

updates by e-mail, for example, copies of newsletters, planned events and activities.

The home had received 21 written compliment letters or cards in 2016. One card, received on the day of our visit read, "I must congratulate you all on the care you gave [name of person]…your pleasant attitude..your whole organised care at Millbrook was excellent.''

People and their relatives were supported to express end of life wishes and preferences and these were recorded in the care plans. A registered nurse told us they liaised with external health professionals such as MacMillan nurses, for additional support and guidance when providing end of life care.

Good

Is the service responsive?

Our findings

Care was responsive and personalised to peoples' individual needs. People and their relatives told us, "The care plan reflects her [person receiving care] needs. It's reviewed regularly and changed if necessary," and "They [staff] make you feel important, they do things the way you like it. They either know, or ask you, what you want."

A document called 'This is me' was completed which provided detailed information about people's previous life and lifestyle, interests, likes, dislikes and preferences. Staff told us how this information helped them to build relationships with people who may not be able to communicate or recall their past experiences. One person told us, "The 'Me plan' was filled out on the day of arrival."

People's individual needs, wishes and preferences for care and support were recorded. People told us they were able make decisions about their day to day care, such as when to get up and go to bed, where they wanted to eat meals and where to spend to the day. One person told us, "Today I wasn't feeling well, so they [staff] left me in my pyjamas. Fair enough. I'm happy, it's my choice."

A comprehensive activity programme was in place, and the weekly programme confirmed a wide variety of activities offered to people. These included cooking sessions, gardening activities, outings and regular visits from entertainers. One person commented, "We go out on trips, out to lunch. We don't get bored" and another person told us, "The activities here are very good. [Name of activity coordinators] do a great job- they're always busy." On the days of our inspection, we spoke with the activity coordinators who were very enthusiastic about the service they provided. We saw a range of activities taking place. A musical afternoon attracted a number of visitors. The people that participated obviously enjoyed these activities. People and visitors were talking and laughing as they left the room at the end of the entertainment session. We heard staff thanking visitors for coming along and saying, "It was lovely to meet you," "Bye, thank you so much for coming, hope to see you again soon" and, "What a lovely afternoon, hope you enjoyed it too."

In addition to the organised activities and events 'activity stations' had been introduced into each of the four different areas or 'units' of the home. These areas were stocked with board games and books. These were to encourage people, staff and relatives to engage in activities at times other than when the activity coordinators were on duty.

The registered manager told us how they had looked at ways of further developing personalised care within the home. As part of the teaching care home project, the registered manager invited people living in the home, relatives and staff to a meeting to discuss the following situation, 'If I woke up in a perfect care home, how would I know?' The registered manager told us they used the feedback received to further improve and develop care practices and services in the home. For example, to further enhance community involvement in the home, regular mother and baby groups and visits from the local schoolchildren were introduced. In a published article the registered manager commented, "For me, being a teaching care home is about listening to the experienced voices of residents and using that knowledge to teach a new generation".

A communal area known as the tea room was staffed by volunteers on a regular basis with tea and cakes provided for people and visitors. There was a small charge and proceeds were raised for the home amenity fund.

For people who were not able, or who chose not to take part in group activities, and spent long periods of time in their rooms, staff provided social stimulation. For example, activity staff told us they got to know, from people and relatives, what people liked to do. An activity coordinator told us, "Some people look forward to just talking or reading, or things like playing dominoes. People's eyes light up when we spend time with them."

People and relatives had access to a complaints procedure. They told us they would feel comfortable raising a complaint or speaking with the registered manager if they had any concerns.
Comments included, "Any minor issues raised with management are dealt with immediately" "Oh, totally [free to express opinions] and raise any concerns…" and "The manager [name] will come up quickly to talk over things and get them sorted." We looked at the complaints file and saw one complaint had been received in 2016. The registered manager told us they and the staff team had learned from the complaint and improvements had been made.

Requires Improvement

Is the service well-led?

Our findings

We spoke with the registered manager about quality assurance systems that checked the quality of the service provided and helped to ensure risks to people's health safety and welfare were monitored. We checked the records and established there was a range of auditing and quality monitoring systems in place. These included monthly checks of care plans, falls, pressure ulcers, cleaning schedules and catering records. Action plans were in place to make sure identified areas for improvement and action were recorded and monitored. Actions were confirmed when they had been completed, and the action was 'signed off' by the regional manager.

However, the provider's quality assurance checks were not as effective as they should be in identifying areas for improvement. For example they had not identified the potential risks to people caused by unsafe use of equipment as reported in the safe section of this report.

We also noted the time of administration for one medicine that required additional security had not been recorded on the MAR or in the designated recording book. The provider had stated in their PIR they had introduced a weekly check of medicines that required additional security. A check had been completed but it had not identified the omission noted above.

The provider's quality and compliance team completed annual, unannounced inspections, following which action plans were agreed and implemented. The team also analysed reports of incidents such as falls and pressure ulcers. They provided a summary of findings and identified emerging trends or patterns of behaviour. In addition, the regional manager completed monthly operational reviews of the home. Action plans were agreed with the registered manager and progress was reviewed on a monthly basis.

People told us they considered Millbrook Lodge was well-managed. We received positive feedback from people and relatives about the management of the home. One person told us, "[Name of registered manager] is very approachable. It's not often you can't find him, he's always around" and a relative commented, "He's easy to talk to and usually available."

People and their relatives had been given the opportunity to provide feedback about the service. The most recent survey had been given to people in July 2016. The survey asked that people comment on the care and services they received and what could be improved. The feedback was positive. One person had commented, "If I am not happy, I am open about it, no offence."

Meetings were also held with people on a regular basis. We saw actions taken from the most recent meeting, held in November 2016, where suggestions for improvement were made. For example, one person had asked for a change to their personal care routine. We checked the care records and found the requested change had been implemented.

The provider's values, displayed in the reception area, stated the provider was, 'dedicated to caring, empowering individuals, respecting each other, promoting communities and securing our future'. We

observed during our visit how these values were embedded into day to day practices in the care home.

Staff spoke positively about the support they received from the registered manager. Comments included, "I'm well supported. I can talk to [name of registered manager] anytime. Office is always open," "I like the management of this home" and, "This is a great place to work, we have a good team and a good manager."

A range of staff meetings were held to make sure communication was effective throughout the home. These included specific team meetings, such as three monthly housekeeping, catering or clinical leaders meetings where issues specific to that department were discussed. General meetings were also held where all staff were invited to attend. Staff spoke positively about the service provided for people living in the home. One member of staff told us, "I would have been happy for my Mum to be here [in Millbrook Lodge] if she needed a care home."

Staff feedback had been sought in a 'Care to Talk' employee survey in 2016. The results were compared to the provider's other services, and actions to sustain or actions to improve had been identified and confirmed in an action plan.

A business continuity plan set out the procedures and strategies to be followed in the event of an incident that caused disruption to normal working. If this incident affected the ability of the care home to give care as usual, maintain adequate safety and the well-being of people and staff, the plan had guidance on the action that should be undertaken. These could be events such as disruption to gas, water or electric supply or failure of equipment within the service.

The registered manager understood their responsibilities with regard to the notifications they were required to send to the Commission.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Equipment used for providing care was not always used in a safe way. Regulation 12 (2) (e)