G Hudson & S Dobb

Milford House Care Home

Inspection report

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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

Milford House is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nursing and personal care is provided for up to 65 adults in two adapted buildings, known as The Coach House and Milford House.

At our last inspection in August 2017, we rated the service as Requires Improvement because people were not always provided with safe or effective care. This was because they were not always protected from the risk of avoidable harm and people's care records were not always accurately maintained to account for people's care. We did not ask the provider for an improvement plan as there were no regulatory breaches. At this inspection we found the provider had made improvements to the standard of Good. There were 52 people accommodated, who were predominantly older adults, including some people living with dementia or a physical disability.

There was a registered manager 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were made to ensure people received safe care and effective care. People were protected from the risk of harm or abuse by staff who understood and followed relevant guidance to ensure this.

Known potential risks to people's safety associated with their health conditions, care equipment and environment, were assessed before people received care, monitored and regularly reviewed. People's medicines were safely managed.

Staff understood and consistently followed the provider's operational care policies for risk management, care and medicines' systems; which helped to ensure people's care was consistently safe and effective.

People received holistically assessed, interagency agreed care. A range of health improvement initiatives were in progress utilising evidence based techniques. This, together with partnership working and the provider's introduction of relevant care technology systems, helped to ensure people received timely, informed and effective care.

Staff were effectively trained, supported and deployed. People were supported to have maximum choice and control of their lives and to help recruit new staff. Staff were skilled, knowledgeable and experienced and they supported people in the in the least restrictive way possible.

There was a strong emphasis on the importance of eating and drinking well for people at the service. Creative methods were used to help promote and ensure this. People were supported to maintain and

improve their health and nutrition in consultation with external health professionals when needed.

Environmental upgrading and refurbishment was completed in consultation with people who used the service. This was done in a way that took account of their related needs, choices and independence.

People received care from kind, caring and compassionate staff, who ensured people's dignity and rights in their care. Staff consulted with people and their representatives and followed what was important to people for their individual care, preferred daily living routines and lifestyle preferences.

People receive individualised care, that was usually timely, agreed and regularly reviewed with them, or their representatives when required. Staff understood and followed their roles and responsibilities for people's care and knew how to communicate with people in the way they understood.

The provider had developed accessible information systems and ways to communicate with people, relatives and staff at the service; which helped accurately inform people's care provision.

People were regularly supported to engage and participate in a comprehensive range occupational, social and leisure activities of their choice, which they enjoyed. This was provided in a way that helped to meet their individual preferences, diverse needs and inclusion in home and community life. Work was in progress to further enhance the care experience of people living with dementia.

People and relatives were supported and knew how to raise any concerns or to make a complaint about care or service provision, if they needed to. The provider regularly sought and obtained feedback from people, relatives and external professionals to help inform or improve the quality of people's care and service provision. The provider used findings from this to make improvements when needed.

Staff were trained and informed to follow nationally recognised care principles for people's end of life care when needed. This helped to ensure people would receive informed, co-ordinated and personalised end of life care and experience a comfortable and dignified death.

The service was well managed and led. The provider operated effective systems to ensure the quality, safety and effectiveness of people's care and to ensure service improvements when needed. Staff understood their role and responsibilities for people's care and were recognised for their hard work and contributions to the service, through the provider's award scheme. The provider had notified us of important events when they happened at the service and visibly displayed their most recent inspection ratings in accordance with legal requirements.

Further information is in the detailed findings below.

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.

Improvements were made to ensure people were consistently protected from the risk of avoidable harm or abuse. People's safety needs were accounted for and their medicines were safely managed.

People received care from staff who were safely recruited and deployed. Relevant measures were in place and followed to protect people from the risk of a health acquired infection.

Safety incidents and near misses, were routinely monitored and analysed to help inform or improve people's care and related safety needs when required.

Is the service effective?

Good

The service was Effective.

Improvements were made to ensure people received effective care. Overall, people were supported to maintain and improve their health in consultation with relevant external health care professionals when needed. Creative and innovative methods were used to promote and ensure a strong emphasis on the importance of good nutrition.

People's care was evidence based and holistically assessed. Related care approaches, interagency partnership working and care technology helped to drive care improvement and the delivery of effective care.

People were supported to have maximum choice and control of their lives and help recruit new staff. People received care in the least restrictive way possible. Staff were trained and consistently supported to develop and their skills and experience in a validated way. This helped to underpin and ensure effective, informed care provision for people at the service.

An extensive programme of environmental refurbishment was

completed via relevant consultation methods with people. This helped to inform and ensure their needs, choices and independence.

Is the service caring?

Good

The service was Caring.

Staff were kind, caring and promoted people's dignity, choice, independence and rights when they provided care. Accessible care and service information was provided for people or their representative to help inform people's care. Staff had good relationships with people and their families who they kept regularly informed and involved to agree people's care and daily living arrangements.

Is the service responsive?

Good

The service was Responsive.

People's care was individualised and overall timely. Staff knew how to communicate with people in the way they preferred, and they understood and followed people's views and wishes for their care. This was done in a way which helped to promote people's inclusion and engagement in home and community life as they chose.

Arrangements were in place to promote informed, co-ordinated and personalised end of life care and ensure people's comfort and dignity.

People and their representatives were informed to make a complaint about the service if they needed to and the provider regularly sought their views about the service and people's care provision. Findings and feedback from this were used to help inform or improve the quality of people's care.

Is the service well-led?

Good

The service was Well led.

The service was well managed and led. The provider's service oversight and monitoring arrangements helped to ensure the quality and safety of people's care and any related improvements needed.

The provider's engagement with relevant health, social care and educational authorities helped to inform and further enhance people's care experience at the service.

The provider told us about important safety incidents that happened at the service. Recent inspection ratings were visibly displayed as required within the service.

Milford House Care Home

Detailed findings

Background to this inspection

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

This was a comprehensive, unannounced inspection, which took place on 30 August 2018. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection the provider sent us their completed 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 any improvements they plan to make. We spoke with local authority care commissioners for people's care at the service. We also looked at all the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

We spoke with nine people, seven relatives, one nurse, five care staff including one senior; three catering and two domestic staff. We also spoke with the registered manager, two senior external managers for the provider and two community professionals involved with people's care at the service. We looked at six people's care records and other records relating to the management of the service. This included staffing, medicines and complaints records and records relating to the provider checks of the quality and safety of the service. We did this to gain a representation of views about people's care and to check that standards of care were being met.

Good

Is the service safe?

Our findings

People received safe care. Both they and relatives were spoke with, were confident of people's safety at the service. One person said, "I feel safe and happy here because of staff and the environment." Another said, "oh yes, I feel safe' if I didn't' I would definitely speak up; I know who to speak to if needed." A relative told us, "Yes, I feel [person] is safe here; staff are very good at using the hoist." People, relatives and staff working at the service were informed how to recognise and report the abuse of any person receiving care, or any safety concerns if they needed to. This included related information that was visibly displayed for people and visitors.

Staff were safely recruited and deployed to provide people's care. People, relatives and staff felt there were enough staff to provide people's care. Regular account was taken of people's individual care needs, to help inform staff planning and deployment requirements for people's safety. Throughout our inspection we saw staff were visible and provided timely care when people needed it. Community health professionals we spoke with said staff were always available to assist them when required.

The provider followed safe procedures for staff recruitment and employment. This included checks of staffs' employment history, related nursing or care experience and checks with the governments' national vetting and barring scheme. This helped the provider to make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups of adults or children. Periodic checks were also made of nurses' professional registration status, to make sure they were fit to practice nursing care.

Risks to people's safety associated with their health condition and environment, were assessed before people received care and regularly reviewed. Staff understood and followed people's care plans, which showed any risks identified to people's safety and the care actions required to minimise them. Staff we spoke with described a safe, consistent and least restrictive approach to people's individual care. Any equipment used for people's care was subject to regular servicing and safety checks. For example, hoist equipment to help people move, sensor mats to alert staff to people's movement where they were at risk of falls, or pressure relieving mattresses, used to help prevent skin damage to any person from prolonged pressure.

Key care information associated with people's safety needs were recorded in a standardised format to go with the person, if they needed to be transferred to another care provider. For example, in the event of hospital admission. This helped to ensure people received safe, consistent care.

A range of lead management roles concerned with managing care and service risks, were identified by the provider. This included health and safety, infection control and safeguarding leads. These roles were embedded within the provider's day to day service operations at the service, to help ensure safe practice, reporting, monitoring and timely risk management strategies when required for people's care. Any safety incidents or near misses were routinely monitored and analysed, to check for any trends or patterns. This information was recorded and used to inform and improve people's care and safety needs. For example, in relation to falls management, equipment or medicines safety. This helped to protect people against the risk

of avoidable harm or abuse at the service.

Emergency business contingency planning arrangements and related procedures helped to ensure peoples' safety. Staff responsible, were able to describe the procedures they needed to follow to ensure people's safety at the service. For example, following a health emergency, safety incident or in the event of a fire alarm. Checks made by local fire and environmental health authorities before our inspection, found satisfactory arrangements at the service for fire safety and excellent arrangements for food safety and hygiene.

People's medicines were safely managed, stored and given to people when they needed them. Related records were accurately maintained. Staff responsible for the handling and administration of people's medicines, were regularly trained and assessed to make sure they were competent and safe to do so. Regular management checks helped to ensure this. For example, revised management monitoring of medicines ordering was recently introduced, to help ensure the timely receipt of people's medicines ordered. Staff were supporting one person's choice to administer their own medicine safely. Related records showed this was managed in a way that met with nationally recognised practice guidance concerned the with self administration of medicines in a regulated care setting.

People and relatives were satisfied with standards of cleanliness and hygiene maintained at the service, which we also observed. Staff understood and followed their related roles and responsibilities concerned with the prevention and control of infection and cleanliness at the service. Equipment provision, staff training, guidance and regular management checks, helped to ensure this.

Good

Is the service effective?

Our findings

People received effective care. People and relatives were happy and confident with the care provided by staff at the service. One person said, "I get the care I need; staff know what they are doing." A relative said, "As [person's] condition has changed, the staff have moved with it; they notice and act promptly to give the right care." Two Visiting community health professionals we spoke with at our inspection, told us they felt staff were knowledgeable and had the skills to support people effectively. They also confirmed that staff followed their clinical guidance and instructions when required. One of them said, "Staff err on the side of caution, rather than let things slip;" and "Residents needs are paramount here to staff; they are proactive when people's health changes and respond quickly."

Staff supported people to maintain or improve their health in a way that met with their needs and choices. This was usually done in a timely manner, following consultation with relevant external health professionals when needed. For example, for routine or specialist health checks, treatment or advice. However, in the Coach House unit we found there had recently been a delay, where additional care assessment instructions for one person's care from a community healthcare professional, had not been followed. The care instructions were important to help inform the person's ongoing care requirements following changes in their health condition. Another external health professional who had been previously involved with people's care at the service, told us they had found episodes of inconsistent care from staff who had not always followed their instructions consistently. We discussed our findings with the clinical lead nurse manager, recently appointed for the Coach House and found they had identified and acted to rectify this, to help prevent any further reoccurrence. The provider had also recently introduced holistic, evidence based care planning technology with related staff training for its use. We spoke with staff about this and found the system helped to support the delivery of informed, timely care and prevent further care omissions.

There was a strong emphasis on the importance of eating and drinking well. People were fully involved in meal planning and received sufficient amounts of food and drink they enjoyed, which, met with their assessed dietary needs. Catering staff were provided with accurate written information for people's dietary needs and regularly sought feedback from people to help inform meal planning. We saw lunchtime was a sociable occasion with a choice of drinks, including wine, which people said was routinely offered. A choice of drinks, snacks and fresh fruit were readily accessible to people and regularly offered throughout the day.

Staff supported people's choice of food and drinks and provided any assistance or equipment they needed to eat and drink. For example, help to cut up food for people or by providing adapted crockery, cutlery or drinking cups when needed, to enable people to eat and drink independently. People's intake of drinks was closely monitored to ensure their hydration was maintained when required. Mealtimes were flexible to support people's health needs associated with their diet, and accommodated their choices.

Special diets were catered for, such as gluten free or diabetic diets. Culturally appropriate foods could be made available, when needed. Healthy eating was promoted in consultation with people and they were also provided with the correct consistency of foods when required. For example, soft or pureed diets for people who had swallowing difficulties because of their health condition. Staff offered support and encouragement

to people who were reluctant or having difficulty eating and drinking. Creative methods, such as, 'smooth foods' were provided for people who needed pureed diets. This is a product designed to take on the appearance of actual food. For example, a pureed carrot, has the appearance of a whole baby carrot. This helped to make food more visually appealing to people. People's care plan records we looked at showed how their nutritional intake and status, including body weights were monitored and maintained.

Where people had a reduced appetite, or were at risk of malnutrition because of their health condition, this was closely monitored in consultation with relevant external health professionals when required. Following relevant assessment and consultation, people were provided with fortified food or drinks when needed, to help ensure their individual daily calorie intake requirements for their health. The provider had also purchased a nationally recognised food system, to promote basal stimulation and moistening of the mouth for people who were no longer able to take nourishment orally, because of their health condition. This consisted of flavoured 'foam' bubbles containing tastes of various drinks, such as coffee, wines and fruit juices, to help stimulate people's taste buds, moisten their mouths and improve their sensory experience. The chef said, "We could only offer lemon flavoured mouth swabs before; this is proving popular as it gives people the opportunity to taste and enjoy their favourite flavours." This showed that people were creatively and effectively supported to maintain or improve their nutritional status.

There was a thorough approach to planning and co-ordinating people's move to another service, or for their discharge home as appropriate. This was done in a way that met with people's assessed needs, preferences and circumstances and ensured timely information sharing with relevant care agencies or providers. For example, staff had worked collaboratively and efficiently with one person and relevant external care professionals to enable their reablement and return to live in their own home in the local community. Staff held a 'Graduation' party for the person to celebrate their achievement. This showed the provider worked collaboratively, to ensure people received the right care, as agreed with them.

Wherever possible, people who used the service were supported to take part in the recruitment of staff and to influence the outcome. We saw photographs, which demonstrated two people taking part in interviewing for a nurse at the service and looked at their subsequent written feedback following the interview, which was use to help inform the final decision.

The provider worked in partnership with other organisations to benefit people's health and care experience. They regularly reviewed nursing and care practice against nationally recognised legislation, guidance and standards. Recent examples, included research based care development work in progress. This was led by an external nurse consultant, to help enhance the care experience for people living with dementia. A sample study was completed with people, to help optimise their confidence through meaningful participation in daily living activities and engagement with others. For example, occupational or creative tasks they had previously enjoyed doing in their lives, such as re-learning to knit or crochet or helping with laundry or tidying. Related photographs of people engaging in this way and recorded feedback from their relatives showed this had improved people's confidence, wellbeing, autonomy and inclusion.

Other health improvement initiatives in progress included, an interagency falls prevention project and an independent, specified health promotion research trial, involving a study group of people living at the service, with their consent. The provider has also recently commenced working with a group of local medical and lead community health professionals; to help develop a multi-disciplinary single assessment tool and needs led approach to older people's care. This aimed to develop a new primary and community multi-disciplinary care model for people who live in care homes. This showed the provider sought to review and improve people's care, against nationally recognised best practice guidance and research participation.

Staff we spoke with said they received the training, information and support they needed to understand and follow people's care requirements, which related records showed. One nurse said, "I really love working here; communication, training and support opportunities are regularly given." Another care staff member said, "Training is at the right level and pace; we are well supported and encouraged to develop and learn; it makes for better care." Related records reflected this.

Staff leads were identified to help champion aspects of people's care. For example, in relation to falls prevention, wound and end of life care. Nurses were supported to access training to enable them to effectively and safely carry out relevant extended role nursing procedures, when needed for people's care. For example, such as taking blood samples for health investigation purposes, urinary catheterisation or to support any person with enteral nutrition when required. Enteral nutrition is used to deliver nutrition via a tube into the gut, where this cannot be taken normally by mouth due to a person's health condition.

Staff understood and followed the Mental Capacity Act 2005 (MCA) when required for people's care. The MCA provides a legal framework for making particular decisions, on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People's consent to their care was sought in line with the MCA. Staff understood how to support people to make decisions, or respond when people were unable to make specific decisions. Formal applications to the local authority responsible for DoLS authorisations were submitted and related authorisations were followed when required for people's care. Care records showed assessments were made of people's capacity when needed, which specified any best interest decisions required for people's care. This helped to ensure people received care that was lawful and in their best interests.

The environment was adapted to meet people's individual safety, independence and orientation needs. The provider had recently completed extensive refurbishment and upgrading of the premises, in consultation with people living there, which people were pleased with. This included the use of 'mood' boards and meetings held, to help people to choose décor and colour schemes. There was clear, easy read, written and picture signage around the home for those living with dementia. This included visible information in toilets, to aid people's memory for hand washing, including how to operate soap dispensers and where to obtain hand towels. There were a range of photographs, memorabilia items and articles around the home, that were often meaningful to people. This helped to stimulate people's personal memories and their sense of belonging.

People were able to move around the home with a range of areas where they could spend time alone, with others or in private and with access a pleasant outside patio and garden area. Décor promoted a pleasant, peaceful environment with sufficient space for people to move with any equipment they needed to use, such as walking frames. We saw and people said they were happy and comfortable with the environment and their own rooms, which they had personalised as they wished.

Good

Is the service caring?

Our findings

People received care and support from staff who were kind, caring and compassionate. One person said, "All the staff are very caring, very kind and patient; They treat me with dignity, respect and care." Relatives and other people's comments also reflected this. One person said, "Care staff are excellent here." All felt they had good relationships with staff and were made to feel very welcome at the home." A visiting health professional said they found staff were 'consistently kind, caring and patient' with people.

We observed throughout the day that people were treated with care and kindness. Staff had a good understanding of people, their care needs and there were clearly strong and caring relationships formed. Staff were caring and tactile with people. For example, giving people of hugs or sitting and holding their hands when appropriate.

We saw staff consistently followed the provider's published care aims and values, by promoting people's dignity, equality and rights when they provided care. The provider's operational measures, which included related staff training, instruction and regular management checks of people's care helped to ensure this. People were offered a choice of where and how to spend their time. We saw staff regularly consulted with people and their representatives, to agree individual care, meals and preferred daily living routines. This information was clearly recorded in people's individual care plans and regularly reviewed with them or their representative. Written and picture food menus were provided and catering staff spoke with people each day about their meals choices. At lunchtime we saw staff showed some people living with dementia, a tray containing the three meal menu options on offer, to help them choose their meal. Feedback from people, relatives and staff told us this was routine practice, to ensure people received meals of their choice.

Staff were mindful to check with people, whether they were comfortable and had their personal items to hand, such as drinks, spectacles, call bells or walking frames before leaving them. Staff made sure they knocked on people's bedroom doors before entering and introduced themselves and the reason for their visit to people's rooms. We also saw that staff closed doors to ensure people's privacy when they provided their personal care, such as supporting people to use bathroom and toilet facilities. Staff also supported people to change or adjust their clothing when needed; and offered people the use of napkins or aprons to protect their clothing at meals times. This showed staff promoted people's, dignity, comfort, choice and independence.

People and relatives felt staff knew people well, understood and followed what was important for people's care. Everyone we spoke with felt they had good relationships with staff who made them feel welcome at the service. Staff we spoke with understood and followed relevant care principles to maintain confidentiality and ensure appropriate information sharing concerned with people's care and treatment. A visiting healthcare professional told that staff always ensured privacy for their nursing consultations, assessments and people's related care and treatment; thereby promoting patient confidentiality.

Staff took time with people and knew how to communicate with them in the way they preferred and understood. For example, we saw staff used simple language, gestures or objects of reference to support

people who were experiencing communication difficulties because of their health conditions. Staff listened when people were talking with them and made sure they positioned themselves at people's eye level to support effective communication. A senior care staff member said, "It's so important to take time with people. Another care staff commented, "I get great satisfaction seeing people smile, it's the best part of my day; spending time properly with people helps to uplift them and us." Throughout our inspection we found a friendly atmosphere with good banter and humour from staff that was appropriately placed, or quiet reassurance for people who needed any emotional support.

People and relatives were provided with a range of service information, to help them understand what care and daily living arrangements they could expect people to receive. This could be made available in relevant alternative formats to suit the person. People were informed how to access independent professional and lay advocacy services, if they needed someone to speak up on their behalf. Related information was visibly displayed around the home to support this.

Good

Is the service responsive?

Our findings

People received personalised and usually timely care, which took account of their assessed needs, preferred daily living routines, care and lifestyle choices. One person said, "Staff know how I am; They keep to what I like and want and help me when I need any help; They take time with me." A relative said, "Care staff are very good; they can tell straight away about [person's] care, without having to go off and check all the time; it's on the devices they carry." A staff member said, "Care provision and changes are quickly communicated."

A few people said they had experienced some recent delays at night time when they had used their call bells for staff assistance. However, they also felt this was taken on board by management. The registered manager confirmed they had recently increased staffing levels at night to address this, following staff reporting an increase in some people's care needs during that time.

The provider's introduction of an electronic care planning system was almost completed. Nurses and care staff were trained to use the system and had their own linked hand held electronic tablet devices, which they kept on their person. This enabled staff to access people's care plan information whenever they needed to, and also to record care given at the point of delivery. Staff felt this, along with recent staffing revisions, benefitted the timeliness and effectiveness of people's care.

We saw staff followed people's individual care and daily living preferences, which were detailed in their care plans and regularly reviewed with them. During our inspection we saw a care staff member sat with one person and used a laptop computer, to review and agree the person's care plan with them. This showed people received timely care that was responsive to their needs and wishes.

Staff understood what was important to people for their care and knew how to communicate with them in the way they understood. For example, some people living with dementia could easily become anxious or confused, when they didn't understand what was happening around them. We saw staff provided one person with the guidance, emotional support and reassurance they needed when this occurred. This helped the person to understand and become more visibly relaxed, so they were able to eat their lunchtime meal.

One staff member was able to use British Sign Language. Sign Language is a visual means of communicating using gestures, facial expression, and body language. Sign Language is used mainly by people who are Deaf or have hearing impairments. This enabled communication with one person who also preferred to use this, to help them agree their care and daily living arrangements.

People were provided with a range of accessible information to inform and support their care, orientation and daily living arrangements. Such as large print, picture, written and verbal explanations. This met with the Accessible Information Standard (AIS), which states that providers should take account of any communication difficulty or disability when sharing information with the people they support.

Initiatives were in place to assist people living with dementia. For example, meals continued to be served on

coloured plates, to encourage people to eat. This was based on nationally recognised research, which showed that people living with dementia recognise food better from a red plat than a white one. This helped to promote people's autonomy and independence.

People were often supported to engage in home and community life, as they chose. We found there was a comprehensive range of daily and varied opportunities for people to participate in social, recreational and occupational activities of their choice. For example, this included games, sensory and reminiscence therapies, access to animals, music, crafts, quizzes, regular gentle exercise, visiting external entertainments and via links with local schools. People were often involved in community fund raising events such as the 'Poppy Appeal' in support of world war veterans as well as for a local maternity hospital. A few relatives felt that arrangements could be further improved for some people living with dementia to further regular opportunities for their individual participation and engagement. We found this was identified as part of the provider's service improvement plan to further this.

Coffee mornings, seasonal events and celebrations of national or individual importance to people, were also arranged. People's spiritual and cultural needs were identified with them, supported and met. Staff, people using the service and their relatives, were involved in regular fund raising to support people's participation in their chosen recreation and leisure activities. Meetings were regularly held with people, relatives and staff to help inform and agree people's home life and daily living arrangements.

People and their relatives were informed and knew how to raise any concerns or make a complaint about their care if they needed to. Any complaints received were handled in accordance with the provider's complaints procedure. People's and relatives' views about the quality of care provided were regularly sought. Findings from complaints and feedback was used to help inform or improve people's care when required. Examples of recent improvements made from included, people's hearing care and equipment use and a review of pre-admission assessment procedures, to help accurately inform and agree people's care plans.

There was no person receiving end of life care at the time of our inspection. Staff responsible, understood were trained and informed, against nationally recognised principles and standards concerned with people's end of life care, including after death. Links were established for staff to work in consultation with relevant external health professionals and care providers concerned with people's end of life care. A dedicated chaplain also provided spiritual support for people, their relatives and staff access, if they needed to. This and the provider's related operational policy for people's end of life care, aimed to optimise people's involvement, comfort, choice, symptom control and access to any related care equipment. This helped to ensure, that people received informed, co-ordinated and personalised end of life care; and a comfortable, dignified death.

Good

Is the service well-led?

Our findings

There was registered manager for 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 service was well managed and led. People, relatives and staff were positive about the management and running of the service. Most people and relatives knew who the registered manager was and confirmed they were visible, approachable and accessible. One person said; "The manager is just lovely." A relative told us, "The home is very well led and managed. The manager has always responded to what I've asked; Everything is organised."

Staff consistently described the registered manager and provider's management team as supportive and approachable. Most visiting health professionals, we spoke with described the service as 'well run' and 'organised.' They told us the registered manager was, "Very present and visible manager; I feel welcome at the home." And, "The manager always asks me if everything is alright, we have a good working relationship."

We found an open, positive culture at the service, where individualised care was promoted and ensured. There was a strong management team, which included the provider's external management support, who were visible and worked closely with the registered manager and staff teams in both units at the service. Our discussions with staff and general observations found there was a strong, collaborative team working ethos. One care staff said, "I love my job here, the people we care for – it's a great team." Staff told us they felt comfortable to approach any of the management team. All felt management communications with them were productive, where they could share any views, opinions or comments relating to people's care and their working arrangements at the service.

Staff were recognised for their hard work and contributions to the service through an award scheme called, "Milford Care Awards." The provider told us they hold a "Milford Care Awards" ceremony, in which members of staff, who go the extra mile for people's care, are rewarded for their hard work. People, their families, visiting professionals and staff are encouraged to nominate staff and a number of residents and relatives attended the staff award ceremony. Two members of staff had received the Leadership award and Spirit of Milford award. Some staff had also been nominated for various awards within The Great British Care Awards and a member of Milford House care team was short listed as a finalist.

Staff understood their roles and responsibilities for people's care and they were informed and confident to raise any related concerns if they needed to. The provider used a range of consistent operational measures to inform and support staff to provide people's care. This included stated care aims and objectives, which staff understood and followed; and a range of staff performance and development measures, communication and reporting procedures. It also included a comprehensive range of care policies and related safety and work procedures for staff to follow, which were regularly reviewed by management.

The registered manager and provider's external senior managers, told us they carried out regular checks of the quality and safety of people's care at the service, which related records showed. For example, checks relating to people's health, medicines and safety needs. Accidents, incidents and complaints were regularly monitored and analysed, to help identify any trends or patterns that may inform any care improvements required. When any changes or improvements were needed for people's care; staff confirmed this was communicated to them in a timely, accessible and relevant manner. For example, via staff meetings, care handovers, written and electronic communications.

The provider sought opportunities to review and improve the service against nationally recognised guidance and through regular consultation with people, relatives and staff who worked at the service. This included participation in relevant research, development and training initiatives. Examples, in progress at this inspection included participation in an interagency falls prevention project and an independent health promotion research trial, involving a study group of people living at the service, with their consent. They also regularly sought to engage with external health, social care and educational authorities and agencies to help inform, enhance or improve people's care at the service. This showed the provider regularly took account of the quality and safety of people's care and acted to inform, maintain or improve this when needed.

Records for people's care and the management of the service were accurately maintained and safely stored. With an exception of one delay, the provider met their legal obligations to send us timely notifications about important events which occurred at the service when they needed to.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website. This showed there were effective arrangements in place for the day to day running of the service.