Care Quality Commission

WCS Care Group Limited

Mill Green

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Mill Green is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Mill Green accommodates up to 15 people across one ground floor level.

What life is like for people using this service:
Staff were safely recruited. Where this was a part of their care plan, people's medicines were administered safely and in accordance with the prescribing instructions. However, risk management plans and the response to epileptic seizure required improvement to ensure people were always cared for in an effective and safe way.

The management team and staff placed people at the heart of their home. The provider and registered manager ensured their service was delivered according to their values. The home had a strong person centred and local community-based ethos. The staff team worked hard to promote people's dignity and prevent people from becoming socially isolated within their home.

Respect and dignity were cornerstones of the values upheld by the staff and role modelled by the management team. Innovative approaches such as assisted access to electronic records and feedback tools, provided people and their relatives options in shaping a personalised service and making decisions.

People and their relatives were involved in choosing their care and support, from pre-admission to living in the home. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were aware of how to report any concerns about neglect or abuse and were confident they would be addressed. They felt they were listened to and were part of an organisation that cared for them and their wellbeing, as well as the people they were supporting.

Regular audits were carried out; people were asked their views in person and via questionnaires. Changes were quickly made if issues were identified. The service learned from recorded incidents, concerns or accidents to help prevent a reoccurrence.

Rating at last inspection:
The last comprehensive inspection report for Mill Green was published in August 2016 and we gave an overall rating of Outstanding. At this inspection we found the service was Good. Safe has been rated as Requires Improvement and all other areas have been rated Good.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always Safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was Effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service was Caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was Responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was Well Led. Details are in our Well Led findings below.	**Good**

Care Quality Commission

Mill Green

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection Team:
The inspection team consisted of one inspector and an expert 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.

Service and service type:
Mill Green is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission (CQC). This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection visit took place on 4 June 2019 and was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included information received from the provider about deaths, accidents and incidents and safeguarding alerts which they are required to send to us by law. We used information the provider sent to us in the Provider Information Return. This is information we require providers to send us at least once a year to give some key information about the service, what the service does well and improvements they plan to make. We requested feedback from the Local Authority quality monitoring officers. We used all this information to plan our inspection.

During our inspection: We spoke with four people using the service and two people's relatives. Some people living at the home, due to their complex health needs, were unable to give us their feedback about the

service. We spent time with people to see how staff supported them. We also spoke with two care staff, the registered manager, a service manager, a quality assurance manager and a care coordinator. We later received feedback from health professionals and commissioners of services, which was also shared with the registered manager, about how the risk management of epilepsy could be improved at the home.

We reviewed a range of records, including four people's care records and medication records. We also looked at records relating to the management of the service, including audits and systems for managing any complaints. We reviewed the area manager's records of their visits to the service; when checks were made on the quality of care provided.

Following the inspection: We received updated information from local commissioners of services.We also reviewed additional information that the registered manager sent us at our request regarding how they planned to improve epilepsy risk management.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement: At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:
•Risks to people were assessed and mitigation plans were in place to reduce risks posed to people.
•However, following our inspection visit we received feedback from local commissioners of services, stating that risk assessments and risk mitigation plans needed to be improved to support people with specific health conditions such as epilepsy and autism, so that staff were given information on how to support them safely. Following feedback, the provider was reviewing risk assessments to ensure commissioners and health professional's advice was followed and information on how to respond to certain risks was expanded.
•All identified environmental risks had an associated risk assessment in place which guided staff how to mitigate risks within the service. Equipment was maintained and there was a fire alarm system that was fit for purpose.
•People told us they felt safe at the home. One person said, "it's great, the staff are wonderful." A person's relative said, "[Name] is definitely safe and secure here."

Learning lessons when things go wrong
•Staff knew how to report and record accidents and incidents. The registered manager was responsible for analysis of accidents and incidents to identify patterns and trends and prevent a reoccurrence. Learning from incidents were shared with the staff team, to drive forward best practice.
•However, the recording of some incidents, such as when people had epileptic seizures was not consistent. This meant there was a lack of analysis of this type of event, preventing staff from learning how future incidents could be avoided or managed, to provide better outcomes for people.
•Staff who administered medicines reported any errors they made, and these were investigated, so that further training and learning reduced the risks of reoccurrence.

Using medicines safely
•The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
•Staff were trained in the administration of prescribed daily medicine. However, staff had not been trained in how to administer some medicines that could control and reduce epileptic seizures, that could be used on an 'as required' basis. Following feedback from local commissioners and health professionals the provider arranged for staff to have additional training in the administration of these types of medicines.
•People told us they usually received their medicine when they should. One person said, "If I needed pain relief I'd press the buzzer, staff would give me headache tablets."

•Medicine Administration Records (MAR) were completed as required when they administered medicines.

Staffing and recruitment
•People, relatives and staff told us they felt there were sufficient staff to keep people safe. Although some people said they would prefer more staff at busy times to spend quality time with them. Throughout our inspection visit we saw people's needs were met in a timely way. Staff were not rushed and had time to spend with people.
•Following our inspection visit the provider had increased night-time staffing levels and was reviewing their staffing needs following advice from visiting health professionals. This was to ensure night-time monitoring and checks on people who were at risk of seizures could be increased.
•The registered provider undertook background checks of potential staff to assure themselves of the suitability of staff to work at the home. New staff worked with experienced staff to understand people's individual needs.

Systems and processes to safeguard people from the risk of abuse
•Staff had received training in recognising abuse and understood their roles and responsibilities in keeping people safe. Staff told us they would report any concerns if they suspected abuse and had confidence the registered manager would investigate.
•The registered manager understood their legal responsibilities to protect people and share important information with the local authority and CQC.

Preventing and controlling infection
•Staff had received training in infection control and infection control precautions.
•Staff understood the importance of using gloves and aprons to reduce risks of cross contamination. Around the home there were hand sanitizers for everyone to use to reduce the risk of infection.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: The effectiveness of people's care and treatment supported good outcomes for people.

Staff support: induction, training, skills and experience
•People and relatives felt staff had the skills they needed to effectively support them. Staff used effective skills in assisting people to move around the home, where people required their support. One person commented, "Staff really know how to support me with my wheelchair, and when I'm in the shower."
•However, following our inspection visit, we received information from local commissioners that staff needed more advanced training in epilepsy management and how to support people with conditions such as autism. This training was arranged by the provider following our visit.
•Staff told us they received an induction when they started work which included working alongside an experienced member of staff. The provider's ongoing training programme provided staff with refresher training to keep their basic skills up to date.
•The provider maintained a record of staff training to identify when staff needed to refresh their skills.
•Staff were supported through one to one and team meetings. All staff told us they felt supported by the registered manager.
•Staff were supported to complete national vocational qualifications in health and social care.

Adapting service, design, decoration to meet people's needs
•The service was purpose built with a design and décor that met the needs of people living with physical disabilities. For example, the home had wide corridors and space in communal areas for wheelchairs and equipment.
•People had individually decorated bedroom doors with photos or objects important to them to help them identify their bedroom.
•The provider ensured people could use technology to support them in communicating with staff, friends and relatives, providing internet access throughout the home. Some people used mobile phones or had telephones in their bedrooms to maintain relationships with people outside the home.

Ensuring consent to care and treatment in line with law and guidance
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. 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA applications procedures called the Deprivation of Liberty Safeguards (DoLS).
•We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found the management team and staff were working within the Act.
•Care staff understood the importance of gaining people's consent and explaining what was happening.
•People's capacity to make decisions had been assessed and 'best interests' decisions had been made with the involvement of relatives, staff and health care professionals. Where people had restrictions placed on their care, appropriate DoLS applications were made to the local authority.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Prior to people moving into the service, the registered manager undertook a needs assessment. This was done in consultation with people, health professionals, advocates and family members. This assessment was used to determine if the service could meet the person's needs and to inform their care plan.
•Protected characteristics under the Equality Act were considered. For example, people were asked about any religious or cultural needs so these could be met. The provider had policies in place to ensure they protected people's, and staff's rights, regarding equality and diversity.

Supporting people to eat and drink enough with choice in a balanced diet
•People were given choices about what they ate and drank. People were offered a range of visual choices at mealtimes, to ensure food met their support needs and preferences. Most people told us they enjoyed the food on offer to them. Where people didn't like the food on offer on the daily menu alternative meals were prepared at their request. A relative told us, "The food is excellent, it's like home cooking. [Name] often chooses something else that's not on the menu, which is prepared for him."
•The registered manager told us about a new initiative for people, as they got up at different times, called the 'breakfast club'. Staff spent time with people at breakfast, eating with them to socialise and find out what people wanted to do today. People were encouraged to eat breakfast and take their time.
• A new food company had been trialled for pureed food options, cultural foods such as Indian curry, and additional recipe options to tempt people's appetite.
•People's dietary preferences were met and respected by staff. For example, where people were on a soft diet, pureed diet, or were vegetarian, different food options were available.
•Staff and the registered manager monitored people's weight, and action was taken when people needed extra calories because of unplanned weight loss. The registered manager recognised the need to encourage people to eat and drink enough to maintain their health. People were encouraged to make drinks and snacks for themselves, and people were able to have fridges in their rooms, to keep food and drink items.
•Where people needed assistance from staff to eat their meal staff were patient and supported people at their own pace.
•Those people who required their food and fluid intake to be monitored to ensure nutrition levels were maintained, had food and fluid charts in place. These charts were completed by staff daily and were monitored to ensure people received the correct levels of nutrition to maintain their health.

Staff working with together and with other agencies to provide consistent, effective, timely support
Supporting people to live healthier lives, access healthcare services and support
•Staff communicated effectively with each other. There were systems in place, such as electronic care records accessible to all staff and handover meetings to share information amongst staff. This meant that staff knew what was happening in people's lives and when changes had occurred that might affect their support needs.
•Staff considered people's feelings, and regularly checked if people were okay. For example, we saw staff check if people were anxious, felt well, or needed help with their daily tasks or plans.
•People saw their doctor, dentist and other health professionals when needed to maintain their health. Where advice was provided from health professionals, care records were updated, and the advice was discussed with people to ensure they understood how this might impact on their health. One person told us, "I have some tablets that aren't working well, so staff have contacted the GP for me."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Good: People were well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity
•Staff communicated with people in a warm and friendly manner. Peoples' responses indicated that people were well treated and enjoyed the company of staff and each other. Comments from people included, "The staff are very kind", "All the staff are friendly and wonderful, it's like one big happy family. I trust people here." Comments from relatives included, "The care here, I've never seen better. [Name] is incredibly happy and content."
•The provider and staff respected people's equality and diversity, and protected people against discrimination. Staff were recruited based on their values and abilities. People and staff were treated equally according to the guidance on protected characteristics.
•Staff knew about people's cultural and diverse needs and how this may affect how they required their care. For example, respecting people's spiritual needs or choices and the gender of the staff member providing their personal care. Staff had received training in equality and diversity and explained how they used this knowledge to reduce any possible barriers to care.
•Care records provided information about people's cultural and personal preferences, such as their sexual orientation. These personal preferences offered people an opportunity to engage in personal preferences to maintain their sense of individuality and identity.

Supporting people to express their views and be involved in making decisions about their care
•People were involved in decisions about their care. One person said, "Staff help me choose my clothes." Other people told us they made decisions each day about how they wanted to spend their time. We observed one person make himself a coffee before their lunch, with staff providing hot milk. He then called a member of staff to accompany him to his room.
•Most people could communicate their wishes verbally. We saw easy read documents, documents in picture format, and information was also available in different formats where required. This meant people could be involved, as much as possible, in making decisions about their care and treatment.
•People had regular reviews to discuss their health and support needs, and to make decisions about how their care should continue to be delivered.

Respecting and promoting people's privacy, dignity and independence
•There was an attitude of respect and inclusion within the culture of the home. For example, when new people came into the home, they were encouraged to feel welcomed and were greeted by staff on their arrival. People were offered the support of a keyworker to ensure their personal needs and wishes were considered.
•People felt cared for and valued as individuals. Staff were highly motivated to empower people to maintain a sense of purpose and achievement in their lives. People chose when and how they socialised with others

and were encouraged to be as independent as possible. One person told us they did their own washing. We saw people who were able to, helped in the garden. One person said, "I do as much as I can for myself, my own dusting and polishing. Sometimes I hoover and wash up to help staff."
•Care Staff respected people's individual privacy in the home by knocking on doors. The provider ensured the premises also protected people's privacy, by covering windows and glass doors with privacy screens where people could see into their room from gardens and public areas.
•The service complied with data protection law. The information we saw about people was either kept in lockable cabinets in locked offices or on password protected computers. This meant people's private information was kept securely.
•People were supported to maintain relationships with those that mattered to them. Friends and families could visit people when they wished. Private areas were available for people to spend time together when needed or requested. A relative told us, "I am here at least once a week, anytime from 5am to 11pm. [Name]has a phone in his room and rings us when he wants."
•The provider continually monitored the impact of care and support on people's lives and implemented innovative methods to support people to express themselves. The provider was introducing a new initiative to record people's long-term goals, and how these might be achieved.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: This meant people's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Since our previous inspection the provider had introduced technologies and tools to enhance and personalise people's care. For example, electronic care records and updated electronic tools enhanced the provider's ability to monitor what people enjoyed doing, by recording data about what social events people enjoyed, their mood states around times of the day, and provided the management team with how people could truly be supported in an individual way. The provider used this new type of information and people's views, to decide how to structure their activities and services.
•However, we found care records were not always as detailed as they needed to be to be, such as showing what individual support each person required to respond to their health needs. This meant the ability of staff to respond to people's individual needs was affected.
•Electronic care records had improved efficiency as staff could update people's records as they supported them. People's relatives were encouraged to share their knowledge of their relation, so staff could get to know them better and input more information on their records. One person told us, "Staff really know me well."
•All the information staff entered was available to the duty manager, people and their relatives if they wished. One person at the home monitored their own care and support, and visually checked and updated their care records using the system. When care tasks were due reminders were sent to staff minimising the risk of care tasks being forgotten.
•Trained lifestyle coaches worked seven days per week encouraging and supporting people to take part in fun exercise sessions as a group and in individual one-to-one sessions. Group and individual exercise sessions involved moving to music, playing with 'poms-poms' and dancing. Staff joined in and people laughed and smiled together. Exercises encouraged people to improve their strength, muscles and mobility which people said kept them active for longer.
•Lifestyle coaches organised trips out based on people's preferences using the home's minibus. People told us about the activities they most enjoyed, these included trips to local parks, visiting other homes and shopping.
•The provider had recognised the importance of people having time in the fresh air and opportunities for daily exercise, to improve their health and feelings of wellbeing. The secure gardens had raised beds for planting vegetables, bird feeders, colourful flowers, and outside meeting areas. A new sensory area had also been developed with fragrant flowers and water features to enhance people's enjoyment of the garden. One person said, "I like going for walks here, the quarry, town and nature reserve is also close by." A relative told us how their relation benefited from the outside space, "There is a bird feeder outside [Name's] room (which they enjoy) and we grow vegetables together."
•People were supported to take an active interest in the life of the home. The provider had purchased chickens and arranged visiting pet therapy animals to offer people comfort. One person who was keen on chickens enjoyed collecting and eating daily fresh eggs.

•The registered manager and lifestyle coaches worked together introducing clubs. These clubs involved people, their families and volunteers to encourage people to meet and form relationships. For example, the gardening club.
•The provider had strong and clearly defined values that were shared consistently across the staff and management team, who led by example. Values included making sure people lived every day, enjoyed their life, and staff attitudes were positive around people to enhance their mood and enjoyment. Staff consistently reflected the values of the service, they made time to sit and socialise with people and demonstrated an extremely positive attitude which enhanced people's mood and enjoyment.
•People told us they liked living at the home because they were able to carry on living their day-to-day lives in the way they preferred. A relative said, "People live how they want to. [Name] can go to the shop with staff when he wants, he has freedom."
•The provider promoted local community events, such as the 'Care in Bloom' competition, across all their homes. Each of their homes competed. The provider said, "The competition encourages people to spend time outdoors, which we know from studies improves people's wellbeing."
•The registered manager increased the home's ties to local community groups to enhance people's everyday lives. For example, by hosting local coffee mornings, and taking part in National events such as National Care Home Open days, village activities and fetes. We saw the home involved in the local community in events such as the annual lighting of the Christmas tree, which was in their front garden in the centre of the village.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carer.
•Where people had specific disabilities that affected their communication, the provider used a range of accessible communication techniques including picture cards, graphic images, white boards, foreign language formats, magnifiers and electronic devices. A staff member explained how they also used innovative techniques to monitor people's body language, to help people communicate in a non-verbal way. For example, one person loved Abba music, when this was played they displayed clear enjoyment. This response was recorded in their care plans, along with other physical responses to different stimuli, so staff knew what each response signified.

Improving care quality in response to complaints or concerns
•People told us they knew how to raise concerns or complaints with staff and the management team if they needed to. One person said, "Talking to someone, that's the best thing to do." Typically, people said they had no reason to complain. One relative told us, "[Name] has been here for 7 years and I've never had a serious complaint."
•The registered manager logged all issues raised, not just formal written complaints, to improve their responsiveness and learning from people's feedback at the home. There was a 'suggestions box' and regular meetings for people and their representatives or relatives to make sure their views about how the service was run were known.
•The registered manager responded to complaints quickly to minimise people's anxiety and stress levels.
•Where learning was acquired through feedback, the registered manager shared this across the staff group and the provider's group of homes to encourage learning. The manager told us the most recent complaint involved the person's relative in the outcome and resolution, to ensure lessons were learnt.

End of life care and support
•The provider offered people a home for life. People and their relatives were supported to make decisions

and plans about their preferences for end of life care. Advance planning took account of people's wishes to remain at the service, in familiar surroundings and supported by staff who knew them well.
•The provider utilised lifestyle coaches to encourage people to share their 'bucket list' of wishes. Lifestyle coaches also led sessions to raise awareness of end of life care, during May and 'Dying Matters' week, a national initiative to increase people's understanding and awareness of how they could achieve their wishes by advance planning.
•Staff had received training in how to support people and their family members with end of life care arrangements and grief. Family members were encouraged to continue visiting the home after their relation had passed away, which some relatives regularly did, continuing to support the home.
•The registered manager worked in collaboration with healthcare professionals, to ensure people were supported to have a pain free and comfortable end, surrounded by their friends and family. Areas where family members could stay at the home to support their relatives had been created, so people and their families could be supported at this difficult time.

Good

Is the service well-led?

Our findings

Well Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Good: This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;
•People, relatives and staff told us managers had an 'open door' and were always available and 'very approachable'. We saw people did not hesitate to approach the registered manager and duty manager during our visit.
•People and relatives told us, "They [staff] are brilliant, on the phone with any issues and keeping us informed", and "It's the best home I've ever seen, we've never looked back."
•Staff told us they enjoyed working at the home. Comments from staff included, "I love it here", I couldn't think about leaving." This was demonstrated by two members of staff who had previously left the home for alternative work and had later returned. In a recent staff survey 9 out of 10 staff said they would recommend the home to family and friends.
•The provider invested in their staffing team, offering them awards for achievements, a career pathway, supporting staff to achieve recognised qualifications, and through a reward and bonus scheme. This enhanced staff's knowledge, increased staff retention, and in turn benefited people by having consistent and motivated staff.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements;
•The service was led by a dedicated, experienced registered manager, who with the provider's support strived to improve their service. Since our previous inspection a range of innovations and technologies had been implemented to continuously develop the service. These included electronic care records which gave people the opportunity to track and monitor their own care outcomes and additional support for people and staff at management levels seven days per week.
•The whole staff team had an understanding of their roles and responsibilities toward people living in the home. Staff told us they attended arranged training, which was factored into the rota as 'paid time' and they could ask for refresher training. This encouraged staff participation.
•The staff team embraced the registered manager's passion and provider's vision to ensure people's lives were enriched and meaningful. For example, staff members took part in fundraising activities. Such activities had funded the purchase of equipment, games and development of garden areas. People at the home sponsored such events and decided how the money was spent with care staff.

Continuous learning and improving care:
•The provider facilitated 'registered manager' meetings which ensured opportunities were offered to managers to share their practices and learn from one another. The registered manager attended local

management groups, internal and externally organised registered managers meetings.
•The registered manager was supported by a regional operations director. The regional operations director undertook unannounced visits and checks on audits completed, to ensure compliance with regulations.
•The registered manager delivered monthly reports to the provider, so they could be assured that care was delivered and monitored consistently across the group of homes. The provider produced monthly statistics for a range of indicators, which enabled managers to compare their performance and learn from other homes. For example, the results of pilot programmes such as acoustic monitoring, and how this improved people's outcomes at night gave managers an opportunity to discuss whether this would suit people at Mill Green.
•Information sent to CQC prior to our inspection visit showed an awareness of how the service could be improved further, which resulted in an improvement cycle including updates to the décor in the home, sensory spaces being developed such as gardens and bathrooms.
•Medicines errors, accidents and incidents were analysed to identify possible causes and actions that might reduce the risk of them reoccurring. However, following our recent inspection visit we found some incidents had not been consistently recorded, which did not allow for a complete analysis of all incidents at the home. The registered manager had increased staff training to ensure incidents were consistently recognised and recorded when they occurred.
•From recent learning across the group the provider had established a new quality monitoring and improvement plan. New quality improvement models focussed on areas where previous auditing had been less robust, to ensure the highest quality of care. The new system involved the random checking of electronic care records to enhance systems and outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
•The provider promoted an open culture by encouraging staff and people to raise any issues of concern with them, which they always acted on. For example, one person had raised an issue with where their relative usually ate their lunch, due to their social engagement. Arrangements had been made to find a solution that suited everyone and increased the person's enjoyment at mealtimes.
•People, relatives and staff were encouraged and supported to make suggestions for improvements through regular meetings, surveys, a 'suggestion box' and the staff and management team's willingness to listen. For example, recent feedback had asked for improved sensory areas, which were being developed. A new, accessible kitchenette had been installed in the dining room at Mill Green to encourage people to take part in the preparation of snacks and lighter meals.
•The provider actively shared information about innovations, technology and development of their services. This included a range of newsletters, posters, leaflets, and announcements to ensure people were kept up to date with what was available to them.

Working in partnership with others:
•The provider's emphasis was on continually striving to improve by implementing innovative systems and practices. As part of their research into dementia care, the provider participated in studies with universities to find the best outcomes for people. Results of studies are shared with participants and will inform the development of best practice guidance and how new technologies can reduce falls and anxiety levels for people with confusion and memory loss.
•The registered manager actively sought opportunities to work with other bodies to increase people's enjoyment in life. For example, the registered manager had gathered information from specialists in autism and sensory impairment, on how to engage and stimulate people with these. High levels of social and staff engagement was clearly beneficial; people smiled, were cheerful and enjoyed everyday life at the home.