The Orders Of St. John Care Trust

OSJCT Millbrook Lodge

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

This inspection took place on 27 February 2018 and was unannounced.

Following the last inspection on 10 and 11 January 2017 we rated the home 'Requires Improvement' overall. We asked the provider to complete an action plan to show us what they would do and by when, to improve the key questions Is the service safe? and Is the service well-led? to at least good. We found improvements had been made to both these key questions. However, in is the service safe?, where people had made a decision to continue to use equipment [bed rails], which did not reach the required safety height, records did not reflect that people had been fully informed of the potential impact on them when continuing to use these. We did find improvements in records relating to medicines and the use of drink thickeners. Although, staff required a better awareness of the potential risks to some people when supporting them to eat safely. In is the service well-led? we found audits were used to identify shortfalls and to drive improvement.

Millbrook Lodge 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.

Millbrook Lodge can accommodate up to 80 people, in one building, which is split into four separate units, each of which have separate adapted facilities. Three of these units care for people with nursing needs and one unit for people without nursing needs, where some also lived with dementia. Each unit provides single bedrooms which have private toilet and washing facilities. On each unit is a lounge, dining room with kitchenette area and additional communal bathrooms and toilets. The home provides a large and secure adapted garden. On the ground floor there was a central lounge with a tea room area and a separate hair dressing salon.

The home had a registered manager who had been in post since 2014. 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.

At this inspection we rated the service 'Good' overall.

People told us they felt safe. Risks to people were identified and managed appropriately. Where people were able to make decisions, about risks which may have an impact on them, they were supported to do this. We have made a recommendation about the records kept about the information given to people, which supports them to make independent and informed decisions about the use of bed rails. People received their medicines safely and clear records were kept in relation to these. This reduced the risk of potential errors associated with medicines.

Risks relating to people's nutrition and the potential risk of choking on food or drink had been assessed and

action taken to reduce these. Staff were well supported and received training in order to meet people's needs. We have made a recommendation about reviewing the training given to staff in relation to supporting people who are at high risk of choking.

People had good access to medical support and other health and social care professionals when needed. The principles of the Mental Capacity Act were met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care was provided in a kind and compassionate way. Staff took into consideration people's wishes and preferences and tailored their care around these. People's dignity and privacy was upheld and their diverse needs and beliefs supported. Relatives and friends were made to feel welcomed and were seen as integral to supporting people's wellbeing.

People and where appropriate, their relatives, were involved in planning their care. Care plans gave staff guidance on how people wished their care to be delivered. People were supported to take part in activities, which they enjoyed and enabled them to be socially included. Arrangements were in place for complaints and areas of dissatisfaction to be raised, listened to and resolved, where possible. People were supported to have a dignified and comfortable death. End of life wishes and preferences were discussed and met. Relatives and those who mattered to people were supported at the time of a person's death and afterwards.

The service was led by a proactive registered manager. They were involved in initiatives and projects which improved the services provided to people who lived in the home, but which also made a wider contribution to improvements in adult social care generally. They were an effective communicator who could also listen, reflect on and use the feedback provided by people, visitors and staff to improve the service. They valued their staff and empowered them to challenge practices and to make ideas and suggestions. They went out of their way to make sure people's individual life achievements and contributions were recognised and celebrated.

The registered manager ensured the home was in a position to maintain best practice and that it continued to have links with professionals, forums, agencies and places of learning, which could support this. There were arrangements in place to monitor performance, which they continually reflected on in order to drive further improvement. Strong links with the community had been made which benefited those who lived in the home. The home provided the local community with a valuable resource, but was also in the position to act as a resource for other adult social care services and professionals.

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 fully safe.

Risks to people's health and their safety were identified. However, the process of helping people to make informed decisions about risks, which may have an impact on them, needed improvement to ensure people remained as safe as possible following their decision.

Staff required further awareness to be able to safely support those who had complex eating and drinking needs.

People received support to take their medicines safely and as prescribed.

There were enough staff to ensure people's needs were met. Thorough staff recruitment processes helped to protect people from those who may not be suitable.

Action was taken to protect people from potential abuse and discrimination.

People lived in a clean home where infection control measures were in place.

Is the service effective?

Good

The service was effective.

People's nutritional wellbeing was supported.

People's care and treatment was delivered by staff who had been appropriately trained and supported.

People were supported to make independent decisions. The principles of the Mental Capacity Act were adhered to and this protected those who lacked mental capacity.

People had access to health and social care professional as needed.

Adaptations had been made to the environment to meet

people's diverse needs.

Is the service caring?

Good

The service was caring.

People's care was delivered with kindness and compassion.

Staff had taken time to get to know people and they delivered personalised care which met people's diverse and individual needs.

Relatives received support, were welcomed when they visited and their input valued.

People's dignity and privacy was maintained.

Is the service responsive?

Good

The service was responsive.

People and relatives were involved in planning the care which was delivered.

People were supported to take part in activities they enjoyed and which had a therapeutic value. There were strong community links which supported this.

There were arrangements for complaints and areas of dissatisfaction to be raised, listened to and addressed.

At the end of their life people were supported to die in a dignified and comfortable way. Relatives were supported at the time of a person's death and there were arrangements in place to continue supporting relatives who needed this.

Is the service well-led?

Good

The service was well led.

People and staff benefited from a proactive and strong leader who had clear visions and values which staff were also committed to.

The registered manager was involved in several initiatives and projects, both locally and nationally, which had improved outcomes for people.

Staff were provided with support to carry out their jobs. They

were empowered to question and challenge practice and to reflect on what was best practice.

There were arrangements in place to monitor the services provided and there was a strong desire to drive improvement.

OSJCT Millbrook Lodge

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 site visit took place on 27 February 2018 and ended on this day. The inspection was unannounced. Two inspectors and an expert-by-experience visited the home and carried out the inspection. An expert-by-experience (EXE) is a person who has personal experience of using or caring for someone who uses this type of care service. The EXE has looked after relatives with complex needs and who continues to work with people who live with dementia.

Prior to the inspection visit we reviewed the information we held about the service. This included all notifications received from the service since the last inspection. The provider must, by law, inform us of significant events which have an impact on people in the home. We did not request a Provider Information Return (PIR) prior to this inspection. A PIR is a form which gives some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also reviewed information we had received from one member of the public and from commissioners of the service.

We spoke with nine people who lived at the home, but 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 spoke with three groups of visitors and relatives and two further relatives on their own. We spoke with five care staff, three nurses [two day nurses and one night nurse], one member of the housekeeping team, the chef, both activities co-ordinators and a self-employed hairdresser. We spoke with members of the management team which included the registered manager, deputy manager and an operations manager.

We reviewed nine people's care files, which included care plans, risk assessments and other relevant care records. We reviewed records pertaining to the Mental Capacity Act 2005 for five people. We reviewed the staff training record and three staff recruitment files. We also reviewed a selection of audits which included

medicines, 'dining experience', the last infection control audit, care plans and catering audits. We reviewed records kept for each complaint received by the home.

We were provided with a copy of the provider's bed rail policy. We requested and received further information from the home in relation to bed rail risk assessments. We were also provided with reports on the findings of the last satisfaction survey completed on people, their relatives, friends and the staff. We attended one staff hand-over meeting.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 10 and 12 January 2017 risks relating to the use of bed rails and some pressure reducing mattresses had not always been properly identified and managed. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Records relating to the use of drink thickeners and some medicines did not always record necessary information in order to protect people from potential risk. We asked the provider to take action and improve on how these risks were identified and managed to ensure people remained safe. The provider told us these shortfalls would be addressed by 30 April 2017. During this inspection we found the necessary regulations had been met and action had been taken to improve people's safety. However, further improvement was needed to demonstrate that people had been fully supported to make informed decisions about risks which may have an impact on them and that actions had been taken to ensure their safety following these decisions. Staff needed to have a better awareness of the potential risks for some people when supporting them to eat.

Records on each unit told us who had bed rails in use. We reviewed completed bed rail risk assessments for people whose bed rails did not meet the safety height recommended by the Health and Safety Executive (HSE). The HSE states that bedrails should measure 220mm from the top of the mattress to the top of the bedrail to ensure their safe use. Bed rails with height measurements of 170mm and 180mm were in use, meaning potentially the bed rails may not be high enough to prevent a fall from the bed. In the cases we looked at, the use of air pressure reducing mattresses, were the reason for these reduced measurements.

The provider's policy on the safe use of bed rails explained that people should decide if they have bed rails or not, if, they have the mental capacity to make this decision. It stated, in cases where there was a reduction in the effective height of a bed rail, an assessment for the use of extended bed rails should take place. Extended bed rails provide an increase in bed rail height to meet the HSE recommendation. The provider's policy also stated a risk balance tool must be completed. The risk balance tool took staff through a sequence of questions, which had to be answered; about the risk of using bed rails versus the risk of not using bed rails. One of the questions to also be considered was, 'will the person feel anxious if bed rails are not in place?'

We reviewed the completed risk balance tools and the spoke registered manager spoke with us about the conversations that had been had with people about the safe use of bed rails. The registered manager told us it had been explained to people, that their bed rails were not at the recommended safety height and why this was. They told us the potential risks associated with using reduced height bed rails had also been fully discussed with them. Relevant records stated what the bed rail height was and that people had been told what that measurement was, what it should be and why it was reduced. They stated bed rail extensions had been offered and that they had been declined. We were told by the registered manager that no one had wanted the extensions put on. The registered manager told us people had said they felt too enclosed with these fitted.

Where people had said, that despite being given this information, they would feel anxious without bed rails in place and they wanted the reduced height bed rails to remain in place, a mental capacity assessment had

been completed. This assessment sat alongside the bed rail risk assessment records. This assessment had been completed to ensure the person had understood, retained and had been able to weigh up the risk of having reduced height bed rails in place without bed rail extensions.

The conversation which had been held with people, about the potential risks and impact on people when reduced height bed rails were used, was not well recorded. The records gave little detail about what was actually explained in order to help the person make an informed decision. A written risk assessment had also not been competed to show how the risk relating to the use of the reduce height bed rails would be managed for each person. Comprehensive information was therefore not available, to show that people had been fully supported to make an informed decision about the use of equipment which may potentially have a detrimental impact on them.

We recommend that the service seek advice and guidance from a reputable source, in relation to recording the information given to people about risks; in this case related to the use of reduced height bed rails.

We found the provider's policy on the use of bed rails had been followed. The initial need for bed rails had been correctly assessed, the fact that some bed rails were not at the recommended safety height had also been identified. The potential risks associated with this had been discussed with people [although not well recorded] and a way of reducing this risk had been offered to them. Where people were able to then make an independent decision about the use of unsafe bed rails, this had been respected but also not further assessed.

The provider had placed an order for alternative pressure reducing mattresses, which did not reduce the height of bed rails. Following delivery and an appropriate risk assessment, it was planned that these would be offered to those who still required pressure reducing equipment and who had reduced height bed rails in place.

Risks of choking and potentially inhaling food had been identified. Food and drink thickening agents were managed safely. Two people with swallowing difficulties had been prescribed a thickening agent to add to their drinks. By altering the consistency of the drink the risk of choking was reduced. There was clear information about people's needs with regard to this in their care plans. Direction and guidance had been supplied by speech and language therapists. This included guidance on the required consistency of their drinks and food. Staff used the thickening agent specifically prescribed for the person and used the specified amount to achieve the correct consistency. We observed a member of staff preparing one person's drink using their thickening agent. The kitchen staff were aware of what texture people required their food to be, for example, pureed or fork mashable food.

One person's care records however, recorded that they were at high risk of inhaling their food and potentially choking. They had been assessed by a speech and language therapist who had provided clear guidance on how to manage this person's condition. A relevant care plan referred to the person's necessary posture when eating or drinking. For example, sitting upright and at a dining room table, which we observed to be followed. The information also stated the person was at high risk of inhaling their food "on each intake." We observed the support this person received to eat their food. Although we observed a kind approach, the member of staff supporting the person to eat did not always wait for the person to swallow the food they had in their mouth, before they provided them with more. This increased the risk of this person potentially choking or inhaling their food.

The member of staff told us they had not received specific training on how to support such a person to eat. They and others did confirm they had received training on what to do if a person choked. We fed this back to

managers who told us the training provided, as seen on the training record, included how to support people with these kinds of risks, to eat.

We recommend that the service review the contents of this training to ensure it provides staff with the practical skills they require to safely support a person who has been assessed as a high risk of choking or inhaling their food.

People who had been assessed as being at risk of developing pressure ulcers had been provided with pressure relief mattresses and cushions. Where air mattresses were in use, those seen during the inspection had been set at an inflation rate appropriate for the person's weight. At the last inspection these inflation rates were not always seen to be correct for the person's weight. A daily check of the function and pressure settings of these mattresses was now in place to ensure the setting remained correct. These checks and the inflation rates were recorded. There were no cases of people having developed pressure ulcers whilst living in the home. Where people had been admitted with established pressure ulcers appropriate action had been taken.

People received their prescribed medicines and the overall medicine system was managed safely. All medicines were stored securely and at the recommended temperature to maintain optimum effectiveness of the medicine. All medicine administration records (MARs) and other associated records were maintained correctly. These included a specific record of when certain medicines, such as pain relief medicines had been administered. This avoided potential overdose. We observed senior staff checking people's MARs at the beginning of their shift to ensure these were completed correctly. This reduces the risk of further potential medicines errors. Appropriate guidance was in place for the use of certain medicines, such as those prescribed to be administered 'when required'. Best practice was in place for the management and administration of medicines, such as, blood thinning agents, blood sugar regulating medicine, creams and lotions and some pain control medicines not taken orally.

People who we spoke with told us they felt safe living at Millbrook Lodge. The relatives we spoke with told us they did not worry about their relatives because they knew they were being well looked after. One person said, "I actually put myself in here because I was getting worried about my memory - and I've got no regrets. I can still do what I want but now I feel safe."

People were protected from potential abuse and discrimination. The registered manager adhered to the provider's safeguarding policy and procedures and those of the local authority. They therefore shared any concerns and relevant information with other agencies and professionals, when it was needed, to safeguard people. Staff had received training on how to recognise potential abuse and report concerns. They had received training on the Equality Act and issues around potential discrimination. People were treated equally, irrespective of their gender, disability, sexuality, spiritual and religious and cultural beliefs. Staff were expected to apply these values towards each other. The provider's policies supported this approach.

People's risk of falling was assessed and action taken to reduce this and the danger of them being injured. One person was able to walk independently but was prone to falling. A risk assessment of their room had been carried out to review potential hazards and reduce the risk of tripping. We found that the person's furniture had been placed around the outside of their room, leaving clear floor space, free of trip hazards, in the middle. When the person walked around the home, staff were seen to offer them support, which they sometimes accepted.

Another person had fallen and had sustained an injury which had been appropriately reported to other agencies. Following a review of the risks associated with this, as well as the person's physical abilities, it was

found the person required the use of a hoist to help them move. A safe moving and handling assessment stated what hoist and which sling staff needed to use to transfer the person safely. It stated the support of two staff were required to do this. A padded mat [crash mat] was also provided alongside the person's bed at night to reduce the risk of injury should the person roll off their bed. Safe ways of working had therefore been applied. The person confirmed that the equipment was always used and that two staff were present when they transferred them in the hoist. This person told us staff moved them safely and they had no concerns about how they were moved.

Other potential risks to people, staff and visitors were assessed and managed so these were reduced. A health and safety policy was in place, in date and followed. Current and comprehensive environmental and other relevant risk assessments were seen completed. These covered risks associated with asbestos, slips, trips and falls, first aid, fire safety, hoists and lifting equipment, hot water and legionella, housekeeping and the kitchen. A monthly health and safety checklist was completed by the registered manager who monitored all associated risks and the actions taken to reduce these.

We reviewed other health and safety related records. For example, the fire log book contained evidence of checks at required intervals of fire alarms, emergency lighting, fire exits, fire doors, escape routes, nurse call system, lift alarms and fire drills. The maintenance log book provided evidence that routine checks and servicing had been carried out on electrical appliances, gas and electrical services, lifts and lifting equipment, slings and baths and water temperatures.

Records seen indicated that accidents and incidents were being reported. Relevant information on these was then analysed and trends looked for. This process helped managers ensure the actions being taken following these events was effective in aiming to keep people safe. A record of people's personal evacuation plans were kept in a 'grab bag' in reception, along with a floor plan of the home. This information was kept up to date and ready for use by emergency services. An emergency contingency plan was in place.

People lived in a home which was kept clean. There were no malodours and cleaning staff adhered to the prepared cleaning schedules. One housekeeper showed us the record they kept of the cleaning they completed. These records were monitored by the lead housekeeper. Measures were in place to avoid and control the spread of infection. For example, care staff put on protective aprons and had access to disposable gloves for when they delivered people's personal care. They wore protective tabards when serving people's food. Hand sanitising agents were available for staff and visitors to use and signs reminded people, staff and visitors to wash their hands. Soiled laundry was managed separately from other laundry. Equipment for cleaning and that used for the management of laundry was colour coded to reduce the risk of cross contamination.

Staffing numbers were monitored by the registered manager. They ensured there were enough staff on duty and they employed staff with the correct skills and experience to meet people's needs. When we asked staff if they considered there to be enough of them on duty, they agreed that during the day time there were enough staff to meet people's needs. A member of staff for example, commented, "Yes it's alright." On one unit, one member of staff had been unable to come to work because they were poorly. Senior staff had not been able to cover this absence with another member of staff. The staff on duty told us they would organise their work so that people's individual needs would still be met. They said, "We will manage." The home had some bed vacancies and staff from other units helped out.

We observed people's needs being met, call bells were answered and we saw staff going about their work in an unrushed manner. One member of staff commented that the night time staffing could be improved. They told us some staff members finished earlier in the morning, explaining this left a reduced number of staff

during a busy period before the day staff arrived. The registered manager stated there was only one staff member that this applied to and when they were on duty a member of the day staff came in earlier to cover this period.

Staff recruitment files showed staff were recruited safely so people were protected from those who may not be suitable.

Good

Is the service effective?

Our findings

People spoken with told us they felt well looked after and their health needs were addressed. Relatives also considered their relatives to be well looked after and told us staff made them aware of any changes in their relatives' health.

People received support to eat and drink and maintain nutritional wellbeing. There was a strong focus on ensuring people's nutritional needs were met and to make sure people remained well hydrated. The importance of this ran throughout the home from staff in the kitchen who understood the need to prepare food and drinks at various times of the day, to the care staff and domestic staff who understood the importance of ensuring, for example, people's jugs of water remained topped up and people were provided with support to drink. We observed, over the course of the day, people regularly being offered hot and cold drinks. People were supported to make choices with regard to what they ate and drank. People who lived with dementia were shown the food options already plated up which helped them make a choice at each mealtime.

People's weight was monitored and any concerns were discussed with the person's GP. Additional calories were provided for people who struggled to maintain their weight. This was done by fortifying foods for example, adding extra butter, cream and powdered milk. The kitchen staff were aware of people's nutritional and dietary needs and met these. Allergens in foods had been identified and information on this was available.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found people were supported to make their own decisions and their permission and agreement was sought before care was delivered. One person said, "It actually gets a bit annoying sometimes. They always ask me, even though they do the same things every day. But I understand why they need to ask [my permission] and really I'm glad they do."

Where people were not able to make decisions about their care and treatment, these were made on their behalf and in their best interest. The provider had records in place which recorded best interests decisions and how these were made. People's care records referred to people giving consent or them not having mental capacity to do this. This showed that staff were aware of this legislation and considered it at all points of care delivery.

We also checked to see if people, who were deprived of their liberty, were protected under the MCA and that appropriate applications had been made to the 'supervisory body'. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation

of Liberty Safeguards (DoLS). We checked to see whether any conditions on authorisations to deprive a person of their liberty were being met. One person had authorised DoLS and there were no conditions applied to these. Where an initial application had been required or where DoLS authorised had expired and a new application was needed, these had been completed but not yet responded to by the supervisory body.

People had access to health care professionals when needed. The registered manager told us a "very good" working relationship existed between the home and a local GP surgery. Each unit was visited by a specific doctor on a regular basis. This allowed for consistent review of people's health by one dedicated doctor. Other doctors provided support during 'out of hours' as did the NHS Rapid Response team who could often provide treatment in the home and avoid a hospital admission. People's care records showed referrals to and visits taking place by speech and language therapists, physiotherapists, community nursing teams and mental health specialists. Professionals from the local care home support team also provided support and guidance on the care of individual people with specific and complex needs. People had access to chiropody [foot care], free optical [eye] assessment and NHS dental care. One person told us staff were very proactive with their particular health need. They told us staff knew what was needed and they paid particular attention to this. They told us when staff were concerned they would ask the nurse to come and have a look.

The registered manager was proactive in supporting staff to complete basic training and then to improve their knowledge and skills further. Millbrook Lodge had a dedicated training co-ordinator who had just updated the home's main training record. This showed what training had been completed, by whom, and when updates and new training was required. The co-ordinator booked all training requirements through the provider's training department and followed up on any training not attended. The training record showed that staff training was well managed. Dates for fire safety training had not been provided by the provider. We were told this was a national problem. However, managers in Millbrook Lodge ensured new and existing staff kept up to date with 'in-house' fire safety arrangements and they attended fire drills.

All staff completed induction training when they first started work at the home. A probationary period also had to be successfully completed where staffs' progress and suitability was reviewed. New staff and staff new to care completed modules of training from the care certificate. The care certificate provided staff with training which, once completed, aimed to enable them to deliver care to a recognised national standard. The certificate was used along with the provider's 'back to basics' training to ensure staff remained up to date with current best practice in basic care delivery. Links with external professionals, various forums and learning exchanges ensured the additional training and guidance given to staff, met with best practice guidance. Staff competencies were reviewed and individual meetings were held with staff to give them an opportunity to discuss their learning needs and any concerns about their progress with their managers.

Nurses were supported with their personal professional development in order for them to remain registered with the Nursing and Midwifery Council (NMC). Staff competencies, including those of nurses, were reviewed. Specific areas of clinical update and learning were provided to nurses on dedicated study days. Specialist knowledge was supported by professionals employed by the provider, such as The Admiral Nurse team. An Admiral Nurse is a specialist practitioner in the care and support of people and their families, who live with dementia. They also provided staff with support in meeting the principles of the Mental Capacity Act. Some staff had lead roles, for example, in health and safety, infection control, falls management and skin and wound care. They attended local forums and provider study days in their specialist's area and in turn promoted and supported best practice in the home.

The home was purpose built and had been adapted further to support people's physical and mental

wellbeing. Corridors, bedrooms and communal areas provided space for wheelchairs and other care equipment to be easily manoeuvred. Bathroom and toilets were fitted with grab rails and bath hoists, for example, to make bathing accessible to those who were not mobile. Appropriate signage helped people orientate themselves as they moved through the building.

Good

Is the service caring?

Our findings

All people and relatives spoken with confirmed staff showed kindness and professionalism when caring for them or when speaking with them. The inspection team were surprised at the breadth of diverse needs and abilities being catered for at Millbrook Lodge. The provider's policies and procedures supported the Equality Act. In practice, we observed an approach which recognised everyone as an individual, that each person had different needs and abilities but everyone had something different and valuable to contribute. This ethos was also applied to the management of the staff.

In order to support lesbian, gay, bisexual, and transgender (LGBT) people the registered manager had sought guidance and information from Stonewall. Stonewall is a lesbian, gay, bisexual and transgender rights charity in the United Kingdom.

People agreed that their dignity, privacy and independence was maintained and supported. One person described the impact of their life altering illness and said, "They [staff] really try to help me keep doing things for myself because they know that's important to me." When talking about retaining the ability to eat independently they said, "They [staff] got me assessed straight away….and got me some special equipment (a plate guard and adaptive cutlery). I've always enjoyed my food and I still do."

We observed sensitive and very good-humoured interactions taking place. Staff showed a good level of knowledge and understanding of the people they looked after and an affectionate regard for them. People praised the staff highly and the atmosphere was very warm and relaxed. People and staff tended to be on first-name terms with each other, but where a person did not want this, this was respected. One person told us they preferred it if staff were not "over-familiar."

People were listened to and made to feel cared for. People had been made to feel as if they mattered. One person had been admitted for short-term care but had remained in the home. They spoke with us about their need to be cared for in a care home, the fact they had never been to a similar place before, how the staff had helped them to adjust and how they now felt about this. They said, "I've been dreading this day but realistically I think it's time to accept that I might not be able to cope on my own anymore. And, I must say I've found it alright. If I end up staying here, I think I will be able to get used to it. Of course, there are compensations, too. I haven't felt lonely since I've been here and I think I was rather lonely before."

Staff were not unnecessarily over-supportive which allowed for people's desire to be independent to be met, but staff were quickly available when they were needed. The staff had a good understanding of the effects of living with dementia. When people were distressed or required additional support, staff adopted non-threatening body language and a smiley, cheerful demeanour to reassure people and promote feelings of wellbeing. Staff respected people's individuality as well as alterations in mood and behaviour. On one unit, where most people lived with dementia, we observed staff speaking to people as they would to any other adults; respecting people's intelligence and autonomy.

Staff promoted and supported friendships which had been formed between people and staff. We observed

many examples of where positive relationships had been formed and where these clearly supported people's day to day wellbeing. One example included a person who had formed a friendship with the housekeeping staff. This person had not wanted to eat with other people and there had been concern for their nutritional wellbeing. The housekeeping team found the person had wanted to remain with them during their lunch-break. By welcoming the person they found they were also happy to eat with them. This was an example of the caring culture in the home and where staff had been prepared to go over and beyond what would normally be expected of them to support a person's feeling of belonging.

There were several visitors on the day of the inspection and those who mattered to people were welcomed and supported to feel included. A poster in reception told us the home participated in "John's Campaign". A pledge had been made to the principle that: those who had previously cared for people should not just be allowed to visit but should be welcomed, and that a collaboration between the people who lived at Millbrook Lodge and all connected with them, was crucial to their health and well-being. We observed and visitors told us, how relaxed and comfortable they felt in the home. We observed three families visiting with children who had been made to feel welcomed and comfortable. Visitors told us they were able to visit whenever they wanted to and were usually offered refreshments. The visitors we spoke with in more depth told us they felt communication with the staff was very good. They told us, if they telephoned the home, the call was usually answered quickly and they were kept updated about their relatives' wellbeing.

The activity coordinators were aware of who did not have family or friends visiting and the need for everyone to feel connected with and included. This was considered in how their one to one time with people was organised and in how the volunteers' time was allocated.

People who did not have family support, or who wanted independent advocacy support, were helped to source this. Independent Mental Capacity Advocates (IMCAs) were also involved as required. These professionals supported people to 'have a voice' when decisions were being made about their care or treatment or could speak on behalf of a person who could no longer do this.

Good

Is the service responsive?

Our findings

People, their relatives and representatives [where appropriate], were involved in planning and reviewing the care which was delivered. People's care records contained written reviews which had taken place with people or family members. This input helped people's care remain personalised and relevant to their needs. Where people were no longer able to independently contribute to this process, their relatives and representatives [where appropriate] were consulted with. Information about people's personal history, their life stories, preferences, likes, dislikes was gathered. This helped staff tailor the care they provided, but also supported the conversations and activities which helped bring quality to people's lives.

Care plans were devised and provided staff with the guidance needed to support people's health and diverse needs. Those seen by us had been reviewed monthly or beforehand, when needs or care had altered. This was in accordance with both the registered manager's and provider's expectation and kept the information relevant. This was particularly important when visiting professionals needed to reference these when carrying out reviews or assessments.

Care plans and other support records contained specific information about how to support a particular individual. In places these were so personalised it was clear the person receiving the care had been involved in developing these. Some people were able to tell us about the support they now required and how they had some control over the care provided. For example, one person said, "The staff always ask if I'm okay before they do anything. I can't stand by myself anymore and using a standing board [stand-aid hoist] to get out of my wheelchair has taken a bit of getting used to. They [staff] are very good about making sure I feel safe and solid."

The extra knowledge, information and support provided by family members and friends was valued and used by staff to support people. The registered manager's view was that both staff and family needed to be "a team". One relative talked about their family's involvement in supporting their relative. They said, "One time [relative] just couldn't settle after [spouse] had been in to see them…and they [staff] had tried everything. They [staff] gave us a call and asked if we had any ideas about what might help. In the end we went in, but it was reassuring to know how well the staff seemed to know [relative]."

We spoke with the two activity co-ordinators for the home. They told us how they provided activities and one to one sessions to people. They were supported by four volunteers who visited regularly, at different times across the week. Guidance from The National Institute for Health and Care Excellence (NICE) was on the activities noticeboard and followed. This said, "People with dementia are offered opportunities to join in meaningful activities."

There was a choice of things to do every day which was advertised on notice boards throughout the home. What we observed taking place and heard about during the inspection seemed to be an accurate representation of what was advertised. There was a well-stocked 'library' [bookshelves] and one person told us the books were frequently changed. This person said they liked to use this resource… "in the winter, when I can't get out to the library in town." This person also told us they loved music and staff got CDs for

them when they asked.

We observed a 'Music Therapy' which was not well - attended [only five people] and which could have been more interactive to support people's engagement. The registered manager explained that the volunteer delivering this was relatively new at doing this and needed time to develop the session. They were however fully qualified to deliver the session to people who lived with dementia. We also observed a 'pamper session' which was well attended [14 people] and which had a chatty, cheerful atmosphere. People were laughing together and were well engaged. This offered moments of close, personal interaction with gentle physical contact, which people appeared to benefit from.
There were several men who lived at Millbrook Lodge and we only saw one man participating in the activities. The men we spoke with told us they organised their own card games and were happy to do their "own thing." One man said, "I suppose we don't tend to mix very much. The women prefer the company of other women and the men prefer the company of other men." The activity co-ordinators were aware of the men and told us they were always looking for ideas which would appeal to them. They told us that one activity, for one man, had proved to be very therapeutic for them. They told us the other men enjoyed one to one chats and the male volunteers tended to spend time with the men, providing the same gender company which the men enjoyed.

People were supported to use the local community socially. For example, a group of four or five people went out on a regular basis, for lunch, to a local café. The community centre opposite the home was visited for tea and cake, as was the local Library. Links had been made with two children's nurseries who visited at festive times. On a monthly basis a baby and toddler group was held at the home. This provided a location for this group and people enjoyed interacting with the children. One person told us how much they and the other people enjoyed it when the children visited. They said, "The little ones visit. Some of them don't have grandparents so it's good for them, too." A link had been made with a local veterans' club and some people were supported to meet for lunch. The home had its own transport and people were able to go out for a drive or visit areas further away from the home.

There were arrangements in place for people, relatives and visitors to raise a complaint, have this listened to and resolved where possible. The provider's complaints procedure was seen in various places throughout the home. The registered manager told us this could be provided in different formats. For example, in larger print or audio for people who were visually impaired. The management were aware of the need to ensure people could access information in a format which suited their needs. All complaints and how they were responded to had to be reported to the provider by the registered manager. This ensured these were followed up in the timescale given by the provider [28 days] and that any subsequent actions were completed.

We reviewed complaints which had been received by the home since the last inspection. One complaint, received by the registered manager had also been shared with the Care Quality Commission prior to this inspection. One of the provider's operation managers had investigated the issues which had been raised. They confirmed to us that these had not been upheld and they were completing information for other professionals involved in the case. Although the Care Quality Commission does not have the statutory power to investigate individual complaints, some of the themes raised in this complaint, were looked at as part of this inspection. We did not identify any concerns relating to these whilst inspecting the service. Another complaint, received by the registered manager, had been partially upheld following investigation. Actions had been taken to improve communication with a relative.

People and visitors spoken with told us they had never had cause to complain, but most were aware of the complaints procedure. One visitor said, "There's an open-door policy here which means that things tend to

get addressed very quickly. A couple of times I popped into the manager's office about some small thing. Once, it was because [relative] wanted to change a newspaper order and it was all sorted out with no fuss and bother."

People received care at the end of their life which supported a dignified and comfortable death. Advanced care planning made sure people's wishes were explored and recorded so they could be met at the appropriate time. Some of the wishes which had been met had included the playing of a certain type of music and those in line with people's particular beliefs. Arrangements were in place for end of life medicines to be prescribed and to be available in the home for when they maybe needed. Nursing staff had updated skills in administering these. Staff received training to be able to deliver end of life care. There were links with the Sue Ryder Hospice which ensured current best practice was followed. An end of life care pathway was followed by all professionals which helped to ensure people received consistent care.

Relatives were supported during this time and afterwards. Two relatives had come in to talk to the registered manager about their relative who was dying. They told us the care being delivered to their relative was "absolutely fantastic.…. really really cared for". They told us they also felt really supported. One of these relatives said of the staff, "It's the kindness.…..so kind." The home could provide overnight sleeping arrangements for relatives who wished to remain close during this time.

A remembrance service [recognising all faiths] was held each year, in the care home, for those who wished to attend. During the last service 80 visitors attended and supported each other in remembering their relative or friend. A remembrance tree stood in the home and we saw messages and prayers hung on this. Reflective conversations were sometimes held with staff following a death, in order to provide them with support and closure. Staff often attended people's funerals. Learning opportunities were also identified so that this area of care could be continually improved.

Good

Is the service well-led?

Our findings

The management team at Millbrook Lodge were effective and well-respected. Everyone we spoke with described the managers [registered manager and deputy manager] as being highly visible and involved in what was going on in the home. All the visitors spoken with told us the registered manager was "approachable", "friendly", "highly competent and proactive." All the people we spoke with [apart from one who could not immediately remember], knew the registered manager's name. They told us he was "approachable" and said they would recognise him as he often had a chat with them. The staff held him in high regard and they confirmed they felt well supported by him.

We observed the registered manager had a relaxed and calming approach when dealing with issues that arose and when communicating with people, visitors and staff. This was reflected in how the home operated, busy, but relaxed and running smoothly. We observed the registered manager frequently leaving their office to visit units for various reasons. Staff told us they felt able to speak with him whenever they needed to. The registered manager told us they were available to support staff at any time. They told us staff sometimes approached them about personal matters, which they were happy to provide support with, where possible.

The registered manager told us the skills of the deputy manager complimented theirs and they made a good team. A joint approach and effective communication helped the managers remain aware of the home's culture and staff morale. Regular meetings were held with heads of departments and different staff groups. Managers used these meetings to pass on important information, report on progress and discuss areas for improvement. Meetings were very much a two way process, with managers also keen to gather feedback from the staff. Reflective meetings were used to provide staff with opportunities to explore and reflect on particular issues. One meeting had been held with staff on one unit. This had explored individual staff roles and responsibilities so the team could work more effectively. The registered manager reported this to have been helpful with improvements having followed.

The registered manager had promoted a whole team approach where every staff member was a valued member of the overall team. Managers were open to ideas and suggestions from staff which would improve outcomes for people. One person had spoken to a team member about a particular aspiration they had. Staff had shared this with the registered manager who was open to staffs' ideas and suggestions on how this could be met. A personalised plan to support this person to meet this had been agreed on.

The registered manager was involved in several initiatives, which not only improved people's overall experience whilst at Millbrook Lodge, but which had a wider impact on how adult social care was provided locally and nationally. There had so far been three projects. The first, sponsored by Care England and the Department of Health, to develop the concept of teaching care homes. Supported by Manchester University, the Foundation of Nursing Studies and the International Longevity Centre, the home, along with four others nationally, had been chosen to participate.

This was a nurse led project which aimed to improve the profile and status of care homes, as part of the

wider health system, to create centres of innovation and encourage the nursing workforce to take on roles within care homes. Home Managers and the nurses involved were tutored, supported and encouraged to make innovative changes to their practice. Nurses, who had been aware of the project, had applied for jobs and some now worked at Millbrook Lodge. The registered manager and the home was now a resource for other professionals.

The second, an innovation which stemmed from the first project, aimed at improving the experience of people transferring between NHS services and adult social care services. The registered manager, along with acute hospital and ambulance service leaders had been involved in planning and co-ordinating a new integrated pathway in Gloucestershire. Called the Red Bag Pathway, its aim was to meet the requirement set by The National Institute for Health and Care Excellence (NICE); to make better provision for the safe transition of people between inpatient hospital settings and community or care home placements.
A red bag was used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout any hospital episode and was returned home with them. The standardised paperwork would ensure that everyone involved in the care for the person would have necessary information about their general health, e.g. baseline information, current concern, social information and any medications. On discharge the care home would receive a discharge summary with the medications and the person's belongings in the red bag. At the time of the inspection final checks had recently been carried out on the implementation of the pathway. This had involved co-ordinators of the project, physically tracking the journeys of red bags and evaluating the impact and success of the pathway. The initial pilot had proved to be successful and the scheme was due to 'go live' in the near future.

The third, as a result of the registered manager's involvement and experience in learning and teaching forums and, the home's ability to embed best practice, it was used by the University of West of England (UWE) as a nursing placement for adult and mental health student nurses. Student nurses were accepted and received mentorship from designated staff, whilst experiencing working in a community nursing home.

Other events and community engagements had been attended or organised in order to recognise and celebrate the contribution people had made in their lives. The registered manager said, "I firmly believe this is a university of wisdom – older people's wisdom." The recognition of one person's contribution came about through a link with a local school. The person had subsequently accepted an invite, by the school, to be a guest of honour. Another opportunity, which had brought different generations together, came about when a school pupil, visiting the home, was completing a project on the D-Day Landings of 6 June 1944. The registered manager said, "I had been able to introduce this student to a person who had actually taken part in these." Both the person and the student had benefited from this encounter.

Since the last inspection the registered manager had also planned and coordinated a ceremony which had taken place at the home. This saw two British Normandy veterans, who lived in the home, receive France's top military honour, the Legion d'Honneur. This acknowledged their bravery and contribution to the Allied landings. This had been attended by local district counsellors, school students and families.

We found there was a constant desire and drive to improve the services provided. Arrangements were in place to monitor these and the standard of care. The provider had carried out a full audit of the service in November 2017. There were some actions from this for the staff team to complete, in order to meet with the provider's expected baseline requirements. We reviewed this audit and were able to identify actions, which had already been taken in response to this audit, throughout the inspection. A program of on-going audits and checks were completed throughout the year by staff. The findings and planned actions for improvement were reported to the provider. One of the provider's operation managers was present during the inspection. They visited the home on a regular basis to provide support to the management team and monitor progress

and improvements. Both the operations manager and the registered manager for example, told us that once the new pressure relief mattresses had been delivered the use of these would be discussed with people on existing air pressure relief mattresses in order to review the outstanding risk of the use of reduced height bed rails.

The registered manager constantly self-assessed their contribution and reflected on the effectiveness of the service generally. They told us they were always asking the questions, "what are we doing well and what would be even better if…..." These questions had originated from the first project. The registered manager told us it was easy to "take an eye off the basics" and these questions helped them to focus again on what was really important to the people who lived at Millbrook Lodge. The registered manager also wrote a professional 'blog' [an on-line discussion via a website] which promoted discussion between care home leaders. Areas for discussion, seen on some of the 'blog' transcripts included "So what is a good care home in the 21st Century? and "If I woke up in a perfect care home – how would I know?.

The service used various methods for seeking feedback from people and visitors. Two people told us about being asked to fill in a satisfaction questionnaire about the home. We reviewed the collated information provided to us on the last survey completed on people, relatives and friends. This information was to be made available to people and visitors and areas of low score such as, the response to "staff have time to talk with me" would be looked to see how at improvements can be made. People were also asked for their feedback in meetings and informally. We reviewed the comments made by relatives and people which had been made on –line (via a website) since the last inspection. Nine out of the 10 reviews were positive.

The registered manager had ensured the last inspection rating had been correctly displayed. They also notified the Care Quality Commission (CQC) of the necessary things which they are required to do as part of their registration responsibilities.