MNP Complete Care Group

Millfield House

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

The inspection took place on 28 November 2017. This inspection was unannounced.

The service is a care home that provides care and accommodation for up to eight people with a physical disability and cognitive brain impairment caused after an accident, stroke or by cerebral palsy. Cerebral palsy is a lifelong condition that affects movement and co-ordination. At the time of our inspection there were eight people using the service. The accommodation was situated over three floors. A lift was used for people to access different floors in the service.

A registered manager was employed at 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 registered manager was not available for this inspection. However, the deputy manager and provider's group manager were on site and assisted the inspection process.

The provider trained staff so that they understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise any concerns they may have.

The provider offered an inclusive service. They had policies about Equality, Diversity and Human Rights.

The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The provider was consistent in measuring the quality of people's experiences and continued to work at putting people at the heart of the service.

The quality outcomes promoted in the providers policies and procedures were monitored by the management in the service. Audits undertaken were based on cause and effect learning analysis, to improve quality. All staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice. The provider shared their learning with other services in the provider group of care homes.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health.

We observed and people described a service that was welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered.

Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected. Some people employed their own external care staff for some activities. We observed people being consulted about their care and staff being flexible to requests made by people to change routines and activities.

Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these happening again. Staff were trained about the safe management of people with behaviours that may harm themselves or others.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The provider recruited staff with relevant experience and the right attitude to work with people who had physical disabilities and cognitive impairment. New staff and existing staff were given an induction and on-going training which included information specific to the people's needs in the service.

People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, by telephone, or by using formal feedback forms.

Staff assessed people as individuals so that they understood how they planned people's care to maintain their safety, health and wellbeing. Risks were assessed within the service, both to individual people and for the wider risk from the environment. Staff understood the steps to be taken to minimise risk when they were identified. The provider's policies and management plans were implemented by staff to protect people from harm.

Meals were suitable for people's individual dietary needs and met their preferences. People were supported to eat and drink according to their assessed needs. Staff supported people to maintain a balanced diet and monitor their nutritional health.

Staff received supervision and attended meetings that assisted them in maintaining their skills and knowledge of social care.

The premises and equipment in it were regularly maintained and serviced to minimise risks to people's safety.

Management systems were in use to minimise the risks from the spread of infection and keep the service clean and odour free.

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.

People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns.

The provider understood how to report safeguarding concerns and notified the appropriate agencies.

The provider used safe recruitment procedures and general and individual health and risks were assessed. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk.

The premises and equipment were maintained to protect people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood by the provider and staff received training about this.

Is the service caring?

Good

The service was caring.

Staff used a range of communication methods to help people engage with their care.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect. Staff understood how to maintain people's privacy.

Is the service responsive?

Good

The service was responsive.

Staff provided care to people as individuals. People were provided with care when they needed it based on a care plan about them.

People could take part in activities and socialise according to their lifestyle choices.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The provider operated systems and policies that were effective and focused on the quality of service delivery.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

Staff understood they were accountable for the quality of the care they delivered.

Millfield House

Detailed findings

Background to this inspection

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

We carried out the inspection because the provider had changed their legal entity in December 2016. We inspect new services within 12 months of them being registered.

The inspection took place on 28 November 2017 and was unannounced. The inspection was carried out by one inspector and one expert by experience. The expert-by-experience had a background in social care settings.

We reviewed the information we held about the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

We observed the care provided for people. We spoke with four people and two relatives about their experience of the service. We spoke with six staff including the deputy manager, provider's group manager, one team leader, two care workers and the chef. We received feedback about the service from a health and social care professional.

We looked at records held by the provider and care records held in the service. This included four care plans, daily notes; safeguarding, medicines complaints and a range of policies; the recruitment records three staff employed at the service; the staff training programme; medicines management; complaints and compliments; meetings minutes; health and safety assessments and quality audits.

The service had been registered with us since 11 September 2016. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

We observed that staff delivered safe care. People and relatives we spoke with told us the service was safe and that if they did not feel safe they would speak to staff. One person said, "I feel very safe at Millfield."

One relative said, "Millfield is well run and clean, it feels like home for my brother." Another said, "The care is very good, would not have him here if it was not any good."

A health care professional said, "I have always felt that the provider makes sure residents are treated as equals and given as much autonomy over their lives as possible."

People were protected from the risks of potential abuse. The provider had a safeguarding policy that informed staff about their responsibilities to safeguard people and what constituted abuse. Staff received training in safeguarding, knew what signs to look out for and now felt confident the management team would listen to and act on any concerns they raised. Staff told us they understood how abuse could occur and how they should report abuse. One member of staff said, "I receive regular training on safe care." They clarified this by telling us about scenarios of abuse they may encounter and how they would respond. For example, if staff noticed bruising or changes in people's behaviours. Staff we spoke with were confident they could challenge any poor practice within the service and report it appropriately. Staff had read and understood the provider's whistleblowing policy.

There were no safeguarding concerns about this service at the time of the inspection. Safeguarding was an agenda item for themed staff team meetings and supervisions. Should there be any safeguarding issues raised the deputy manager understood these should be reported and investigated. Some people spoke to us about issues that had made them feel unsafe in the past. However, the deputy manager told us how they had responded to these issues, for example by taking disciplinary action against staff involved. The deputy manager told us they would continue to reassure people that the past issues had been addressed.

There were policies about dealing with incidents and accidents. There were no records of any incidents or accidents occurring since the service was registered. Staff received training about how to report accidents and incidents to the deputy manager. The providers policy set out that incidents and accidents should recorded, investigated and responded to, this reduced the risk of future incidents.

People received their medicines safely to protect their health and wellbeing. Medicines were administered safely by senior care staff who had specialist training in this area. Medicines were ordered, stored and managed to protect people. 'As and when' required medicines (PRN) were administered in line with the providers PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Staff followed the provider's medicines policy. People were able to refuse or consent to allow staff to administer medicines for them within the Mental Capacity Act 2005. Where people refused their medicines, they signed to acknowledge they had withdrawn their consent or best interest meetings had been recorded.

The deputy manager checked that staff followed the medicines policy and that they remained competent by checking staff knowledge and practice when they administered medicine's. Medicine audits were carried out. Physical quantities of stock and quantities that should have been remaining were correct. For example, we checked that the recorded amounts matched the actual amounts left and that liquid medicines had a 'date of opening' recorded on the label. Staff administering medicine's were provided with training so that they understood the broader principals of medicine's safety and record keeping. Staff we observed administering medicines showed us how they supported people safely when dealing with medicines.

Medicines were stored safely in a locked medicines trolley which was secured to a robust wall fixing by a chain when not in use to prevent the trolley being moved. Other medicines were stored in the registered manager's office when not required. A locked fridge was available specifically for medicines that may require low temperature storage. The fridge and temperatures within the medicines trolley were recorded by staff daily and records of this showed they were stored within normal temperature ranges. This meant that medicines would remain safe and effective and would not degrade through exposure to incorrect temperatures.

People were protected by staff who understood their responsibility to record the administration of medicines. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff. The MAR sheets were being completed correctly by staff, there were no gaps on the MAR records. We saw records of referrals to GPs and of staff seeking advice from other external professionals when required. Records showed that medicines were reviewed with people's GP's.

The provider assessed risks to people's individual health and wellbeing. For example, they assessed people's care needs, mobility, nutrition and communication. Audits of medicines and specific risk to people from the care being delivered were in depth and reviewed with frequency to maintain safety. Where risks were identified, people's care plans described the equipment needed and the actions care staff should take to minimise the risks. For example, people had access to their own hoist when they needed lifting from bed to chair. If the actions taken to minimise identified risks restricted people's rights, their consent was sought or their rights were protected with the guidelines set out in the Mental Capacity Act 2005. For example, to maintain safety people may need constant staff supervision when in the community for their safety. We found that people were protected by staff following people's assessed needs.

The provider assessed risks to the premises and equipment and took action to minimise the identified risks. Records showed that they had implemented a system of regular checks of the premises, the fire alarm and essential supplies such as the water, gas and electricity. Equipment, such as hoists, profiling beds and wheelchairs, were serviced and staff regularly checked that items such as slings were safe and fit for use.

Emergency policy and procedures were understood by staff. The fire plan had been translated into a more easily understandable picture format to assist people who used the service to understand the premises fire safety plans. The fire safety in the service had been reviewed by an external consultant with an expertise in care home fire safety in June 2017. The deputy manager told us that the lift shaft and loft space had been protected within the fire warning systems. We saw that recommended work to improve fire safety had been carried out. For example, the external consultant had recommended a vent in the basement be removed and this work had been completed. Staff had training in fire safety and practised the routine. Evacuation response times were recorded and staff involved were debriefed to improve practice and understanding. Signage advised the 'fire plan' for everyone and people's personal evacuation plans (PEEPs) were kept with the emergency pack.

The provider's recruitment policy and processes were followed to minimise risks. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants had references, full work histories and had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Staff were deployed in appropriate numbers within the service to keep people safe. Day time staffing numbers were flexible and more staff were made available at busy times. Back up staff had been recruited to cover staff absences, for example staff holiday. This gave people consistency of care. In addition to the care staff, there was a cleaner, cook and maintenance person employed in the service. This meant care staff could concentrate on meeting people's care needs.

The provider had assessed general and individual risks and safe working practices were followed by staff. People had risk assessments that were specific to their needs. People's risk assessments addressed areas like communication, mobility, medicines, personal care and community safety. Infection control risks were managed through maintenance and cleaning practices. For example, cleaning was completed following a daily, weekly and monthly schedule. Cleanliness and infection control practices were recorded and audited as part of the quality management systems in the service. Our observations in the service confirmed that infection control guidance had been followed. For example, bins in bathrooms and toilets were covered, personal protective equipment like aprons and gloves were available to staff and the service looked clean and was free from unpleasant odours.

Documents were kept securely in an office and the access was restricted to staff. When staff completed paperwork this was either stored in the office to maintain confidentiality. Information about medicine's were securely stored in the medicines trolley between medicine's rounds. Care plans were kept in locked cabinets. Detailed daily records were kept by staff. Records included personal care given, well-being, concerns to note and food and fluids taken. Staff understood their responsibility to maintain people's confidentiality.

The provider had checked that the environment was safe for people. Other environmental risks were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, to minimise the risks from water borne illnesses. There were up to date safety certificates for legionella, gas appliances, electrical installations, portable appliances, lift and hoist maintenance.

Staff logged any repairs in a maintenance logbook and the maintenance staff monitored these until completion. The maintenance staff carried out routine health and safety checks of the service including regular checks of water temperatures, fire safety equipment and fire drills. Comprehensive records confirmed both portable and fixed equipment was serviced and maintained.

Good

Is the service effective?

Our findings

We observed and people told us that staff met their care needs.

A relative said, "I feel my wife's health needs are being met." And, "The managers are very approachable and very fair and the staff meet his needs." Another said, "The care had been good, especially around fluid intake." Another said, "I cannot praise them (staff) enough, I know he is in good hands."

A health care professional said, "There are no concerns raised, the service was delivering person centred care, ensuring dignity and respect at all times. Residents were fully involved in their care and personal preferences were adhered to."

There was an initial assessment process in place for people before they moved into the service. The assessment checked the care and support needs of each person so the deputy manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The provider also assessed people's dependency levels to capture how much staff care was required and how independent people could remain. However, it should be noted that not all of people's care was provided by staff employed at Millfield. Some people employed their own personal assistant through a private arrangement for certain task and activities. This was accounted for by the provider in their assessment. This arrangement worked well for people. The provider's processes involved people and their family members in the assessment process when this was appropriate. Capturing information about people was an evolving process.

The initial assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist, (SALT) team and the tissue viability nursing team. People accessed a range of health and wellbeing services. For example, podiatry and dental care. Where people's health was at risk from not drinking enough a plan was in place to monitor and respond to the risk. For example, people had been assessed by a speech and language therapist (SALT) or other professional who advised the staff of the amounts someone should drink in a day. Staff recorded what people drunk in their care plan. At the end of each day the total drunk was calculated. If people had not drank enough to maintain their health, staff referred them back to the SALT. People at risk of choking were assessed and measures were put into place to minimise the risk through foods that were easily digested or pureed. People's nutritional risk and allergy needs were shared with the chef.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The staff on shift told us they had received training to carry out their roles. Records showed staff

had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Much of the training undertaken by staff was face to face training rather than computerised courses. Staff benefited from this type of training as they could ask questions to clarify their learning. Staff received additional specialised training from community nurses, for example in the management of diabetes. We checked the effectiveness of this training and the staff responded in line with care plan guidance for the management of a person's diabetes. For example, they understood what blood readings meant and how they should respond if the readings were not right. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. They confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised.

The deputy manager checked how staff were performing through an established programme of daily staff handover meetings, team meetings and formal supervision. These are a one to one meetings and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the deputy manager was monitoring. We observed a hand over meeting between the morning and afternoon staff. We reviewed supervision notes from November 2017. These indicated managers were supporting a learning culture through discussion about important issues affecting staff work. For example, safeguarding and infection control. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings.

People continued to be supported to have enough to eat and drink and were given choices. The chef had introduced a menu that was responsive to people's likes and needs. The chef showed us how they constructed the menus to provide balanced and nutritious foods and how they knew which people had specific dietary requirements. Medical information was recorded where this impacted on the persons eating and drinking. For example, if the person was a diabetic or had an allergy to any foods. Staff were aware of people's individual dietary needs and their likes and dislikes. Access to the kitchen was restricted to the chef, but people had access to drinks and snacks from a small kitchenette in the dining room.

Throughout the inspection people were regularly asked if they wanted tea/coffee or a cold drink and there was always a drink by their sides. Kitchen fridges and food storage larders were well stocked. Care records contained information about people's food likes. People were provided with adapted crockery where required, which ensured they could remain independent when eating their meal. For example, plate guards to prevent food coming off the plate. Staff supported those who required assistance with their meal. We observed staff respecting people's choices, but also giving advice to people about foods that were most suitable for them to eat. For example, staff advised one person to have mashed potatoes, which was easier to swallow, rather than rice. The person was adamant they wanted rice and staff respected their choice, but the person then changed to mashed potato after they found it difficult to swallow the rice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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 what any conditions on authorisations to deprive a person of their liberty were.

The service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles.

People's consent and ability to make specific decisions had been assessed and recorded in their records. People were making day to day decisions and these were respected by staff. Where people needed staff supervision in the community due to their physical disability, they consented and agreed to this. Where people lacked capacity to make more complex decisions, for example, deciding where they should live, their relatives or representatives and/or relevant healthcare professionals were involved to make sure decisions were made in their best interests. Staff had received training in MCA and DoLS and understood their responsibilities under the act. Applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. One person had been referred to the authorising body by the provider and they were waiting for a response. The provider was in contact with the authorising body about this. The provider applies the principles of MCA 2005 within the service in a person centred manner which involved people in decisions about meeting their needs effectively.

People used a range of assistive technology to help them remain independent and communicate with staff. For example, people could turn on their televisions, call for assistance from staff or type out words using their head to communicate their needs to staff. The premises were situated near the centre of the town and was a large Victorian type building. People chose the decor of their rooms and we observed one person choosing new wallpaper for their bedroom. It was clear this person's choice of décor were not restricted by the provider's policies. Areas in the service were adapted for wheelchair access, for example the entrance path had a suitable ramped slope. People living on the upper floors could access a lift to move between floors. There were adapted bathrooms and people had a choice between bathing or showering. All of the bedrooms had a sink for people's use. This provided people with comfortable living accommodation.

Good

Is the service caring?

Our findings

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care.

A relative said, "All staff treated his wife with respect and dignity." Another said, "We are always happy with staff and how they care for our daughter." Another said, "My brother is very happy and ask that you keep up the good work." Another said, "The staff are definitely caring."

The care people received was person centred and met their most up to date needs. People's life stories and likes and dislikes had been recorded in their care plans. Staff encouraged people to advocate for themselves when possible. Each person had a named key worker and some people had staff called personal assistants (PA's). These were staff who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. This helped minimise the risk of social isolation for people.

We observed the relationship between a staff member and a person. The staff member was by the person's side all the time. Some of the communication was through a board word communicator whereby the staff pointed to each letter on the board with the person nodding when the letter was successfully touched to make a sentence. The person would also blink in answer to any questions. Our observations concluded that this was a very positive relationship with the staff member.

The staff on shift knew and understood each person's needs very well. Staff knew people's preferred names and they spoke to them in a caring and almost affectionate way. They had knowledge of their past profession and who was important in their life. They understood the importance of respecting people's individual rights and choices. People's right to privacy and to be treated with dignity was respected. We saw staff did not enter people's rooms without first knocking to seek permission to enter. Staff kept doors to people's bedrooms and communal bathrooms closed when supporting people with their personal care.

The provider had policies setting out their approach to dignity, equality, diversity and human rights. These were accessible to staff at any time and included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. All of the staff we spoke with displayed a caring attitude. We observed that people were supported by caring staff that were sensitive in manner and approach to their needs. We saw that people looked relaxed, comfortable and at ease in the company of staff.

We observed positive interactions between people and staff. Staff gave people their full attention during conversations and spoke to people in a friendly and respectful way. Staff gave people the time they needed to communicate their needs and wishes and then acted on this.

People's bedrooms were filled with their items, which included; photographs, pictures, furniture and ornaments. This combined with information in their care plans, provided staff with a wealth of information about people, for staff to use to engage them in conversation. Staff had a good understanding of people's

personal history and what was important to them.

The deputy manager reviewed people's individual records so that they provided up to date information for staff on how to meet people's needs. Relatives were encouraged to be part of the care planning and their views taken into consideration when completing care plans. This helped staff understand what people wanted or needed in terms of their care and support.

Good

Is the service responsive?

Our findings

People told us that the service was flexible and provided care that met their needs. One person said, "There is always something to do here". Another person told us, "We get asked about activities and changes to the menu". People and their relatives knew how to make a complaint if they needed to. They told us that they were confident that any concerns they raised would be taken seriously.

A health care professional said, "People accessed the community and used facilities and services within the local area. Holidays and days out were organised for those wishing to take part. Good interaction between staff and residents was noted and the visiting officer witnessed people being offered choices with meals and activities."

Care plans covered all aspects of people's daily living and care and support needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, emotional feelings, cultural needs and dignity and independence. The cultural needs plans identified the support required by each person for example, one person accessed television programmes from another country, another person went to church. Sometimes people were reluctant to agree to the care recorded in their care plans. In these instances, staff returned a short time later and asked again, or a different member of staff asked. If people still chose not to receive care, this was respected as their decision at that time.

Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs. They said they also supported people to be able to take part in activities in the community. The staff showed in discussion with us they understood people's conditions and how they impacted on their life. For example after a stroke.

Staff were responsive and flexible to people's choices and needs. Whilst the provider organised activities for people, in the main people in the service choose the activities they wanted to do. There was an activities notice board showing activities that people could do. For example, art. We observed people doing word search puzzles in a book with staff. Two others were active television watchers. We discussed the levels of in service activities with the deputy manager. They told us that the care plans were being reviewed and that activities were being explored with people on an individual basis. However, people spent time out of the service. They could easily access the town, meet friends or go out using transport provided by the provider. On the day of the inspection two people went out shopping for most of the day. In response to feedback from people and to facilitate more of this the provider has recently increased the availability of qualified minibus drivers. This meant that people could go out more often and for longer.

Staff helped people to stay in touch with their family and friends. For example, we observed relatives and friends freely coming into to visit during the inspection.

Residents' and relatives meetings were held. The minutes showed that they were able to contribute to the meeting and to make suggestions concerning their welfare and future service provision. For example, one relative told us they had asked for more activities. In response the provider had employed another driver to give more scope for longer trips out for people. The relative said, "People can now do longer days out, have 1-1 staff care and get out more."

People were aware of the complaints procedure. People told us they felt confident to raise any concerns and felt the provider would take them seriously. People told us they did not have cause to complain. The deputy manager told us there had been no complaints recorded this year. However, the provider had systems in place to monitor the outcomes of any future complaints and learn from them. This took the form of regular audits, conducted by both the manager and a member of the provider's senior management team.

An annual customer satisfaction survey was carried out. The findings of the 2016 residents and relatives' satisfaction survey showed the feedback was positive from the people using the service and relatives of people who used the service. Everyone who responded said that they would recommend the service to other people.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively of the staff and management team. A relative commented, "I would recommend this home to others." Another relative said, "There is good communication with the management, they definitely listen to what I have to say."

Staff told us that they had been employed at Millfield for a number of years and felt that the management respected their views. All of the staff we spoke with told us they enjoyed working at Millfield and felt it was a well led organisation. Staff also said that they all had a good working relationship with each other, but if they observed a member of staff doing something that they were not entirely happy with, they would have no hesitation in bringing it to their manager's attention.

The provider proactively sought people's views and took action to improve their experiences. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the home. The questionnaires asked people what they thought of the food, their care, the staff, the premises, the management and their daily living experience. Other meetings were advertised and took place for people who used the service and their relatives. The provider had a history of taking action to improve the quality of the service based on the results of their surveys.

Staff told us that the management team continued to encourage a culture of openness and transparency. Staff told us that the registered manager had an 'open door' policy which meant that staff could speak to them if they wished to do so and worked as part of the team. Support was provided to the registered manager and deputy manager by the provider's group manager in order to support the service and the staff. The provider's group manager shared quality practice across the services they covered. Managers from the different services met to discuss issues support each other. The provider's group manager was responsive with their support. For example, the registered manager was not available on the day of our inspection, but the provider's group manager visited to support the assistant manager with the inspection.

There were systems in place to check the staff training records to make sure staff training was up to date and staff were equipped to carry out their role and responsibilities and any training needed was booked.

We looked at the arrangements in place for quality assurance and governance in all areas. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their services. We found that the provider had implemented good quality assurance systems and used these principles to critically review the service. They completed monthly audits of all aspects of the service, such as medicines, kitchen, personnel, learning and development for staff. The provider also carried out a series of audits either monthly, quarterly or as and when required to ensure that the service runs smoothly, such as infection control. We found the audits routinely identified areas they could improve upon and the deputy manager produced action plans, which detailed what needed to be done and when action had been taken. We saw the provider checked people's care plans, risk assessments and daily logs to ensure they were up to date and completed to a good standard. For example, in one person's care plan we saw six changes had been made and recorded for staff to follow between 08 September 2017 and 20 October 2017. Keeping

people's care reviewed meant that their current needs were always met.

The provider had clear values which was promoted by the management team to all staff. The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live as independently or with as little support as possible. Staff told us they felt part of the team and were able to contribute to meetings and share ideas for the benefit of the people using the service. The management team met with staff in meetings. They discussed the operational effectiveness of the service and any issues or concerns arising with the service they were providing to people. The deputy manager and provider's group manager provided leadership in overseeing the service and provided support and guidance where needed.

The provider worked closely with social workers, referral officers, occupational therapists and other health professionals. The right support and equipment were secured promptly and helped people continue to live independently, safely or be referred to the most appropriate services for further advice and assistance. For example, we saw people had bespoke wheelchairs, designed and made specifically for them.

We reviewed some of the provider's policies and procedures and saw these were updated on a regular basis to ensure they reflected current legislation. The provider was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. Staff told us policies and procedures were available for them to read and they were expected to read these as part of their training programme. The deputy manager had recently attended a conference about the Mental Capacity Act 2005. This meant that people experienced care from staff who were kept informed of current social care practice.