Care UK Community Partnerships Ltd

Milner House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 July 2018 and was unannounced.

Milner House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Milner House is owned and operated by Care UK Community Partnerships Ltd. It provides accommodation and nursing care for up to 46 older people. People living at the service had a variety of medical and health care needs and some were also living with dementia. The service is laid out over two floors, although at the time of our inspection, the first floor was being refurbished and was therefore not in use. On the day of our inspection 18 people were living at the service, all of whom were accommodated on the ground floor.

We last carried out a comprehensive inspection of this service on 23 November 2017 when we rated the service as Inadequate and the service was placed in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as Inadequate overall or in any of the key questions. Therefore, this service is now out of special measures.

A new manager had recently been registered at Milner House. 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 had worked with a regional support team to deliver improvements across the service. Some work in respect of improving record keeping and refurbishing the environment was still ongoing, but it was clear progress was being made. We will continue to monitor the service and these areas will be followed up at our next inspection. Systems for auditing were now effective in developing quality within the service and the management team were committed to completing their own plan for improvement. A key priority for Milner House now will be stabilising the new staff team and ensuring people continue to receive a personalised service as the number of people accommodated increases.

The registered manager and staff had worked collaboratively to develop principles of person-centred care, empowerment and inclusion across the service. The result of this being that people now felt listened to and involved in the planning of their care. Staff took the time to engage with people in a kind and compassionate way and support was delivered in a personalised way that was no longer task led.

There was a relaxed and friendly atmosphere within the service and people enjoyed positive and caring

relationships with staff. Support was provided with patience and empathy in a way that upheld people's privacy and dignity. People now had opportunities to spend their time doing the things they enjoyed and that were meaningful to them.

People's needs had been properly assessed and each person had a plan of care which enabled staff to deliver appropriate support. Staff were responsive to people's changing needs and liaised with other health care professionals to ensure they received the care and treatment they required. People were supported to make informed decisions about their end of life care and medicines were managed safely and administered as prescribed.

There were now sufficient care and nursing staff to support people safely and in accordance with their needs. Staff received ongoing training and the clinical supervision of nursing staff kept them up to date with best practice.

There were systems in place to safeguard people from abuse and the recruitment processes for new staff helped ensure only suitable staff were employed. Risks to people were identified and managed and there was now a culture of learning and reflective practice when things went wrong. The service was clean and hygienic, and the management of infection control had greatly improved.

Staff were knowledgeable about people's individual preferences and supported them to make decisions in a way that protected their legal rights. People had choice and control over their meals and specialist dietary needs were managed well.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Overall, care was delivered safely, but some records that were important for monitoring people's well-being were not always accurately completed and therefore could not be wholly relied upon.

People were better protected because risks to them were identified and managed safely.

People lived in a service that was clean and the management of infection control had considerably improved.

There were sufficient staff in place to support people safely. Appropriate checks were undertaken to ensure only suitable staff were employed.

People were better safeguarded from abuse. Staff understood their roles and responsibilities in this area and people were now able to freely raise any concerns and know they would be listened to.

Medicines were managed safely and people received their medicines as prescribed.

There was a newly established culture of reflective learning when things went wrong.

Is the service effective?

Requires Improvement

The service was not wholly effective.

Staff had a good understanding of people's capacity and legal rights, but best interests' decisions and assessments of capacity were not always fully recorded.

A programme of refurbishment and redecoration was in progress to bring the service in line with its statement of purpose. The current design and layout was not wholly suitable to effectively support people living with dementia.

People benefitted from being cared for by staff who were appropriately trained and supported to deliver their roles effectively. Nursing staff received regular clinical supervision to ensure their competencies were checked and updated.

People's needs and choices were assessed. Staff worked collaboratively to ensure people received holistic personal and health support.

People were supported to maintain adequate levels of nutrition and hydration and specialist diets were identified and respected.

Is the service caring?

Good

The service was caring.

There was a relaxed and friendly atmosphere across the service and people had developed good relationships with the staff who supported them.

Care was provided with compassion and staff respected people's privacy and ensured their dignity was upheld.

People were involved in making decisions about their care and staff had a good knowledge of people's individuality and preferences.

Is the service responsive?

Good

The service was responsive.

People experienced a more personalised approach to care and staff were responsive to their changing needs.

End of life care enabled people's final wishes to be respected.

People had opportunities to participate in activities of interest and staff engaged with people in a way that was meaningful to them.

There were now effective systems in place to ensure that people were listened to and concerns were addressed in a way that improved the quality of care.

Is the service well-led?

Requires Improvement

The service was becoming well-led.

Whilst the leadership of the service had significantly improved,

the new management culture needs to be embedded and sustained as the service grows and regional support decreases.

The new registered manager had worked collaboratively with staff to develop principles of person-centred care, empowerment and inclusion across the service.

Systems for auditing were now effective in monitoring and developing quality within the service and the management team were committed to completing their own plan for improvement.

Milner 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 carried out to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 9 July 2018 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with eight people who lived at the home, three relatives and six staff, including the registered manager. We observed interactions between people and staff throughout the day and joined people in the dining room at lunchtime to gain a view of the dining experience.

As part of our ongoing monitoring of the service since the last inspection, we have been in regular contact with the local authority who have also provided feedback about the ongoing improvements at Milner House.

We reviewed a variety of documents which included the care plans for eight people, four staff files, medicines records and other documentation relevant to the management of the service such as audits, meeting minutes, surveys and action plans.

Requires Improvement

Is the service safe?

Our findings

Our last inspection of 23 November 2017 identified insufficient staff and unsafe systems which meant that the service had failed to support people safely and appropriately. Consequently, we took enforcement action to ensure the service improved. Following that inspection, the provider sent us an action plan outlining the steps they had taken and would be taking. This inspection found that the staffing levels were now sufficient to support people safely and risks to people were now better managed. The service is therefore now compliant with Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe with the care they received. For example, one person said, "I feel safe here – it's the knowing staff are around if I need them to help me that makes me feel that way." Similarly, a relative told us, "I have no worries about my family member being here at all. We used another service before coming here, that was awful, but I have no such worries about her safety here."

A lot of work had taken place to ensure staff were confident in supporting people to mobilise safely. All staff had been re-trained in this area and regular competency checks were carried out to ensure staff followed best practice. One staff member told us, "We're very strict with moving and handling now and staff have been trained very well."

We observed a person in a wheelchair and they told us that staff used a body hoist to help them transfer to different positions. They said that they felt safe and well supported when this was carried out. We saw the information recorded in this person's care plan reflected the equipment and methods described by staff and available in the person's room. A relative also commented that they had observed their family member being lifted by a hoist and told us, "They [staff] do it very safely and always talk to her as they go, so she knows exactly what's happening and feels reassured."

Individual risks to people were identified and managed safely. For example, staff spoke with us about how a person frequently became anxious and frustrated in the afternoons and how they managed this. A review of the person's care records provided detailed information about the triggers for this person and guidelines for staff to follow to try to de-escalate behaviours. We observed staff following the guidelines in place and effectively supporting the person throughout the day.

Where people had specialist medical needs there were clear plans in place to support them safely. For example, one person was receiving continuous oxygen therapy. We saw precautions and risk assessments were in place to safely manage this. Throughout the inspection we observed staff following these safety guidelines.

Risks associated with weight loss and dehydration were managed well. Each person had been appropriately assessed to identify whether their weight was maintained within safe limits. People were weighed monthly or more frequently where a low body mass index (BMI) or previous weight loss had been identified. Food and fluid intake charts were maintained in accordance with people's care plans and nursing staff had oversight

of these documents each day to ensure any issues were immediately identified and responded to.

Whilst we had no concerns about the safety in the way care was being delivered, we did identify that the records used to monitor people's medical needs were not always accurately completed. For example, the care plan for one person stated they should be supported to change their position every four hours. Whilst we saw this was usually being done, there were some occasions where the chart had not been fully completed. This person was identified as being at high risk of developing pressure wounds and as such this support was crucial to their care. The person did not have any current wounds, which would indicate that appropriate care had been delivered, but it is important that staff record this information in line with the guidelines for this person. Similarly, additional information about how people's medicines were given or whether a PRN medicine had been offered and refused were not consistently recorded. Staff were once again observed to be aware of and following best practice, but this was not always reflected in the records.

These issues relating to records had been recently identified by the provider in their own auditing of the service and the registered manager confirmed that they were now regularly spot checking the records and would continue to do so. We will follow this up at our next inspection to ensure these improvements have been sustained.

Environmental risks had been considered and mitigated. A daily maintenance checklist covered the environment, fire safety and health and safety and records showed a daily walkaround was completed. A monthly checklist looked at the building and grounds. The last one had identified some loose paving slabs and an action plan documented a quote had been obtained and that work to fix this was scheduled for the near future. Following previous positive testing for Legionella, regular flushing of unused water outlets now took place and the latest sampling confirmed the service was clear. With so many parts of the service not in use, the registered manager and maintenance staff were aware of the added risks and taking active steps to minimise these.

The service was clean and improvements to the management of infection control had improved significantly since our last inspection. People told us that staff kept the home clean and tidy and relatives confirmed the same. Sluices were found to be clean and the laundry was well organised with good systems of infection control in place. Regular monitoring checks were carried out by the housekeeper, as well as formal audits by the provider.

There were now sufficient staff in place to support people in a safe and person-centred way. People told us that staff were available to support them when they needed it and that they no longer had to wait long for help. One person informed us, "They are always around, but if I need something quickly then I press my bell and they come straight away." Likewise, relatives told us that staff responded to people's requests quickly.

The registered manager told us that staffing levels included one nurse, one team leader and five care staff during the day and one nurse and four care staff at night. Management, activity and domestic staff were in addition to this number. A review of the rotas confirmed that these staffing levels were typical and that the reliance on agency staff had significantly reduced since our last inspection. On the inspection day, all staff working within the service were permanently employed at Milner House.

Throughout our inspection we found that people were appropriately supported and that people's calls for help were responded to promptly. There were also enough staff to ensure that people who remained in their rooms received attention and meaningful engagement. Staff told us that current levels enabled them to do their job well and spend time supporting people in the way they wished. Staffing levels will require ongoing monitoring and review to ensure people continue to receive appropriate support as other parts of the

service are re-opened and the number of people accommodated increases.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and character references, job descriptions, evidence of up to date registration with the Nursing and Midwifery Council (NMC) and Home Office Indefinite Leave to Remain forms in staff files to show that staff were suitable to work in the service. The provider had systems in place to ensure that DBS, NMC and training checks were undertaken on all staff supplied by external agencies.

People and their representatives said staff treated them well and that they felt able to raise any concerns they had. For example, one person said, "There were previously some night staff I didn't think much of, but that's been sorted now and on the whole, they are all pretty good."

Staff understood their roles and responsibilities in protecting people from harm. Staff completed regular safeguarding training and were knowledgeable about safeguarding procedures and how to report any concerns. One staff member told us, "We're all open-minded now. If there's a safeguarding concern or anything, we just report it." Likewise, another member of staff commented, "If I was worried about anything, I would speak to the manager, the local authority or CQC."

The registered manager had a good understanding of his safeguarding responsibilities and made appropriate safeguarding referrals as required and co-operated fully with safeguarding investigations and the local authority when previous concerns had been identified. There were no ongoing safeguarding investigations at the time of this inspection.

Medicines were now managed safely and people received their medicines as prescribed. Due to the previous reliance on agency nurses, the regional clinical lead for the provider had been based at Milner House. They told us that they had been responsible for training staff and following up on medicine issues or errors.

Qualified nurses were responsible for medicines at the service. They gave people their medicines as prescribed by the doctor and in a person-centred way. For example, we saw the nurse spend time with people, offering them a choice of drink and giving medicines when the person was ready.

Nursing staff did not sign medicines administration records (MAR charts) until medicines had been taken by the person. There were no gaps in the MAR charts we looked at. When one person refused one of their tablets, the nurse returned the medicine to the clinical room where the medicine was appropriately disposed of and the person's records updated.

MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as Warfarin. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with their MAR charts. This described the reason for the medicine's use, the maximum dose, minimum time between doses and possible side effects.

Medicines were delivered and disposed of by an external provider and stored safely within the service. Both medicines rooms were locked, air-conditioned with temperatures documented daily. Fridges used to store medicines were also temperature checked daily and this recorded. Medicines trolleys were fixed to walls and medicines were neatly stored in baskets with people's names and photographs on.

There was now a culture of reflective learning when things went wrong. The registered manager and staff understood the importance of learning from events. Accidents and incidents were reviewed after occurrence to identify causes and actions to prevent re-occurrence. For example, following a recent fall, one person's care plan and risk assessments had been reviewed and a sensor mat put in place to alert staff if the person tried to stand independently. This information was shared at the daily heads of department and clinical meetings discussed to ensure staff were aware of the changes.

Requires Improvement

Is the service effective?

Our findings

Our last inspection of 23 November 2017 identified a lack of training and support, especially in respect of nursing staff and we made it a requirement for the service to improve. Following that inspection, the provider sent us an action plan outlining the steps they had taken and would be taking. This inspection found that staff received training and support relevant to their roles and the service is therefore now compliant with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt well supported by staff who were competent in their roles. Relatives said that they too had confidence in the staff who cared for their family members. This feedback was echoed by staff who confirmed they received the necessary training and support to perform their roles effectively. For example, one member of staff commented, "The training is really good now and we get lots of ongoing support and regular supervision."

Training and support were provided to ensure care staff undertook their roles and responsibilities in line with best practice. New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. In addition to formal learning, new staff also shadowed more experienced staff.

Staff were confident in their work and told us that they received ongoing training in areas such as safeguarding, moving and handling, infection control and fire safety. In addition to mandatory training, we also found that staff had the opportunity to undertake more specialised training to meet the needs of the people they cared for. For example, wound care, dementia and nutrition.

Staff repeatedly told us that felt supported in their roles and that the registered manager was approachable and accessible. Staff received regular supervision. A supervision is a one-to-one meeting between a staff member and their line manager to discuss practice and training requirements. We saw the minutes for some of these meetings which identified that development and practice issues were continually discussed. Staff skills and interests were now being used to promote good practice across the service. For example, one staff member had previously qualified as a physiotherapist and as such was now completing a train the trainer qualification to enable them to take the lead on moving and handling training within the service.

The regional clinical lead for the provider had been based at the service since April 2018 and spoke openly to us about the changes that had been implemented since that time to improve the clinical care provided. They told us, "Previously the service lacked clinical leadership, but through training and coaching we are now confident that the nursing staff are competent in their roles." Nursing staff told us that they had received regular clinical supervision with the regional clinical lead and felt well supported to deliver good care. Records from clinical meetings provided evidence of good discussion, learning and reflective practice taking place amongst nursing staff.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that appropriate applications had been to the local authority where people had been judged as being deprived of their liberty. The registered manager maintained a tracker of these applications and the outcomes. Staff spoken with were clear about people's individual levels of capacity and able to describe how this may fluctuate and the steps they took to deliver support in the least restrictive way.

We identified that whilst staff were aware of issues around consent and care plans highlighted the need to offer choice, detailed capacity assessments had not always been completed where a DoLS authorisation had been approved. For example, care records did not always reflect the best interests' processes that had been followed to ensure care was delivered in a least restrictive way. The registered manager shared with us an action plan they had devised in response to a recent governance audit on behalf of the provider that had identified the same issue. Following the inspection, the registered manager wrote to us to say they had completed all assessments in line with the MCA. We will check this at our next inspection.

People and their representatives spoke positively about the living environment of Milner House. Despite this feedback, the current design and layout was not wholly suitable to effectively support people living with dementia and did not enable people to mobilise around the service independently. The provider had taken on board the concerns relating to the environment and as such a programme of refurbishment and redecoration was in progress to bring the service in line with its statement of purpose.

People's needs and choices were appropriately assessed and information used to plan their care. Due to previous restrictions on admissions, only one new person had been admitted to Milner House since our last inspection. This person confirmed that they had been consulted about their care and we saw a detailed pre-admission assessment had been completed prior to them moving in. Information gathered at this assessment stage had been transferred into support plans to guide staff in the delivery of personalised care.

The management and nursing team worked in partnership with other healthcare professionals to ensure they received the care and treatment they needed. People and their relatives confirmed that people received medical attention as required. We read in care records that where people experienced pain, this was appropriately followed up. For example, one person talked to us about their dental concerns and we saw in their records that they had recently visited the dentist and further follow-up treatment was planned.

People were supported to maintain adequate levels of nutrition and hydration. People spoke positively about the food and informed us they were given choices at each mealtime. For example, in the morning one person said, "I had porridge for breakfast – it's what I like to have, but I could have had a cooked breakfast if I wanted it." Similarly, relatives commented that the food served was fresh and appetising. One family member told us, "They have been making mum protein drinks and smoothies to help build her up and she loves them."

People had choice and control over their meals. Menus were displayed on dining tables and around the service and people were visually shown plated meals to enable them to make a choice. A bistro area was laid out with a variety of drinks and snacks which allowed people to independently help themselves to what

they wanted throughout the day. For those people who spent time in their room or were less mobile, we saw drinks and snacks placed within their reach and support and prompting was provided.

Staff had a good knowledge of people's dietary needs and preferences and used this information to support people effectively at mealtimes. For example, at lunchtime, we heard one person tell staff they weren't feeling very hungry. It was obvious that staff knew the person's favourite food types and they used this information to gently encourage them to eat. Similarly, one person's care records identified that they were living with diabetes but enjoyed sweet foods. Staff were again aware of this and the chef made desserts and cakes they could still enjoy without affecting their health.

Where people needed specialist support with eating and drinking, this was provided appropriately and discreetly. For example, for people who required food to be served at a specific consistency, this was done with thought and attention to presentation. At lunchtime, we saw a person who needed a pureed meal be served lasagne with layers of piped mashed potato to replace the pasta. Staff who supported people to eat and drink did so safely and appropriately. They provided support at a pace which was comfortable for the person and communicated with people throughout their meal.

People were encouraged to provide feedback about their meals and their views were used to shape the menu. A new chef had recently been recruited and it was obvious that they were enthusiastic about creating meals that people enjoyed. They spent time each day talking with people about their likes and dislikes in addition to attending the daily staff meeting to ensure they were up to date about people's dietary needs. We also saw a feedback book in the dining room for people to write their comments about the food. As a direct result of feedback provided, new meals such as lambs liver and steak and kidney pie had been introduced to the menu. During the inspection we overheard one person mention to a staff member that their egg had been served cold. We later noted that this had been recorded in the comments book and the chef had arranged to meet with the person.

Good

Is the service caring?

Our findings

Our last inspection of 23 November 2017 identified that people did not always receive support in a dignified and respectful way and we made a requirement for the service to improve. Following that inspection, the provider sent us an action plan outlining the steps they had and would be taking. This inspection found that people now received kind and compassionate care and the service is therefore now compliant with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The atmosphere within the service was relaxed and friendly. People spoke positively about their relationships with staff and told us that they were treated with kindness. One person commented, "They [staff] are so lovely and so willing to help." Likewise, a relative told us, "The staff are so kind, so caring and couldn't do more." They later went on to say that their family member had been very unwell at one point and described, "I thought mum was going to die, but it really felt like staff were rooting for her to get better and she did."

We saw lots of positive and meaningful engagement between staff and people. In the morning, we were talking with one person and when a staff member joined us, the person's face lit up and they took the staff member's hand to hold. The staff member immediately reciprocated and joined in the conversation with us whilst smiling and stroking the person's hand. On another occasion, a person took a staff member by the hand and led them to the window. After looking out at the garden for a short while, the staff member asked if the person if they would like to go to the lawn, they said yes and the two went outside together.

Staff routinely crouched to people's eye level to talk with them and listened with empathy and patience. We observed that when one person became anxious, staff immediately noticed and went and sat next to them and engaged them in a reassuring conversation. Likewise, another person was feeling unwell and staff took them to a quiet area where they watched television together.

Staff respected people's privacy and dignity and promoted their individuality. Personal care was provided discreetly and sensitively. Staff were observed knocking on people's doors before entering their rooms and ensuring doors were closed when care was being given. Two people visited the hairdresser who was working in the service and we overheard staff complimenting and chatting with them about their new hairstyles. After mealtimes, we saw staff taking steps to ensure people's clothes were clean and their mouths wiped and noticed that this support was provided in a very warm and respectful way.

Staff were passionate about the people they supported. In our conversations with staff, they were very caring and compassionate about the way the described people. For example, one staff member referred to people as "My friends and I am so proud of them." Likewise, another staff member was clearly emotional as they talked about attending the funeral of a person who had recently passed away and reflected, "I really miss them being here."

Friends and families were welcomed into the service and people were encouraged to treat Milner House as a home from home. Relatives confirmed that the service really was an 'open house' and that there were no

restrictions on their visiting. A relative told us, "They are so kind, so caring and genuinely couldn't do any more. It's so nice, I actually enjoy being here and look forward to my visits." During the inspection, one person was hosting a family party for which the chef had prepared a buffet lunch.

People were empowered to be make choices and staff gave them the time to do so. For example, in the morning a staff member was supporting a person with breakfast. The person took a long time to make their food choice, but the staff member waited patiently for them to do so and then facilitated the selection they had made. Care records highlighted how staff should promote independence and we observed this in practice.

People were encouraged to be involved in the running of the service. In addition to daily contact with the registered manager, residents' and relatives' meetings were held every two months. We were told and read in the minutes that these meetings gave people the opportunity to provide feedback on the service and suggest improvements that could be made. A previous request to have a remote call bell in the dining room so staff could be called if needed had been fulfilled and was observed in use during the inspection.

Good

Is the service responsive?

Our findings

Our last inspection of 23 November 2017 identified that people did not always receive person-centred care, feel listened to or have access to activities that were meaningful to them. As such we issued a requirement for the service to improve. Following that inspection, the provider sent us an action plan outlining the steps they had taken and would be taking. This inspection found that people now received more personalised support that was responsive to their needs and interests and the service is therefore now compliant with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff knew them well and had involved them in the planning of their care. For example, one person said, "They know when I like to get up and who I like to help me and that's what happens." Another person who had recently moved in told us that staff had spent a lot of time getting to know them and finding out how they wanted to be supported.

Each person had a plan of care which provided information about their support needs. Care plans were holistic and contained information about how people's physical, social and emotional needs were to be met. Staff also maintained comprehensive daily records about people's care, including how they were and the things they talked about. We could see that where relevant, this daily information had been used to update care plans regarding people's preferences, activities and daily routines.

Staff provided support in line with the information recorded. For example, the communication care plan for one person detailed that when they became confused, they liked staff to chat with them and use a 'low calm tone' to inform them what is happening. We observed staff using this approach when supporting the person to take their morning medicines. The night care plan for another person detailed how they liked to sleep at night with a lamp on and the door closed. The person confirmed this happened.

Staff were responsive to people's changing needs and care records identified the support required to ensure appropriate delivery of care. For example, one person had started to experience hallucinations because of their medical condition. In addition to seeking external health care support in respect of this, staff had also identified the practical steps they could take to reduce symptoms for this person. These included being mindful of where objects in the person's bedroom were placed to prevent shadows being cast. We saw that furniture in this room had been arranged with this consideration and the room was bright and clear to reduce the risk of shadows causing hallucinations.

End of life care enabled people's final wishes to be respected and allowed people to pass with dignity and peace. Staff had sensitively spent time talking with people and their families about their wishes for end of life care. Where people were either unable or had chosen not to participate in these conversations, staff had begun to record other relevant information about the person's beliefs and wishes to assist advance care planning.

People now had opportunities to participate in activities that were meaningful and enjoyable to them. Activities were now being arranged across the whole day and week and the activity co-ordinator we met was

dedicated and passionate about their role. Staff had been working with people to create 'Meaningful Lifestyle' plans that documented the things people enjoyed doing which were then used as the basis for activity planning. Trips to local areas of interest, themed events linked to current sporting events were all reported to have been popular. In the afternoon, we joined a group of people participating in a general knowledge quiz – this was a vibrant and fun activity which was clearly enjoyed by all those taking part. One person said, "We're very competitive, there is a trophy at stake!" Staff made sure that those people who chose not to be involved in group sessions, benefitted from 1-1 time doing a jigsaw puzzle, walking in the garden or just sitting and chatting.

There were now effective systems in place to ensure that people were listened to and concerns were addressed in a way that improved the quality of care. The complaints procedure was prominently displayed and records were now well documented and showed that issues had been responded to appropriately. People said they now felt happy to raise any concerns and confident that they would be dealt with. Both people and their representatives described the registered manager as being "Approachable" and "Open to feedback." One relative told us, "We had an issue, we advised the manager and it was sorted."

Requires Improvement

Is the service well-led?

Our findings

Our last inspection of 23 November 2017 identified a lack of governance and inconsistent leadership across the service. As such we issued a warning notice which required the service to take immediate action to improve. Following that inspection, the provider wrote to us to confirm the improvement plan they had in place. At this inspection, we found that the provider had taken the action they told us they would and the service was now compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their representatives spoke positively about the management of Milner House now and how happy they were with the appointment of the new registered manager. For example, one relative told us, "The new manager is the best that has been here …the staff morale is so good now and that's down to the leadership." Staff also echoed this feedback and said they appreciated the 'hands on' management style of the new registered manager and the additional clinical support that had been placed in the service. One staff member said, "The new manager is really good, it's a happy place here now and we have lots of checks to make sure we are doing ok."

The culture within the service was now open and positive. When asked what the biggest change was that had occurred at Milner House since the last inspection, one staff member said, "All the residents and staff are happy. Staff are giving residents more attention and smiling." Our findings reflected the same. Best practice and learning from events and incidents was shared as. Accidents were discussed to prevent re-occurrence and when things went wrong staff were supported to be reflective of their practice in order to learn from their mistakes.

The registered manager had a good understanding of their legal responsibilities as a registered person. For example, sending in notifications to the CQC when certain accidents or incidents took place and making safeguarding referrals where necessary. The registered manager had a clear vision for the service and was working collaboratively with people, staff and other professionals to achieve it. It is now important that the gaps in record keeping and environmental issues identified through provider audits and this inspection are addressed. Whilst people were experiencing better outcomes as a result of the new leadership, these improvements need to be fully embedded and sustained as the service grows and regional support management support is reduced.

People, representatives and staff alike said that they felt listened to and valued. The registered manager was visible across the service and everyone confirmed that he was approachable and open to feedback. Regular meetings were held and where issues were raised, action was taken. For example, it had been identified that people had to spend a lot of time after appointments waiting for hospital transport to bring the back to the service. As a result, staff now escorted people to attend hospital appointments in the minibus. One person had an appointment in the day of the inspection and told us, "It's much better, it means I can come straight back after I've seen the doctor rather than waiting up to four hours for an ambulance to bring me." A recent relatives' meeting had also identified that relatives would like to see a greater management presence in the service at weekends and as such a new management rota had been introduced to provide this.

Systems for auditing were now effective in monitoring and developing quality within the service. The provider and management team conducted a series of regular audits and checks to ensure the service was continually monitored and assessed. The areas of improvement identified in this report had already been highlighted through provider visits and actions had been were included on the overall development plan for the service.