Avery Homes (Nelson) Limited

Milton Court 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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 2 and 6 November 2017 and was unannounced.

Milton Court Care Centre 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

Milton Court Care Centre accommodates up to 148 older people in a purpose built building which has four floors. Each floor has its own adapted facilities. One floor provided general nursing, two floors provided care and support for people living with dementia and memory loss and one floor provided residential care. At the time of our inspection there were 130 people staying there.

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

People received care from staff that knew them and were kind, compassionate and respectful. However, people's experience of care differed dependent on which area of the home they lived. Care at times was task focussed and there was limited interaction with people outside of completing care tasks.

People's needs were assessed prior to coming to the home and detailed person-centred care plans were in place and were kept under review. Risks to people had been identified and measures put in place to mitigate any risk.

There were appropriate recruitment processes in place and people felt safe in the home. Staff understood their responsibilities to keep people safe from any risk or harm and knew how to respond if they had any concerns.

There were sufficient staff to meet the needs of the people; staffing levels were kept under review. Steps were being taken to reduce the number of staff deployed from an agency which provided staff cover for absences to ensure consistency in the quality and standard of care.

Staff were supported through regular supervisions and undertook training which helped them to understand the needs of the people they were supporting. People were involved in decisions about the way in which their care and support was provided. Staff understood the need to undertake specific assessments where people lacked capacity to consent to their care and / or their day to day routines. People's health care and nutritional needs were carefully considered and relevant health care professionals were appropriately involved in people's care.

People were cared for by staff who were respectful of their dignity and who demonstrated an understanding of each person's needs. This was evident in the way staff spoke to people and the activities they engaged in with individuals. Relatives spoke positively about the care their relative received and felt that they could approach management and staff to discuss any issues or concerns they had.

There were comprehensive systems in place to monitor the quality and standard of the home. Regular audits were undertaken and any shortfalls addressed.

The registered manager was approachable and people felt confident that any issues or concerns raised would be addressed and appropriate action taken.

The service strived to remain up to date with legislation and best practice and worked with outside agencies to continuously look at ways to improve the experience for people.

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 told us they felt safe and there were risk assessments in place to mitigate any identified risks to people.

There was sufficient staff to provide the care people needed. Recruitment practices ensured that people were safeguarded against the risk of being cared for by unsuitable staff.

There were safe systems in place for the administration of medicines and people could be assured they were cared for by staff who understood their responsibilities to keep them safe.

Is the service effective?

Good

The service was effective.

People received support from staff that had the skills and experience to meet their needs and who received regular supervision and support.

People were involved in decisions about the way their support was delivered; staff understood their roles and responsibilities in relation to assessing people's capacity to make decisions about their care.

People had access to a healthy balanced diet and their health care needs were regularly monitored.

Is the service caring?

Requires Improvement

The service was not always caring

People's experience of care differed dependent on which part of the home they lived in. Care was often task focussed and staff had limited time to interact with people outside providing care.

Staff were kind and respectful; people were able to make choices and decisions about their care and their dignity was protected.

Visitors were welcomed at any time.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they came to stay at the home to ensure that all their individual needs could be met.

People were encouraged to maintain their interests and take part in activities.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint.

Is the service well-led?

Good

The service was well-led

There was an open and inclusive culture which focussed on providing person-centred care.

There were effective systems in place to monitor the quality of care and actions were taken whenever shortfalls were identified.

People were encouraged and enabled to give their feedback and be involved in the development of the home.

Milton Court 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.

The inspection took place on 2 and 6 November and was unannounced. The inspection was undertaken by two inspectors, a specialist nurse advisor and three experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert by experiences had experience of caring for a relative living with dementia and supporting older relatives to access similar services.

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 reviewed the completed PIR and took this into account when we made our judgements.

We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.
We also contacted the health and social care commissioners who help place and monitor the care of people living in the home.

During our inspection we spoke with 29 people who lived in the home and 17 members of staff; this included six care staff, two well-being advisors, a chef, a house keeper, three nurses, three unit managers, a trainer plus the registered manager and a regional manager. We were also able to speak to 12 relatives who were visiting at the time.

We observed care and support in communal areas including lunch being served. A number of people who used the service lived with a dementia related illness and so some of them could not describe their views of what the service was like; we undertook observations of care and support being given. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand

the experience of people who could not talk with us.

We looked at the care records of 12 people and three staff recruitment records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Good

Is the service safe?

Our findings

There was sufficient staff to meet people's basic care needs. The registered manager regularly reviewed the staffing levels to ensure that there were enough staff to meet people's changing needs. Where it had been identified someone needed 1:1 care to ensure their safety at all times additional staff was provided. However, the registered manager needed to ensure how best to deploy the staff at key times during the day, for instance on the memory floor more staff needed to be deployed at mealtimes to ensure that everyone got their meals in a timely way.

People looked relaxed and comfortable in the presence of the staff. People told us they felt safe in the home. One person said, " When I lived alone I didn't feel safe and having such lovely people around me makes me feel safe; I don't have any concerns if I had I would tell the manager, he would sort things, he's a nice chap." Another person said, "I do feel safe; I don't think there is anything not to make me feel safe that's why."

We were aware prior to the inspection that a family had raised concerns about the care and treatment of their relative, as a result of the concerns raised an investigation had been undertaken by the local authority. We saw that some of the concerns had been partially substantiated and that the provider had taken action to ensure a similar situation would not arise again. For example changes had been made to the pre-admission assessment process, only the registered manager, deputy manager or clinical lead would carry out pre-admission assessments on all prospective residents. This was to ensure the quality of the assessments carried out and to ensure that the service were able to meet people's individual needs and continue to meet the needs of others. A new weekly care plan audit was in place to ensure the quality and details of information within people's care plans was consistent and that staff had received additional training in relation to the Mental Capacity Act.

Staff understood their roles and responsibilities in relation to keeping people safe and knew how to report concerns if they had any. One member of staff told us, "I wouldn't have any concerns reporting something; it is our job to look after people." Another said, "We have a flowchart to follow so I know the process." We saw from staff training records that all the staff had undertaken training in safeguarding and that this was regularly refreshed. There was an up to date policy and the contact details of the local safeguarding team was readily available to staff. The registered manager had contacted the local safeguarding team when any concerns had been raised. Where the local authority had requested investigations to be undertaken these had been done so in a timely matter. Any lessons learnt had been recorded and shared with staff.

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety. For example, people identified as being at risk of damage to their skin due to pressure or who were at nutritional risk had been assessed; appropriate controls had been put in place to reduce and manage the risks. Records showed that the care specified had been provided for example people were supported to change their position regularly and had their food and fluid intake monitored to ensure their well-being. The information recorded for each person was kept up to date and was regularly collated which helped the nurses and registered manager to monitor people's general health and well-being and keep them safe.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started work at the home.

People received their medicines, as prescribed, in a safe way and in line with the home's policy and procedure. We saw staff spent time with people explaining their medication and ensuring they had taken their medicines. One person said, "My medication is always on time and they are very cautious by making sure I take them, they just don't leave them on the table." Medicine records provided staff with information about a person's medicines and how they preferred to take them. There was also information about medicines people could take on a flexible basis, if they were required and when and how they should be used. People's medicine was stored securely in a locked cabinet within a locked air conditioned room. Staff competencies to administer medicines were tested on a regular basis and audits of the medicines undertaken. If any issues were identified they were dealt with in a timely fashion to ensure medicine errors did not happen, and if they did they could be rectified. There was a system in place to safely dispose of any unused medicines.

There were regular health and safety audits in place and fire alarm tests were carried out each week. Each person had a personal evacuation plan in place. Equipment used to support people, such as hoists were stored safely and regularly maintained. Hoist slings were clean, odour free and the correct size and type of sling was outlined in individual care plans. Where infection was present, people had their own slings which were named to prevent cross infection.

Any accidents/incidents had been recorded and appropriate notifications had been made. The registered manager collated the information around falls and accidents/incidents on a monthly basis and took action as appropriate. We saw that one person who had an increase in falls had an action for a sensor mat to be placed by their bed so that staff were alerted in the night if they got off the bed; we followed this up and saw it had been put in place.

The home was clean and free from any unpleasant odours. The staff wore protective clothing when required and there was information around the home for people, staff and visitors in relation to infection control. The provider had systems in place to monitor the cleanliness of the home and all staff received regular training in relation to infection control.

Good

Is the service effective?

Our findings

People's care was effectively assessed to identify the support they required. Each person received a pre-assessment of their needs before they moved into the home which ensured that they moved in to the right area of the home to meet their individual needs. For example people who had been assessed to require more specialist equipment and a higher level of care moved into the top floor of the home where there were qualified nurses to support them and their care was monitored more closely. We saw that for one person a bariatric bed had been rented to ensure that they had sufficient room and were cared for more comfortably.

The home liaised with other health professionals which ensured people's health care needs were met. A GP visited twice each week and District Nurses visited daily. One person said, "They are very good at looking after all health needs here; the district nurses are wonderful as well, doctor on hand anytime, chiropodist comes about every 6 weeks." Another person said, "My husband is in here and became suddenly unwell, they were excellent they quickly called paramedics, he was taken to hospital but he's back now and ok. I would say all our health needs are met here, doctors, nurses, hairdressers, they even have the audiologist people come to clean our hearing aids out." We saw from people's care records that when health professionals had visited this was recorded, there was a need however to ensure that any actions taken as a result of a visit was clearly recorded. We spoke to the registered manager about this who gave us assurance that this would be addressed.

People were supported and cared for by a well trained staff team. People were confident that the staff had the skills and knowledge to support them. However, some people did not always feel that the staff from an agency that covered for any permanent staff absences were as competent. We spoke to the registered manager about this, they told us if they found agency staff were not providing the standard required, they addressed this with the agency and no longer used that person. The home used the same agency to try and maintain some consistency in the staff deployed. We observed that some of the agency staff were more confident than others and permanent staff offered support when needed.

All new staff undertook a thorough induction programme which was specifically tailored to their roles and experience. One care staff said, "It was the best induction I have ever had, really thorough and all face to face." The induction consisted of a whole week of face to face training which included moving and handling, fire safety, equality and diversity, safeguarding, infection control, dementia awareness, medication administration. It also included the care certificate which is based on 15 standards. It aims to give employers and people who receive care the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The staff then completed a full week of shadowing permanent more experienced staff members. One care staff said, "You could ask for the induction to be extended if you did not feel confident; I found it very good and helpful."

Staff were supported to obtain professional qualifications; some staff had National Vocational Qualifications up to level 5 and all staff were encouraged to undertake further training to enhance their knowledge and skills. On-going training included end of life care, care planning, mental health awareness, Mental Capacity Act and pressure ulcer prevention. The home had their own trainer who was a trained 'train the trainer'. We

spoke with this staff member who told us about a more in depth dementia awareness training they had attended facilitated by the local authority; the plan was to deliver the training to the staff team. Managers had completed an 'advanced carers' course which is a city and guilds affiliated course which involves learning in more detail about areas of care and support, for example tissue viability and infection control. The impact that this had had on people was that there were no people with pressure sores at the time of the inspection.

There was a staff training matrix in place so it was clear for the registered manager and the trainer when refresher training was required. This ensured that all staff remained up to date with their training.

Staff felt supported and listened to. They told us they received regular supervision and had annual appraisals. One member of staff said, "My supervisor has always been really supportive; I am able to raise concerns or discuss new ideas." Another member of staff told us they raised in their supervision that it would be a good idea to have a 'sensory garden' on a safe and secure balcony area. The idea has been supported by their supervisor and the registered manager and they had been give the go ahead to come up with ideas and suggestions of what this might look like and what they would like to purchase.

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 decisions 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The registered manager and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom and the management team were waiting for the formal assessments to take place by the appropriate professionals. Best interest decisions were recorded in care plans where people were unable to consent to medication. Choices and preference were clear in people's care plans including where people had varied capacity. We saw paperwork and care planning that guided staff to always ask a person about choices because some days they were able to make limited decisions. The care plan stated just because a person doesn't always have capacity doesn't mean we never offer choices. Care plans had been signed by people or if applicable their relatives.

People were involved in decisions about the way their support was delivered. We saw that staff sought people's consent before they undertook any care or support. However, when we spoke to people their comments were mixed. For example one person said, "They tell me what they are here for, for example we have come to get you up, here is the cloth. They give me the flannel to wash my own face. I don't really think that they ask." Another person said, "The staff ask if it is ok to do 'this and that' they always ask my permission." The provider needed to ensure that the staff were consistent in their approach and had undertaken the training around the Mental Capacity Act.

People were regularly assessed for their risk of not eating and drinking enough; staff used a tool to inform them of the level of risk which included monitoring people's weight. A daily record was kept for each person assessed at being at risk of not eating or drinking enough which demonstrated that staff monitored people's fluid and food intake. If there were any concerns about people not getting enough nourishment this was discussed at a daily meeting and referrals had been made to the dietitian for advice and guidance.

People were supported to eat a healthy balanced diet. There was a choice of meals available each day; the cook was able to offer alternatives if someone did not like what was on the menu. There was a food comments book on each floor of the home which enabled people to give their feedback each day. We saw that where any negative comments had been made the cook had tried to address them. Peoples views on the food was mixed but overall people were happy with the food. One person said, "My food is fresh, good and its vegetarian, I am very grateful they accommodate my diet." Another person said, "I think the food is very good indeed, it's well-presented and I get enough to eat."

People were able to choose whether they ate in one of the dining areas, lounge or in their own rooms. People who were unable to chew food or had difficulties with swallowing had their food pureed; food that needed to be pureed was kept separated to enable people to experience the different flavours of the food they were having. The cook was regularly updated on any special dietary requirements, the need for fortified foods and any specific likes or dislikes for people. There were drinks and snacks available throughout the day.

People had been encouraged to personalise their rooms. One person said, "My room is very good and my family helped me decorate, we moved the bed closer to the window and we brought some pieces of my furniture; the handy man helped me hang some photos and pictures so I am very happy with my living accommodation." The provider was in the process of looking at the design and decoration of the memory care units to help those people who were living with dementia. We saw that different types of flooring had been used to indicate different areas for people but this was an area which could be improved further.

Requires Improvement

Is the service caring?

Our findings

People's experience of care differed dependent on where they lived within the home. People living on the ground and first floor commented very positively about the care they received. One person said, "When I say this to you, I mean it, they [staff] don't just do the job, they do it from their heart and that makes me feel so good. They say to me they like to treat us like they would treat their own mother, you can't get better than that can you." Another person said, "Can't get any better care, it's like a five star hotel." Relatives were also very positive about the care their relatives received. One relative said, "The carers are excellent; they all talk nicely to [my relative]." However, for some people in the nursing part of the home their experience was different. People commented that they thought the staff were kind but that they did not have much time for them outside of providing the care they needed. One person said, "The staff are efficient, they don't waste much time, there is never a moment to chat to you. If you call them they do what you have asked and they are gone again." Another person said, "Most of the time they are kind and patient with me. One or two of them are in a rush sometimes. The care is generally okay, not better than that."

We spent time observing people living with dementia on the second floor as they were unable to tell us about their experience of care. We saw that the staff were task focussed and only interacted with people when they needed assistance. For example, we sat in a lounge dining area, there were five people sat in there with no meaningful stimulation. Staff came in and out of the room but the only time they spoke to people was to ask if they could weigh a person or if someone wished to go back to their room, no staff sat down with people or engaged with them. We noted that the majority of the staff were from an agency so did not know people well. The permanent staff we talked with all spoke positively about working at the home and how much they enjoyed it. One member of staff explained that if there were a number of agency staff covering that they tried to deploy them to support the more able people leaving the permanent staff to support those people with greater needs. The provider needed to ensure that they took into account the balance between the permanent staff and the agency staff. In one area of the memory care unit there were four out of five carers who were agency.

People looked happy and relaxed and there was a warm, friendly atmosphere around the home. People were encouraged, where possible, to move around the home and use the various areas such as the café and library and small sitting areas to meet with their friends and family. One person told us, "I like walking around, alone or with my family, it's a very safe area so I can venture on my own." Another person said, "Very well looked after they genuinely care, they respect mine and my husband's privacy, and any guests we may have visit us. If we weren't happy with the service we wouldn't stay, everything is very good here. Our laundry is done, our rooms cleaned; top class care."

People's individuality was respected and their dignity protected. Staff knocked on bedroom doors before entering and checked with people whether they were happy for them to enter. One person said, "They [the staff] are very kind, they treat me with dignity and respect. I have not come across a single one of them that hasn't. I'm given the option of going to the dining room or stay in my room. My legs are not good at the minute but they would take me to have lunch down there if I wanted, nothing is too much trouble." Another person said, "They [staff] do all my personal care and are very respectful, they will knock on my door, they

always ask if they can do something, not tell you they are going to do it, and they will always cover me up. I suppose for my privacy and to keep me warm."

Staff spoke politely to people and asked people discretely if they needed any assistance. People told us that their wishes were respected and that they were involved in making decisions about their care and to make choices. One person said, "They [the staff] ask my opinion and abide by it."
Another person said, "I can go to bed when I like. I sleep a lot more lately. I can stay in bed if I like."

People's spiritual and cultural needs were being met. People were able to attend their local church and various faith leaders visited the home on a regular basis. One person told us, "I am catholic and get to go to the regular services they provide here. "

We could see in people's rooms that people had been able to bring in personal items from home to make them feel more settled. One person showed us their memorabilia from their life before they came to live in the home.

People had access to an advocate to support their choice, independence and control of their care. The registered manager had a good understanding of when people may need additional independent support from an advocate and there was information about advocacy available.

Visitors were welcomed at any time and those who we spoke to said they always felt welcomed. One relative told us, "I come when I can at different times; staff are always helpful and often offer to make me a drink or I can make one for myself."

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at Milton Court care centre to ensure that all their individual needs could be met. People and their families were encouraged to visit the home if possible before making the decision as to whether to live there. The registered manager explained that following a recent complaint they had reviewed the procedure around admission to the home and now only the registered manager, deputy manager or the clinical lead went out to complete the pre-admission assessment. This ensured that there was consistency in the quality of the assessment and that people's needs could be appropriately met. One family told us, "When [relative] was in hospital, the manager came and we had a long chat, he assessed [relative] and we were very happy about this treatment. The manager was very open with us; this honest, open approach was very assuring with us so we were happy to hear that they had a place for [relative]." We saw the pre-admission information was used to develop a person centred care plan which detailed what care and support people needed and their likes and preferences.

The care plans contained all the relevant information that was needed to provide the care and support for the individual and gave guidance to staff on each individual's care needs. One of the unit managers' told us, "The care plan is a live document so especially in the first few weeks it is added to every day as we get to know the person better." The care plans were reviewed monthly or more often if things changed. One person told us, "I went through my care plan with my family when I came here; I have put a Do Not Attempt Resuscitation (DNAR) in place so that the staff and my family know that is my wish."

Staff demonstrated a good understanding of each person in the home and clearly understood their care and support needs. For example, when a member of staff was administering medicines they said to the person when they were giving them their medicines, "Here is the 'fat one'", the person told us that they called this particular medicine the 'fat one' because it was the large tablet that they struggled to swallow. They said, "We like to have a bit of fun; it brightens my day when we have a little joke." Another person told us, "I think they know me well by now, I don't have to tell them what I want for breakfast, or how to do it, and it's done for me."

People's needs were continually kept under review and relevant assessments were carried out to help support their care provision. These included assessment of skin integrity and where necessary people were provided with appropriate pressure relieving equipment and were supported to change their position regularly. We saw that adjustable levels of the pressure relieving mattresses were set to the needs of each person. There were records that contained details of when they had been moved or repositioned, what people had drunk and what personal care needs had been undertaken. Additional care plans were put in place on a temporary basis to give the staff the information about any current concerns. For example a person was prescribed anti-biotics and an additional care plan was in place to explain why the antibiotics had been prescribed, the side effects of this medication, how often the person took the medication and the date the medication should be stopped.

We saw that in some rooms where people were living with dementia there was a 'This is me' chart on the wall. A relative told us that they had been asked to provide the information for the chart to help the staff to

be able to understand and engage with the person. Another relative told us about being encouraged to put a photo album together about their relative, they told us that on one occasion when they came to visit they found a member of staff sitting with their relative going through the album. The relative said, "It was nice to see [relative], apparently it had helped them to calm down as they had become agitated."

The home continued to care for people at the end of their lives. People were asked as they came to live at the home what their wishes were in relation to end of life care. If people were happy to discuss this, a care plan was in place and any advanced decisions recorded. Staff received training in end of life care. We spoke to staff about their understanding of providing end of life care, they spoke about following people's wishes, making sure they were kept comfortable and supporting their families. At the time of the inspection there was no one receiving end of life care.

People were encouraged to follow their interests and take part in activities. People told us there were plenty of activities they could do if they wished. One person said, "Activities are very good, you can go if you want or sit and chat in the quiet lounge with other residents." Another person told us about a trip out that had been organised by staff to Silverstone race track. The person was very happy as he had once been a racing driver. We saw that there was a planned activities programme which included Pamper sessions, Bingo, Hair dressing, knit and natter, Ukulele band, boules, Cinema showing, Chutney making, Pub lunch , quiz, crosswords/word searches, tipple tonic, arm chair exercises and a whist club.

The home had three well–being advisors whose responsibilities included supporting people individually to follow interests and to arrange a programme of activities for people to join in if they wished to. On the days of the inspection we observed a group of people taking part in a quiz and another group making apple chutney. We also saw someone having a hand massage and a couple of people playing dominoes. However, with only three well-being advisors for 130 people the access to individual and group activities was limited for people, particularly those people who were less mobile. One member of staff commented, "It would be really helpful if we had planned activities with the additional staff in the evenings, especially on the memory units because staff are busy supporting people with personal care and some people spend a lot of time wandering." We spoke to two of the Well-being advisors, they were clearly well motivated and looked for opportunities to provide a variety of meaningful activities for people but this was limited due to the size of the home and the number of them.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Welcome packs to the home had been printed in large print for people with visual impairments and staff sat and read through information for people.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint. Relatives said that the registered manager was approachable and that if they had any concerns they would also be happy to talk to the staff that provided the care to their family member. The registered manager told us that they tried to resolve any concerns as quickly as possible and we saw that where complaints had been raised the registered manager had responded promptly and sought the relevant advice and support to resolve things and action plans were in place to address any learning. For example more linen napkins were purchased to support someone who often spilt their food down themselves.

During the inspection we found that staff were not always raising concerns addressed to them as complaints

which meant the registered manager may not always be aware if a concern had been raised and addressed. One relative told us of a recent concern they had raised but had not had a response. The registered manager had not been made aware of this and took immediate action to address the issue. On the second day of the inspection the registered manager had already implemented a protocol for staff to record concerns which were to be brought each day to a staff briefing; this would ensure that any concerns raised would be addressed and any lesson learnt shared.

Good

Is the service well-led?

Our findings

People were supported by a team of staff that had the managerial guidance and support they needed to do their job. The registered manager was visible and approachable and when the provider visited they took time to speak both to the people living in the home and the staff. We saw that people were comfortable and relaxed with the managers and all the staff.

Each area of the home had an identifiable manager which the staff could speak to each day. The managers took responsibility for the day to day running of the area and ensured people were appropriately supported. For example, one of the staff told us that if there were agency staff on the shift the manager would ensure that they supported the more able people which left the permanent staff to support the more vulnerable people who may not be able to communicate their needs as well. The registered manager met daily with the managers which ensured they kept abreast of what was going on in the home and any issues that may need to be addressed.

All the staff we spoke with demonstrated knowledge of all aspects of the service and the people using the service. There was a clear emphasis on treating people as individuals and supporting then with care that was tailored to their needs. One person told us, "The care is tailored here for individuals, we are all different with very different needs, and that's what makes this place different. They always make sure we have a lot of laughs before we go to bed so that we sleep with happy faces."

The registered manager had recognised the impact the use of agency staff had on providing consistent person centred care and had taken steps to reduce the impact. Only one agency was used and the registered manager had requested they deploy the same staff each time. If any agency staff did not meet the standards required of them they were no longer used. One person told us, "I was not well one night and I rang my buzzer it was an agency carer that came and she wasn't very caring towards me, I told the senior carer and I have never seen that carer since." The registered manager and provider continued to look at ways to recruit and retain staff to ensure consistency and quality was maintained. There was a Milton Court Stars and Staff Suggestions Scheme in place which recognised staff performance and innovation.

We received positive comments from people and staff about the home and how it was managed and led. One person said, "The manager is always walking around, very approachable chap. When I first came here they said to me my door is always open and I can see them any time. This place is a credit to them." Another person said, "[Registered manager's name] is always very approachable; walks around says hello, them and their team are very good. I would say this home is run very well; we all feel involved here, it's very open."

Staff said they were well supported, listened to and encouraged to develop. One member of staff said, "In my appraisal we discussed my development and aspirations. I am now undertaking training to fulfil my goals." Another member of staff said, "The registered manager is very relaxed and you can approach them at any time and so are the other managers." Following a suggestion from staff to stagger teatimes for people this had been implemented.

People living at the home and their relatives were encouraged to provide feedback about their experience of care and about how the home could be improved. Regular audits and surveys were undertaken and these specifically sought people's views on the quality of the service they received. We saw from a recent survey 79% rated the home as excellent/very good/good. Any negative comments were addressed. For example, comments had been made that staff did not always knock on doors when they entered, this was raised with staff in staff meetings and from our observations and the comments people made to us on the inspection we could see that this had been addressed.

There were regular meetings with the people living in the home and with their relatives. One person told us, "I am a member of a group who represent the Resident's Council here and we try to encourage people to voice their opinions and wishes." A relative told us that the registered manager had asked for volunteers at the last relatives meeting to help with auditing of the home. They told us they had volunteered and had recently spent time with the maintenance person looking at the environment and grounds.

There were systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. People were assured of receiving care in a home that was competently managed on a daily as well as long-term basis. Records relating to the day-to-day management and maintenance of the home were kept up-to-date and individual care records we looked at accurately reflected the care each person received. Staff understood their responsibilities in relation 'whistleblowing' and safeguarding and there were up to date policies and procedures to support them.

People's care records had been reviewed on a regular basis and records relating to staff recruitment and training were well maintained. Records were securely stored to ensure confidentiality of information.

Quality assurance audits were completed by the registered manager and unit managers. The provider made regular visits and followed up on any actions that had been identified through audits. The provider ensured that the systems in place to monitor the home were effective. The audits and visits helped to ensure quality standards were maintained and legislation complied with. Where audits had identified shortfalls, actions had been carried out to address and resolve them; for example it was identified that some care records lacked the detail required; weekly audits were put in place to ensure any shortfalls in recording were addressed quickly to minimise the impact the lack of information may have.

To ensure that the managers and staff were kept up to date with changes in practices, legislation and new innovative ways to deliver care the registered manager attended various conferences and workshop, received information from other agencies and medical alerts which was cascaded to staff through newsletters and training programmes. At the time of the inspection the service had worked with the Central and North West London NHS Foundation Trust Specialist Memory Service who had provided 'Drop-in' Clinics for staff to discuss specific cases and identify ways to help improve experiences for people. The service was awaiting feedback as to how this work had gone.