Mr & Mrs J Fieldhouse

Millfields Residential Care Home

Inspection report

Mill Lane
Nevison
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West Yorkshire
WF8 2LS

Tel: 01977690606

Date of inspection visit:
21 June 2018

Date of publication:
11 October 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 June 2018 and was unannounced. Our last inspection of this service took place in August 2017. At that inspection we identified breaches of regulation in relation to staffing, dignity and respect, consent, nutrition and good governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good. The action plan was submitted as requested and gave detail about the actions they had already taken and were addressing in relation to making sure people were safe, people received adequate nutrition, people's rights were upheld as required by the Mental Capacity Act, people's needs in relation to privacy and dignity were met and making sure the service was well led.

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

Millfields Residential Care Home provides accommodation and personal care for up to 38 older people, some of whom are living with dementia. Accommodation is provided over two floors with communal areas, including two lounges and a dining room, on the ground floor. There were 30 people using the service when we visited. This included one person who was in hospital.

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

People living at the service told us they felt safe. Staff had received safeguarding training and knew what to do if they thought somebody was at risk.

Medicines were generally managed safely. Action was taken during the inspection to improve systems for safe and appropriate storage.

Risk assessments had been completed to mitigate risks to people's safety.

There was a robust system for monitoring and detailing accidents and incidents with lessons learned and action plans formulated where required.

The premises were clean, well maintained and appropriate safety checks were in place.

Effective recruitment processes were in place and systems for staff training had been developed to make sure staff had the skills and knowledge they needed to provide good and effective care.

Staff were well supported through effective training, regular supervisions and annual appraisals.

Staffing levels were kept under review to make sure they were responsive to the needs of the people living at the service.

People were supported to have 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. We saw evidence of consent being sought and best interest meetings where appropriate.

People were complimentary of the care and support they received. Staff were respectful of people's privacy and dignity needs.

People enjoyed the food at the home and their dietary needs were assessed and met.

Care was planned and delivered with a person-centred approach and people were supported with their wishes in relation to the care they received at the end of their lives.

People enjoyed a range of meaningful activities and had choice of communal areas in which to spend their time.

The service was managed well. There was an inclusive culture and people's views and opinions were sought and valued.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe and staff knew what to do if they thought somebody was at risk. Risks to people were managed well.

Staffing was organised to meet people's needs and was kept under review.

Medicines were generally managed safely. Action was taken during the inspection to improve systems for safe and appropriate storage.

Is the service effective?

Good

The service was effective.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) but needed to make sure systems for best interest decisions were followed consistently.

Staff received the induction, training and support they required to fulfil their roles and meet people's needs

People enjoyed the food and their nutritional needs were met. People's healthcare needs were assessed and staff supported people to access health professionals as needed.

Is the service caring?

Good

All of the people we spoke with told us staff were caring. One person said, "I'm definitely looked after here visitors can come when they want, I have company all the time and people to visit." Another said, "The care here is very good they are all very good to me." Another person told us "They don't always have time to sit and talk because they are so busy but they are caring."
A visiting relative told us I think (person) is very happy here they know and understand (them), they know (their) personality and have a joke with (them), from the first day (they) came (they) never looked back." Another relative said, "They are extremely

good with (relative) they talk to (them) and have a very good rapport with (them)."

At our last inspection we found staff did not always treat people with respect or consider their dignity needs. On this inspection we observed staff to be caring and respectful. People had clearly been supported well in their personal care and staff were discreet in their support of people. For example, when assisting people to the bathroom or when offering clothes protectors at meal times.

We observed staff chatting with people. We saw one member of care staff bending down and kneeling on the floor to talk to people and gently holding one person's hand whilst they chatted. Staff clearly knew people well and people responded fondly to staff, using their names, as they chatted.

We saw one person go into the dining room confused as to whether they had had breakfast. Staff checked and reassured the person they had but gave them a cup of tea and biscuits and sat with the person engaging them in meaningful chat about the person's interests and home life which person clearly enjoyed.

We saw little evidence of people having been involved in the development or review of their care plans but did see life story books and personal profiles which people had been involved in developing which contained detail to help staff get to know and appropriately support people. These documents included details about people's families, their backgrounds, school and work life, hobbies and interests and cultural and spiritual needs. They also contained details of days and events important to the person such as anniversaries and family birthdays and a section about what people who know the person admire about them.

Care plans included information about how best to communicate with the people particularly when they became confused, worried or anxious.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered with a person-centred approach. People were supported to make sure their wishes for end of life care were met.
People enjoyed a range of meaningful activities.

Effective systems were in place to record, investigate and respond to complaints.

Is the service well-led?

Good

The service was well led.

Systems for auditing the quality and safety of the service were robust and effective.

There was an inclusive culture and people's views and opinions were sought and valued.

Millfields Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 June 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We sent the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed and returned the PIR as requested.

We spent time observing the care and support delivered in communal areas. We spoke with 10 people who were using the service, six relatives, three care staff, the cook, an assistant manager, a team leader, the activities coordinator, the registered manager, the area manager and both providers.

We looked at three people's care records, three staff files, medicine records, the training matrix, and records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Good

Is the service safe?

Our findings

When we inspected this service in August 2017 we had concerns in relation to some aspects of people's safety. This was particularly in relation to the availability of staff and risk management. The provider sent us an action plan detailing how they were addressing these concerns and, on this inspection, we found these actions had been effective.

Staff understood their responsibilities in relation to making sure people were safe. They told us they would report any concerns they had and were confident senior staff would take appropriate action. They told us they had received training in this area and would not hesitate to raise their concerns with the local safeguarding team if they thought this was necessary. Safeguarding records showed incidents had been investigated and action had been taken to make sure people were protected. We saw referrals had been made to the local authority safeguarding team and notified to CQC.

People told us they felt safe. One person told us they had not felt safe when they first moved in as they were not used to people walking about particularly at night. They said they spoke with staff and it is much better now and the problem no longer exists for them. Other people told us "Yes I feel safe here there are lots of people and there's good banter no problem here." "Definitely feel safe here I stay in my room most of the time because I prefer it." And "Oh I feel safe here, there are people to look after you they are quick to help and get whatever you want." And "I feel very safe here I love it."

Accidents and incidents were recorded appropriately and we saw these were analysed by the registered manager on a monthly basis to look for any themes and trends for which action could be taken to reduce the risk of re-occurrence. As a result of these audits there had been a change to staff's shift patterns and staff deployment within the home. The registered manager had developed a falls data sheet to enable them to look closely at why falls were happening and staff had received further training in relation to falls. This meant the service was learning lessons from incidents and using the information to promote safety.

Individual risks to people were assessed using a traffic light system. We saw risk assessments had been developed in relation to such as falls, skin integrity, inability to use call bell and moving and handling. Clear information for staff to follow to reduce the risk was included. Appropriate assessments such as the Waterlow for skin integrity and the MUST for nutritional risk had been used to inform the risk assessments and associated care plan. Monthly reviews of the risk assessments took place.

Where people displayed behaviour that challenged, this was recorded and assessed using the appropriate format.

Procedures for recruiting new staff were safe with appropriate checks taken. Whilst we did not see evidence of people who lived at the home being involved in the interview process, the registered manager told us that meeting people had been a part of their interview process.

Personal emergency evacuation plans (PEEPs) were in place. However we noted these referred to use of

moving and handling equipment such as hoist and stand aid which may not be appropriate in an emergency.

We looked at the systems in place for ordering, receipt, storage and administration of medicines. We saw this was generally safe but noted staff had not followed manufacturer's recommendations for the storage of an in-use insulin pen. We also saw some medicines stored in a cupboard which was not locked. Both issues were addressed during our visit. Protocols were in place for medicines prescribed to be taken on an 'As required' (PRN) basis. These protocols advised staff when the medicine should be used, what it was for and the recommended dosage. We discussed with the registered manager the advantages of also recording how effective the medicine had been.

We saw competence checks were made for all staff administering medicines on an annual basis. This included observations of administration of medicines. People were asked if they would prefer to administer their own medicines and risk assessments were in place for people who chose to do this.

Most of the people we spoke with said that they thought there was enough staff for most of the time. One person told us "I think most of the time there is enough staff however some days probably not, I've heard buzzers ringing for a long time before being answered, however other times its ok." A relative said that they could always do with more but generally they thought there was sufficient, they said their relative didn't have to wait when they needed assistance. Another relative told us "I think that there is sufficient staff, there always seem plenty of staff about with the residents when I visit."
Staff told us there were particularly busy times when they thought it would be better to have more staff, but felt they were safe. The registered manager told us they had created additional shift patterns to give additional support at busy times depending on people's dependency and level of occupancy. They also told us they had addressed staff deployment to improve efficiency and safety. Staff and people we spoke with confirmed these changes had been effective.

We saw up to date records relating to checks of the safety of the premises, for example in relation to fire, operation of equipment, gas and electrical installations and infection control. We observed the home was well maintained, with appropriate standards of cleanliness and tidiness throughout.

Good

Is the service effective?

Our findings

At our last inspection we found the service was not always working within the requirements of The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw examples of how the service had made improvements since the last inspection. For instance, we saw how staff had supported one person to make their own decision despite this being contrary to what their relative had requested. This meant staff had been supportive of the person's right to make their own decisions about their care.

Mental capacity assessments had been completed and proper process had usually been followed in relation to best interest decisions where people lacked capacity to make their own decisions. However, we noted some inconsistencies in this. For example, the registered manager told us about how one person's family had requested they spend their days in a particular area of the home and this had been addressed through a best interest meeting. However, we found the person had moved to the area requested without the best interest meeting procedure being concluded.

Where people had a DoLS in place this was clearly indicated within their care plan. None of the DoLS we saw had conditions attached.

We saw staff had made checks with the office of public guardian to establish, where needed, if people had a Lasting Power of Attorney in place and if so what it related to. This meant staff were aware of who people had appointed to make decisions on their behalf.

People were supported to make choices. This was evident through our observations and from care plans throughout which were prompts to obtain explicit or implied consents from people before commencing any care intervention. We saw staff communicated well with people, offering explanations and choice. For example, we observed staff explaining carefully to a person why it would be better for them not to visit the hairdresser at their chosen time as the treatment they had requested would affect their enjoyment of lunch. Another example was a statement made in a person's personal profile which read, "It is my choice to spend my days in bed (staff) to respect this but make sure I am clean, tidy and comfortable."

People said that they thought the food was good. There was a choice of meals on the day and people were asked at lunchtime what they would prefer. One person told us: "The food here is pretty good you can have whatever; I'm not a big eater but the food's good." another said,
"The food here is very nice I'm a vegetarian and there is always a choice."

We saw lunchtime to be a pleasant experience. People sat at nicely laid tables with condiments available. A menu on the wall corresponded with the meal served. Staff were available and attentive to people's needs and we saw people happily helping others by, for example, refilling cups with juice and encouraging others to eat their food or to make menu choices. People were offered a second helping if they wished.

We saw any nutritional risks were assessed and actions taken to minimise the risk. For example, where people experienced unintentional weight loss, we saw kitchen staff had been informed of the person's need for a fortified and diet and food and fluid charts were being completed. The registered manager had recently introduced new food and fluid intake sheets which included targets for daily fluid intake.

We saw from one person's care plan file that the Speech and Language Therapist (SALT) had been involved and had their advice, although available in the care plan file, had not been included in the nutritional care plan. We also found the care plan lacked detail in relation to the person's diabetes. We spoke with the registered manager about this who agreed the care plan was unclear and said they would review it.

We saw people were supported to access healthcare professionals as the need arose. This included GP, district nurse, chiropodist, optician and specialist services for such as management of diabetes. A document was available in care files for people to take with them should they need to visit or stay in hospital. The document included good information to help hospital staff care for the person as they needed and preferred.

Staff told us they received good and appropriate training. One of the providers took the lead in organising and recording staff training and the area manager told us, "Training has become a real focus over the last year to ensure we have a workforce that is fit for purpose and one that has the right culture in promoting service users rights inclusive of privacy and dignity." They told us induction was delivered in line with the Care Certificate which is a set of standards to equip staff new to care with the knowledge and skills they needed to provide safe and compassionate care. The area manager also told us how a new training schedule had been introduced to make sure all staff received the training they needed. They told us how they used various training aids including case studies from within their own services to ensure staff received training that is personalised to the homes and reflective of relevant policies. We looked at the training matrix which showed staff had received a range of training which included areas such as safeguarding, moving and handling, MCA and DoLS, dementia, health and safety and infection control.

Staff told us they were well supported by the registered manager and the area manager. They said they received regular supervision and could go to them at any time if they had a problem or needed advice.

Good

Is the service caring?

Our findings

The service was caring.

People told us staff were caring and attentive.

Staff were respectful of people's needs in relation to privacy and dignity.

Good

Is the service responsive?

Our findings

People we spoke with told us staff were responsive to their needs. One person told us, "If I need the toilet they bring a stand aid and they need two carers, I don't have to wait long." another person said, "The home is tidy and they come and clean my room every day it's always kept clean and tidy, I put my washing out in the morning and is back by afternoon."

Records of assessment of people's needs prior to them moving into the home varied in quality. Some of the ones we saw contained only brief information but others contained detailed information about the person's needs and preferences.

Care files included documentation which demonstrated a person-centred approach. For example, we saw a document titled, 'A snapshot of me and my life'. This detailed the person's personal history, gave information about what was important to the person and how best to support them when they needed help. The document also covered such as what might make the person anxious and what would make them feel better.

Care plans were developed with a person-centred approach and although did not always demonstrate the involvement of the person concerned, this was evident in other areas. For example, the review of a risk assessment for a person who chose to have bed-rails in place, showed the person had been involved in the review, understood the risks and continued to want them in place.

Care plans had been developed in relation to people's activities of daily living and we found the care files to be well organised and easy to follow. For example, the section titled 'Mobility' included the appropriate care plan, relevant risk assessments and assessments of need and any other information relevant to that area of need. Care plans had been developed in relation to physical conditions such as epilepsy and skin conditions and we saw information had been downloaded and included in the care file to help staff to understand these conditions. People's cultural, spiritual, lifestyle and communication needs had been assessed and related care plans were in place.

We saw care plans had been reviewed regularly and effectively. Where appropriate people's families were involved in discussions about their health and changing needs. For example, on the day of our inspection, one person's family had come for a meeting with staff and the GP to discuss their care.

We discussed with the registered manager and area manager about how the person-centred approach could be enhanced by daily records being less task orientated and including these and records of health care professional's involvement within the individual care files.

Care plans for people's needs and wishes for when they approached the end of their life were in place. Special wishes and details of what would be important to the person were detailed. This included special people and pets they may wish to see, if they wanted music to be played in their room and any actions staff could take to promote their dignity and offer support through any worries. Where do not attempt

resuscitation (DNAR) orders were in place, this was clearly identified in the care file.

All the people we spoke with said that they enjoyed the daily activities and the hairdresser when she come to the home. The activity coordinator was well thought of by everybody we spoke with. One person described them as "amazing". People also told us how much they enjoyed the involvement of a visiting relative in providing activities. We saw this person providing a quiz during the afternoon. People were engaged and clearly enjoying this.
We spoke with the activities organiser who told us about training they had received and groups they were part of to support them in their role. They were enthusiastic about their role and told us about their plans and ideas to improve activity provision. Records showed how they engaged with people not able to join in group activities on a one to basis. We saw an example of this where they had spent time with a person watching clips on a tablet about things they enjoyed such as planes and gardening. We saw a 'wishing well' had been purchased in which people had been invited to put a personal and realistic wish into. The activities coordinator told us one would be drawn out each month and everything done to make the wish come true.

We saw meetings had been held with people to ask what activities they would like to do more of and what they didn't enjoy so much.

One relative told us about how staff had supported a married couple to live in the home. They said staff "did everything they could to make life comfortable. They were very accommodating they made one room into a sitting room for them."

People told us they would know what to do if they had any concerns or complaints. We saw good systems were in place to respond to and manage any concerns or complaints.

Good

Is the service well-led?

Our findings

When we inspected this service in August 2017 we were concerned that the service was not well led. We saw minutes of a meeting held with people and their relatives following this inspection during which the area manager had told people about the inspection and had apologised for any poor management people may have experienced. They had given people reassurance and outlined plans for future management arrangements.

Since then a new registered manager had been appointed and had been in post for approximately eight months at the time of our inspection. We found the new registered manager to be supportive of the inspection process and open and honest in their answering of our questions. They told us they were well supported by the area manager and the providers and engaged in meetings with other registered managers.

When we asked people about the management of the home one person told us: "The manager comes round most mornings to say hello that's good I think." Another person said the manager had an "open door policy" and said how well they worked together with other staff. This person also complimented the administrative staff.

A visiting relative told us, "The management here are approachable they talk to us and (relative) is happy and that's the main thing for us, we've had a questionnaire to see what we think about things and there are resident meetings but I've not managed to get to many."

One person told us about how they had raised an issue during a meeting and how the manager's changes to staff deployment had been effective in addressing the issue.

We saw systems for auditing the quality and safety of the service had been developed since our last inspection and we found these to be robust and effective. Any issues identified during audit were detailed, actions to address the issue identified and dates of actions completed recorded. Observational audits of such as the mealtime experience had also taken place. We saw the area manager had an overview of audits completed by the registered manager and made regular visits to make sure quality and safety in the home was maintained.

The registered manager told us a refurbishment plan was in place and we saw this was being followed.

We saw meetings were held for people who lived at the home, their relatives and staff. Action plans were put in place to follow up any issues or suggestions made and we saw a 'You said – We did' on the noticeboard to show people what had been done in relation to their suggestions.

It was evident from the actions taken since the last inspection that the service learned from experiences and valued input from people involved.