East Riding of Yorkshire Council

Millside Residential

Inspection report

Granville Court
The Esplanade
Hornsea
North Humberside
HU18 1NQ

Tel: 01964532160

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18 January 2017 and was unannounced. This was the first inspection since the service moved from Driffield to the new location in Hornsea.

The home is registered to provide accommodation for up to five people who have a learning disability, autistic spectrum disorder and / or a physical disability. On the day of the inspection there were five people living at the home. The home is situated in Hornsea, in the East Riding of Yorkshire. It is close to the sea front and to town centre facilities. The accommodation is on one floor and each person has their own bedroom. There is an adapted bathroom that people share. Other accommodation includes a lounge / dining area, a small kitchen, a laundry room and a courtyard garden.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the home.

Relatives told us they felt their family members were safe living at the home and this view was supported by health care professionals who we spoke with. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. There were effective systems in place to manage any safeguarding concerns.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Medicines were administered safely, and staff had received appropriate training on the administration of medicines.

Relatives and health care professionals told us that staff were caring and people's privacy and dignity was respected. We saw very positive interactions between people who lived at the home and staff on the day of the inspection.

People's nutritional needs had been assessed and we saw that meals to meet their individual requirements were provided, following advice received from health care professionals when appropriate.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and outcome. There were also systems in place to seek feedback

from relatives, staff and health care professionals about the quality of the service provided.

Staff, relatives and health care professionals told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote the well-being of people who lived at the home.

Staff told us that, on occasions, investigation into incidents that had occurred was used as a learning opportunity and to make improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medicines policies and procedures and this meant people who lived at the home received the right medicines at the right time.

Staff had been recruited following robust policies and procedures. There were sufficient numbers of staff employed to ensure people received a safe and effective service.

Staff had received training on safeguarding adults from abuse and they were aware of how to refer any concerns to the appropriate people.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and we observed that different meals were prepared to meet people's individual nutritional needs.

People had access to and support from health care professionals when required.

Is the service caring?

Good

The service was caring.

We saw positive relationships between people who lived at the home and staff. Relatives and health care professionals told us that staff were caring.

Staff respected people's privacy and dignity, and it was clear that people's individual care and support needs were understood by

staff.

People were being supported by advocacy services when this was appropriate.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to take part in meaningful activities and contact with family and friends was encouraged.

There was a complaints procedure in place and staff told us they would make a complaint on a person's behalf if they felt this was needed.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for people to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Millside Residential

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.

The inspection took place on 18 January 2017 and was unannounced. One adult social care (ASC) inspector carried out the inspection.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities who commissioned a service from the registered provider. We also requested feedback from a number of health care professionals, and received information from three. The registered provider was not asked to submit a provider information return (PIR) prior to this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with three members of staff and the registered manager. We were not able to communicate verbally with people who lived at the home but we spent time with them throughout the day to observe the care they received and the interactions between them and staff. We looked around communal areas of the home and bedrooms. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Following the day of the inspection we spoke with two relatives of people who lived at the home to gain their feedback.

Good

Is the service safe?

Our findings

We asked staff how they kept people safe and they told us they had in-depth training on topics such as safeguarding adults from abuse and medication that helped them to provide safe care. One member of staff told us, "We make sure equipment is safe. We don't rush anything and two members of staff assist people to mobilise" and another said, "We make sure the environment is safe and we have appropriate equipment." Relatives and health care professionals told us they felt that people were safe living at the home.

We noted that moving and handling plans recorded the level of assistance the person required. These provided staff with the advice they needed to safely assist people to mobilise around the home and in the local community. We observed staff using equipment to move people around the home and saw that this was done safely and with great care.

The registered manager had attended safeguarding 'threshold' training provided by the local authority. This included a monitoring system for managers to help them identify which incidents required managing in-house, and which incidents needed to be reported to the local authority safeguarding adult's team. We checked information in the safeguarding folder and saw that incidents at the home had been thoroughly recorded and alerts submitted to the local authority as required.

The staff we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. They were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or had any concerns. One member of staff told us, "I would tell the duty officer [senior member of staff on duty] and they would inform the manager. I'm confident this would be dealt with properly."

Staff told us that people had lap belts to keep them safe in wheelchairs and that one person spent the day in a bed cocoon. This equipment provided a safe area for the person to spend their day without the risk of falling. Staff recognised that these were forms of restraint and told us that these decisions had been made following best interest meetings. Care plans also evidenced that staff sometimes used 'light touch restraint' to prevent people from harming themselves or getting into risky situations. All staff had received training on using these techniques and following an event they were required to complete a form and a body map. The form was then submitted to the registered manager for monitoring purposes. People had behaviour management plans in place that recorded the behaviours that they might display and how staff should approach the person to manage these situations.

We reviewed the records of accidents and incidents and saw that most accidents were due to seizure activity. We noted that all records included a body map so injuries could be recorded and monitored. There was also a record of any follow up action that was required. These records were submitted to senior managers for monitoring purposes. This enabled them to check for areas that required improvement and to identify whether any patterns were emerging.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk

assessments for communication, allergies, epilepsy, medication, fire safety, moving and handling, the use of equipment, vulnerability, refusal of medication, eating and drinking, self-harm, road safety and specific medical conditions. The assessments recorded the concern, the risks involved and how the risks should be managed. Some people had epilepsy management plans in place. A health care professional told us, "I have found that the staff have been able to identify changes in the individual's seizure frequency and have contacted me when there has been an increase in seizures. The carers follow the epilepsy management plan that is in place and have liaised appropriately with the GP in relation to changes in medication."

People had detailed plans in place about the medicines they had been prescribed, the times they needed to take their medicines and any input from the district nursing team. People had a lockable cupboard in their bedroom where their medicines were stored, along with their medication administration records (MARs). MARs are forms that are specifically designed to record the daily administration of medicines Temperatures were checked in each person's medicines cupboard, in the medicines room and in the medicines fridge to ensure medicines were stored at the correct temperature.

MARs were supported by an information sheet that recorded details of the medicines the person was prescribed, the name of their GP and any known allergies, as well as a photograph of the person. The MAR folder also included details of how each person liked to take their medicines, an 'as and when required' (PRN) protocol, a bowel management chart and an epilepsy management plan.

No-one living at the home had been prescribed controlled drugs (CDs) but there were suitable arrangements for storage and a CD book should they be needed in the future. CDs are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was an audit trail to ensure that medicine prescribed by the person's GP was the same as the medicine provided by the pharmacy. There were robust stock control systems in place and the arrangements for returning unused medicines to the pharmacy were satisfactory.

The duty officer (senior care worker) was responsible for medicines management and usually administered medication. However, most staff at the home had undertaken medication training and were able to administer medication when required. Audits were completed at the end of each medication cycle to check that people had received the correct medication at the correct time, and that the records of administration were accurate.

We checked the recruitment records for two new members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at the home.

On the day of the inspection we saw the registered manager, the duty officer (senior care worker), three care workers and a domestic assistant were on duty. The registered manager told us that the staffing levels they aimed to achieve were a duty officer and three support workers in the mornings and a duty officer and two support workers in the afternoons / evenings. A senior care worker and a care worker were on duty overnight. We checked the staff rotas and saw that these staffing levels had been consistently maintained.

The staff rotas evidenced that staffing levels were flexible; on occasions additional staff were on duty to assist people with attending appointments or social events. Staff told us sufficient numbers of staff were

employed to ensure people received the support they required. One member of staff said, "We are a good team and never have to use agency staff."

There was a fire risk assessment and an arson risk assessment in place that had been reviewed in March 2016. All staff had attended training on fire safety in January 2016 and fire drills had taken place in February, September and November 2016. In addition to this, fire safety inspections had been carried out. The home's handy person had recently left the service and they were in the process of recruiting a replacement. In the interim period, staff were carrying out weekly tests of the firm alarm system and monthly fire extinguisher and emergency lighting checks. This meant that people were protected from the risk of fire.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, portable electrical appliances, hoists and slings, the fire alarm system, emergency lighting and fire extinguishers. The maintenance department of the local authority had been informed of any repairs that were required, and these had been carried out in a timely manner.

There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations. There was also a personal emergency evacuation plan (PEEP) in place that recorded the support each person would need to evacuate the premises in an emergency, including the number of staff required to assist the person and any equipment that they used.

We walked around the home and saw that communal areas, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. The registered manager carried out a three-monthly health and safety check. This included checks on cleanliness, maintenance and decoration for all areas of the home.

Good

Is the service effective?

Our findings

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 MCA 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). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We found that the registered manager and staff displayed a good understanding of their roles and responsibilities regarding MCA and DoLS and promoting people's human rights, and had received appropriate training. Any authorisations in place were being appropriately managed.

People had a 'consent to care' document in place. This covered areas such as communication, epilepsy, allergies, medication, dignity, equipment used, fire safety, awareness of danger and personal care. Each area listed included a record stating the person was not able to give consent and asked the question 'Is this in the person's best interests?' We saw evidence of best interest decisions that had been made about people going on holiday, medical treatment, covert administration of medicines, use of a bed cocoon and use of bed rails.

Staff described to us how they helped people to make day to day decisions, such as holding out DVDs so people could choose their favourite and trying different options at meal times.

Relatives and health care professionals told us that staff communicated well with people who lived at the home. One health care professional said, "I was impressed with the way that staff interacted with the residents and responded to their verbal and non-verbal communication needs, and this was facilitated by the good ratio of carers to residents." Another health care professional told us, "Staff appear to know my client well and understand the way they communicate their wants and needs, and are able to advise me around that." They added that staff were using new technology, such as iPads, with clients to increase their interaction.

We observed that staff had the skills they needed to carry out their roles and this was supported by the relatives who we spoke with. One relative told us, "Staff are always attentive. It's better at Hornsea than it was in Driffield." Records evidenced that new staff carried out thorough induction training and also shadowed experienced staff as part of their induction. Staff told us they could shadow until they felt confident enough to work as part of the staff rota. We saw that a new member of staff was shadowing experienced staff on the day of the inspection, and that they were on duty in addition to the standard staffing levels. A member of staff who had been promoted to a senior position told us they had carried out further induction training to prepare them for this role.

The training record evidenced which training was considered to be essential by the organisation. This included safeguarding adults from abuse, fire safety, basic life support, positive responses to behaviour, medicines, moving and handling of people, the MCA, risk assessment and food safety. We saw that staff had completed this essential training although some refresher training was overdue. Additional training was available for staff to meet their particular interests or the needs of people who lived at the home. These topics included data protection, equality and diversity, diabetes awareness, pressure sores and tissue viability, record and report writing, autism awareness, understanding dementia and epilepsy. We noted that most staff had completed training on epilepsy. New care staff were not allowed to assist with moving and handling people or with the administration of medication until they had completed training on these topics.

The registered manager told us that new staff would be expected to complete the Care Certificate unless they had very recently completed a National Vocational Qualification (NVQ) Level 2 in care or equivalent. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. The Qualifications and Credit Framework (QCF) award has replaced the NVQ award and is the national occupational standard for people who work in adult social care. In the two recruitment files we checked we saw that one new employee had already achieved NVQ Level 2 in Care and the other had completed the Care Certificate.

Staff told us they were well supported, both by their colleagues when they were new in post and by the registered manager. One member of staff said, "I feel very well supported. We have one to one supervision meetings quite regularly." We saw records of staff supervisions and this showed that staff attended these meetings every two months. All staff added that they could speak to the registered manager any time and would not wait for their supervision meeting if they had any concerns.

Meals were prepared by the cook at another care home on the same site. These were brought to Millside Residential in a heated box so that they were hot when served. We observed that the meals provided were based on people's likes and dislikes and their specific dietary requirements. Four people required full assistance to eat their meal and this was provided on a one to one basis by staff. One person could eat a little by themselves and they were encouraged and supported by staff when this was required. We saw that people were allowed to eat at their own pace. Staff chatted to people and encouraged people, and this made the mealtime a social experience.

Care plans recorded mealtime prescriptions that had been prepared by dieticians and speech and language therapists (SALT) following nutritional assessments. These recorded how the person's meal should be prepared, such as pre-mashed food and thickened drinks to reduce the risk of choking. Supplements had been prescribed for people to take when they had declined their meal. 'Personal placements' recorded the adapted equipment people needed to use to eat and drink safely. People had food and fluid intake charts in place. These recorded the meals the person had eaten at breakfast, lunch, tea time and supper. Although fluid intake was recorded in millilitres, the liquid intake for the day had not been totalled and recorded. The registered manager told us this would be actioned immediately. People were weighed on a regular basis as part of nutritional screening. This included the ability to weigh people in their wheelchair. These arrangements enabled staff to monitor people's nutritional well-being.

Staff told us they would recognise if someone was unwell, even if they could not verbally express this, as they knew them very well. They said they would arrange for people to see their GP or other health care professionals if they had any concerns. We saw that contact with health care professionals was recorded, including the reason for the contact. People's records evidenced that advice had been sought from GPs, dentists, district nurses, the community learning disability team, chiropodists, occupational therapists,

physiotherapists and speech and language therapists (SALT), and that any advice received had been incorporated into care plans. People also had annual health and medicine reviews with their GP.

Relatives told us that they were consulted appropriately about health care issues. One relative told us that their family member's key worker had told them about the outcome of a recent GP appointment. Health care professionals told us that the registered manager and staff asked for advice appropriately and then followed that advice. One health care professional said, "There is evidence in notes that staff request input from the person's GP, district nurse etc. when there are concerns, and then follow that advice."

People had health passports in place. These are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that health passports included some details in colour and symbols to help the person concerned to identify the information in the passport. They included, 'Things you must know about me', 'Things that are important to me', 'My likes and dislikes' and 'my mini health action plan'. This meant that hospital staff had information to help them support the person appropriately.

Good

Is the service caring?

Our findings

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient in the way they interacted with people. Staff told us that they felt staff who worked at the home genuinely cared about the people they supported. Comments from staff included, "If I left tomorrow, I would still visit the home", "Staff go the extra mile" and "Staff genuinely care. I love working here and really care about the service users. We have formed strong bonds." Relatives agreed. One relative told us, "We visited on Christmas Day and saw that [name of family member's] key worker had made them a special present." They felt this was 'over and above' what was required of them. Both relatives told us they felt staff cared about them as well as their family member and one relative spoke highly of their family member's key worker.

Health care professionals told us that staff were caring. Comments included, "Staff are caring in their approach to people and take time to talk and work with them", "Considering the needs of the service users at Millside [which can be demanding] I think that the level of care I witnessed was excellent" and "[A situation] was handled with sensitivity and respect for the person in a patient manner."

Staff explained to us how they respected people's privacy and dignity. Their comments included, "We make sure no-one else is in the corridor and that the person is well covered up. We knock on doors, lock the door and pull the privacy curtain round" and "We make sure people are completely covered with a towel. We lock doors and windows". A relative told us, "I've been here when [Name of family member] has been in their room with the Physio. They were very careful about privacy, even in front of me." We saw that people's bedrooms had enough space to enable them to see visitors and health care professionals in private.

Some relatives and staff said it would be preferable for people to have en-suite facilities. However, it was acknowledged that there was no space for en-suite facilities within the premises. There was a large purpose built bathroom that was equipped with an adapted bath and a privacy curtain. The bathroom had enough space for mobility equipment and two members of staff when this level of assistance was required. A health care professional told us, "There are obvious constraints enforced by the building but carers appear to have created a homely environment."

People who lived at the home were dependent on staff for most of their day to day needs. However, we saw that staff encouraged people to be as independent as possible, such as with eating their meals and when mobilising around the home.

People's key workers met to discuss the person they had particular responsibility for. These records showed that they discussed one to one time, people's wishes regarding activities, encouraging fluid intake and birthday / Christmas presents.

Staff understood that it was important to promote confidentiality of information. One member of staff told us, "We never discuss anything private in the corridor". We saw that written or electronic information was stored securely either in the registered manager's office or in locked cupboards.

The registered manager was aware of the need to use advocates to assist people with decision making. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. It had been arranged for an advocate to attend one person's review where a DoLS application was going to be discussed. One person had the support of an independent mental capacity advocate (IMCA) who visited them every three months. Their records included details of occasions when the IMCA should be appointed in respect of decision making outside of these planned visits.

Relatives told us that they were usually kept well-informed of events concerning their family member. One relative told us, "I have never had any concerns. I am always kept in touch."

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We saw that these diverse needs were adequately provided for within the service. The care records we saw evidenced this and the staff we spoke with displayed empathy in respect of people's needs. One person's care plan recorded, "I celebrate traditional events such as Christmas and Easter." We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. Care plans included a document called 'This is Me'. This included information about key people in the person's life, what they liked to eat and drink, how they liked to be supported with personal care needs, their mobility, their daily routines, their culture / religion and their likes and dislikes. One person's care plan recorded, 'I like having a bath with the assistance of two staff – with sensory lights, bubbles and music'. Relatives told us they had input into their family member's care plan, and we saw that care plans included information about the person's life history as well as their hopes and dreams for the future. Staff had signed people's care plans to record they had read them.

We asked staff how they got to know about people's individual needs. They told us that they were introduced to people during their induction period and that they checked care plans. One member of staff said, "You need to keep checking care plans, as they change. There is always someone to ask when you are new" and another told us, "We know service users very well but you never know everything. One keyworker met with the family of [Name of person who lived at the home] and they told us they liked listening to country music. That was added into their care plan." We noted that documents relating to people's care included symbols to assist people in understanding the information.

We saw evidence that care plans were reviewed each month to ensure they were up to date, and more formal reviews had been organised by care managers from the local authority to review the person's care package. We noted that health care professionals were invited to people's care reviews. This meant that the appropriate people were involved in reviewing people's care packages to ensure they continued to meet their needs.

We saw that people received person-centred care. One member of staff told us, "Care is individualised – it is tailored to people's needs." One person spent their day in a cocoon and we saw that a member of staff got into the cocoon with the person to assist them to eat their meal. We saw that this staff member was skilled in retaining the person's attention. The person concerned responded appropriately and this resulted in them receiving adequate nutrition. Another person needed to be positioned in their chair and bed in a certain way. This had been photographed and was in the person's care plan to help guide staff.

Staff told us they thought there were enough activities to keep people occupied. People had a meal out in the community once a month, had aromatherapy sessions, had recently been to the Pantomime and were due to visit a local park as part of the Dignity in Care day. On the day of the inspection we saw that staff played music for people that they particularly enjoyed, played DVDs, read stories to them and took them out for a walk. Daily records were made of how people had spent their day.

People were integrated into the local community, and staff told us that this had improved since the service moved to Hornsea. Staff comments included, "We are more integrated into the community. Staff at the Floral Hall [a local venue] are very accommodating" and "We go out to cafes and to the local pub. We have walks along the sea front." One health care professional mentioned that there was less access to public

transport in Hornsea compared to Driffield, and they felt this impacted on the person's ability to "Get out and about further afield."

People were supported to keep in touch with family and friends and any contact with relatives or friends was recorded on a contact sheet. We saw that this included photographs being sent to relatives to inform them about recent activities and events. One member of staff commented, "We keep in touch with relatives via telephone and email. They are always made welcome." A health care professional told us, "Staff work to help my client maintain a relationship with a friend from a previous care home."

We saw that the organisation's complaints procedure was displayed in the home. We checked the complaints and grumbles log and saw that there had been one complaint during 2015 and another in 2016. Both had been dealt with in accordance with the home's complaints policy and procedure and there was a record of the action taken by the home following the investigation. A compliment had been received in January 2017. This recorded, 'Thanks to all staff for a warm and friendly atmosphere, good quality care and a lovely Christmas day for all service users'.

People who lived at the home did were not able to make a complaint themselves. Staff told us that, because they knew people well, they would recognise if they were unhappy. They said they would raise a complaint on the person's behalf and that they were confident any concerns or complaints would be dealt with effectively. Relatives told us they were confident any concerns or complaints they made would be listened to and dealt with.

People who lived at the home had completed a satisfaction survey during 2016 with assistance from staff; they were not able to complete satisfaction surveys unassisted. This had resulted in service users responding positively to every question asked. The decision had been made not to conduct surveys with people who lived at the home in future. To give people an opportunity to express their views about the care they received, weekly meetings were held instead. At these meetings the staff rota for the forthcoming week was read out to people so they were aware of who would be supporting them. Activities planned for the week were also discussed.

Relatives confirmed that they had received satisfaction surveys and attended meetings. They felt their views were listened to. One relative told us, "I can approach the manager or staff at any time and get a positive response." Another relative told us they did not attend relative meetings as they were happier having "One to one chats and visits."

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) since 2 December 2016. The registered manager had worked at the home for a number of years. This meant the registered provider was meeting the conditions of their registration and that there was a level of consistency for people who lived and worked at the home.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. A health care professional shared positive feedback about record keeping at the home. They told us that care plans, risk assessments and health records were up to date, and that there were records in place in respect of maintaining the safety of equipment used with people who lived at the home.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew about the specific needs of people living at the home. Staff told us the home was well managed. Comments included, "The manager is fair and approachable. They would sort any problems out" and "Since [Name of registered manager] has been the manager there is a different atmosphere. Maybe because they are here all of the time. People are relaxed about discussing things with them and issues are dealt with quickly." One relative described the registered manager as "Open and honest. They try very hard."

A 'family' survey had been distributed during 2016. The responses had been collated and we saw that this document recorded 100% satisfaction with all of the areas covered. A staff survey had also been conducted during 2016. This asked questions about involvement and recognition, communication and support, and training and development. Eleven staff had responded to the survey and the responses had yet to be collated and analysed. We checked the responses and saw that almost all comments from staff were positive. The registered manager told us that a new format of satisfaction survey was being developed for use in all local authority services. These were due to be sent out to staff, relatives and health and social care professionals later in 2017.

Staff told us they attended monthly staff meetings and that they could raise concerns and make suggestions at these meetings, either by adding topics to the agenda prior to the meeting or by raising issues at the meeting. They felt their views were listened to.

We saw a variety of audits were being carried out to monitor the safety of the service and whether the service was meeting people's assessed needs. This included a care plan audit where the registered manager

highlighted any documents that were out of date or missing, a medication audit and health and safety checks. These checks included a monthly manager 'walk around' and a health and safety environmental inspection that checked on the safety of all areas of the home.

We asked staff to describe the culture of the service. Comments included, "We can practice good care here. I feel enthusiastic and feel that everyone does their best. I love it here", "It's positive, joyful and a homely little bungalow", "We are a good team. In the past we were fragmented but that's all sorted out now", "Staff are given responsibility and respond to it" and "The service is professional, happy and safe."

Staff told us they would use the home's whistle blowing policy if needed, and that they were confident the registered manager would respect their confidentiality.

Staff told us that they would discuss any incidents that had occurred. One member of staff gave an example of an accident with a person's sling. This was discussed openly and everyone had further refresher training on the safe use of slings. Checks were made to ensure all staff felt confident when using hoists and slings. This showed there was learning from accidents and incidents and that action had been taken to reduce the risk of similar incidents occurring again.

We saw that information from NHS Choices had been obtained for each medicine prescribed to people who lived at the home, and stored alongside their MARs. A health care professional told us, "When I visited Millside [Name of registered manager] asked me several questions about up to date pharmaceutical reference sources and how to receive regular drug alerts and actions from the MHRA." The MHRA is the Medicines and Healthcare products regulatory agency, who regulate medicines and medical equipment in the UK. This showed that the registered manager obtained guidance to make sure staff had the latest information on health and social care topics available to them.

One member of staff was the moving and handling champion. They had quarterly meetings with champions from other services within the local authority. These kept them up to date with the latest guidance that they were able to share with the rest of the staff team.