One Housing Group Limited

Millcroft

Inspection report

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Date of inspection visit:
29 March 2018

Date of publication:
17 May 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

We undertook an announced inspection of Millcroft on 29 March 2018.

Millcroft provides extra care housing for up to 40 older people. The office of the domiciliary care agency Millcroft is based within the building. The agency provides 24 hour person centred care and support to people living within Millcroft, who have been assessed as requiring extra care or support in their lives. On the day of our inspection 14 people were receiving a personal care service.

This service provides care [and support] to people living in specialist 'extra care' housing. Extra care housing is purpose built or adapted single household accommodation in a shared site or building. The accommodation is [bought] [or] [rented], and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care service.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager was registering with the Care Quality Commission (CQC).

People were safe living in the service. There were sufficient staff to meet people's needs and staff had time to spend with people. Risk assessments were carried out and promoted positive risk taking which enabled people to live their lives as they chose. However, not all risk assessments were accurate, up to date or contained sufficient information for staff to support people safely. The service was aware of these concerns and action was being taken. People received their medicines safely.

People received effective care from staff who had the skills and knowledge to support them and meet their needs. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the procedures in the service supported this practice. People were supported to access health professionals when needed and staff worked closely with people's GPs to ensure their health and well-being was monitored.

The service provided support in a caring way. Staff supported people with kindness and compassion. Staff respected people as individuals and treated them with dignity. People were involved in decisions about their care needs and the support they required to meet those needs.

People had access to information about their care and staff supported people in their preferred method of communication. Staff also provided people with emotional support.

The service was responsive to people's needs and ensured people were supported in a personalised way.

People's changing needs were responded to promptly and their views were sought and acted upon.

The service was well led by a manager who promoted a culture that put people at the forefront of all the service did. The manager was registering with the Care Quality Commission (CQC). There was a positive culture that valued people, relatives and staff and promoted a caring ethos. The service had links with the local community.

The manager monitored the quality of the service and strived for continuous improvement. There was a clear vision to deliver high quality care and support and promote a positive culture that was person-centred, open and inclusive. This achieved positive outcomes for people and contributed to their quality of life. The manager was robustly supported by the associate head of CQC compliance and provider.

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.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to manage the risk and keep people safe.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care planned to ensure it met their needs.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People were treated as individuals and their diverse needs respected.

Is the service well-led?

Good

The service was well-led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Millcroft

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 the 29 March 2018. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be available.

This inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

We spoke with 11 people, three care staff, a team leader, the general manager, the associate head of CQC compliance and the manager. We looked at four people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care. We also contacted the local authority for their views.

Good

Is the service safe?

Our findings

Risks to people were identified and recorded in their care plans. People were able to move freely about the building and there were systems in place to manage risks relating to people's individual needs. However, not all risk assessments were accurate, up to date or provided staff with sufficient information to manage the risk. For example, one person was diagnosed as diabetic. This person's condition was managed through medicine. No other information was available to staff on how to manage this person's condition. There was no guidance relating to the person's medicine or dietary needs. Another person had been prescribed cream for a skin condition. However, there was no body map to indicate where the cream was to be applied and no frequency for application.

We raised these issues with the associate head of CQC compliance who showed us an audit conducted three days before our inspection, that had identified these issues and we saw plans were in place to address them. For example, printed diabetic information sheets had been obtained and were waiting to be inserted into the relevant care plans. The manager also updated the person's care plan to include a body map and details of support the person required relating to their skin condition.

People felt safe. People's comments included; "I do feel safe with them. I like it that they don't fuss and they do what needs to be done" and "I do have panic attacks sometimes but the staff look after me, encourage and reassure me".

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. Staff comments included; "With concerns I would report to the senior person on shift and I'd call the local authority. I can whistle blow as well" and "I'd report to the team leader and the manager. I can also contact CQC (Care Quality Commission)". There were safeguarding procedures in place and records showed that all concerns had been taken seriously, fully investigated and appropriate action taken.

There were sufficient staff on duty to meet people's needs. Staff were not rushed in their duties. One person spoke about staffing levels. They said, "I think they have got it right, the right number of carers to the rising numbers". Staff told us there was sufficient staff deployed. One staff member said, "Everything is covered. I'm not badgered to cover extra shifts, we have enough staff".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Medicines were managed safely. Records relating to the administration of medicines were accurate and complete. One person said, "I do my own medication but there is a choice and if I need it they will do it for me". Staff responsible for the administration of medicines had completed training and their competency was assessed regularly to ensure they had the skills and knowledge to administer medicines safely. One staff

member told us, "I have been trained with medicines and my competency has been checked".

People were protected from risks associated with infection control. Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE), such as disposable gloves and aprons. An up to date infection control policy was in place which provided staff with information relating to infection control. This included; PPE, hand washing, safe disposal of sharps and information on infectious diseases. One person commented on the cleanliness of the building and in particular, the helpfulness of the cleaner. They said, "The cleaning lady here is great. She will do anything for you and lots of things she is not contracted to do".

Accidents and incidents were recorded and investigated. They were also analysed to see if people's care needed to be reviewed. Reviews of people's care included referrals to appropriate healthcare professionals. For example, following a fall, one person was referred to an occupational therapist (OT). The OT recommended specific equipment, the person's care was reviewed and the equipment put in place. This action improved the person's safety and demonstrated the service learnt from incidents.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs. New staff completed an induction to ensure they had appropriate skills and were confident to support people effectively. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control. Induction training was linked to the Care Certificate which is a nationally recognised program for the care sector. One staff member said, "The training has progressively got better. I am up to date with all my training; it gives you confidence to do your job". Training records were maintained and we saw planned training was up to date. Where training was required we saw training events had been booked.

Staff told us and records confirmed that staff received support through regular one to one meetings with their line manager, spot checks and training. Staff comments included; "I get support from my team and managers. I also have one to one meetings which I find useful" and "Yes I am well supported here. I have reviews and meetings and I think they are helpful".

People's needs were assessed prior to their admission to the service to ensure their care needs could be met in line with current guidance and best practice. This included people's preferences relating to their care and communication needs. For example, one person had difficulty hearing and used hearing aids. Staff were guided to 'please make sure [person] is wearing their hearing aids when communicating'. Staff were also guided to 'get down to the person's eye level so they can lip read'. Staff we spoke with were aware of and followed this guidance.

We discussed the Mental Capacity Act (MCA) 2005 with the manager. 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. The manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). Staff had received training and understood how to support people in line with the principles of the Act. One staff member said, "The Act protects client's rights to make decisions. This means care is given their way and I always check their decisions to ensure they are happy". Another staff member said, "I talk to them (people) about their choices and respect their decisions. I report any concerns".

The service sought people's consent. Care plans contained documents evidencing the service had sought people's consent to care. These were signed and dated by the person or their legal representative. Staff told us they sought people's consent. One staff member said, "I never do anything without the client's permission".

Most people did not need support with eating and drinking. However, some people needed support with

preparing meals and these needs were met. People either bought their own food or families went shopping for them. People had stipulated what nutritional support they needed and these needs and preferences were recorded in people's care plans. One person spoke about the onsite restaurant. They said, "The food has been improved since I came here". Another person said, "When I was ill in bed they did bring my lunch up to me in my room".

People were supported to maintain good health. One person said, "It is all very good here regarding GPs coming out to see us". Various health professionals were involved in assessing, planning and evaluating people's care and treatment. Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. Information was provided, including in accessible formats, to help people understand the care available to them.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "We are all cared for here", "It is the tops here", "Very good here, good care" and "The carers are nice".

Staff spoke with us about positive relationships at the service. Comments included; "I love it here, it's the people and the warmth of the place", "Yes, I have very caring relationships. I get on well with all the customers" and "I have great relationships with the clients. They are so lovely".

People were involved in their care and were kept informed about their care and support visits. Daily visit schedules and details of support provided were held in people's care plans. For example, one person's schedule stated the support visit would include preparing the person a meal of their choice, washing up and assistance with 'going to bed'. Details of other specialist support relating to a specific condition were also recorded. Schedules of support were updated in line with care reviews informing both people and staff of the support needs. Daily notes evidenced visiting schedules were followed and consistently maintained.

People had been involved in the creation and updates of their care plans. Staff met with people and their families and sought their input into how care plans were to be created and presented. People's opinions were recorded and incorporated into the care plans. For example, people provided information for their personal profile section of the care plan. People chose how much information to disclose and discussed with the manager how they wished this information was to be presented. We saw people's wishes were respected and each person's personal profile was different.

People's independence was promoted. Care plans guided staff to support people to remain independent. One person's care plan highlighted the person had requested 'I would like the care workers to ask me what help I require". One person told us about their independence. They said, "You can come and go daily". Staff spoke with us about promoting people's independence. One staff member said, "I offer choices such as choosing their clothes. It involves clients to be independent".

People were treated with dignity and respect. People told how they were treated with dignity and respect and how staff respected their privacy. People's comments included; "Carers knock on your door first before they come in", "They [staff] don't impress [impact[on your privacy at all" and "They [staff] are great, they have time for you and don't poo poo you off". When staff spoke about people with us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. People were addressed by their preferred names and staff knocked on people's doors before entering. Throughout the inspection we observed staff treating people with dignity, respect and compassion.

People received emotional support. For example, one person suffered from short term memory loss and could become confused and depressed. Staff were guided to support this person with reassurance and by reminding the person where they were and what they were doing. We were able to observe staff following this guidance and we saw this caring approach reassured the person.

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. A confidentiality and data protection policy was in place and gave staff information about keeping people's information confidential. This policy had been discussed with staff.

Good

Is the service responsive?

Our findings

Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person enjoyed reading and listening to the radio. Staff were aware of, and respected people's preferences.

Staff treated people as individuals. For example, one person had a personal exercise programme. This had been created by a physiotherapist for them and had been incorporated into the person's care plan. The exercises were presented in a pictorial format enabling the person to easily understand the exercise regime. The service had supported this person's individual needs.

People's diverse needs were respected. Discussion with the manager showed that the service respected people's differences and ensured people were treated equally. The provider's equality and diversity policy supported this culture. We asked staff about diversity. One staff member said, "People have diverse needs so I get to know them and their individual ways. People are definitely treated as individuals and their diversity is respected".

People had access to information in a way that was accessible to them. Some care plans had information in a picture format and staff told us information in large print or foreign languages was available. People were able to read their care plans and other documents. Where people had difficulty, we were told staff sat with people and explained documents to ensure people understood. Where appropriate, staff also explained documents to relatives and legal representatives. One staff member said, "I explain the care plan and talk the client through it. Only when I am happy they understand do I move on".

Care plans and risk assessments were reviewed to reflect people's changing needs. For example, one person's condition changed and their medication was reviewed by the GP. We saw these changes had been incorporated into the person's care plan and medicine records.

The service provided communal areas, such as a large lounge and restaurant/dining room, an activities room and a cinema room. A religious group held meetings in the building and people were able to attend and maintain links with the local community. Musical events were held for people and summer time volunteers encouraged people to become involved in maintaining the garden areas. People spoke about opportunities to engage in activities. Their comments included; "The cinema I really like", "There is an Activities Room, it is good but it is not used enough" and "I play bingo, I am not too proud to say".

The service had systems in place to record, investigate and resolve complaints. No formal complaints had been recorded. Details of how to complain were displayed in the reception area and held in the 'service user guide' given to people when they entered the service. One person told us how they raised an informal concern about care visit times and how the service responded. They said, "It was not working in the evening so we switched things [visits] around and all is fine now".

At the time of our inspection, no one was receiving end of life care. People's advanced wishes were

recorded. Care plans recorded people's end of life wishes. For example, where people wished to die and their preferred funeral arrangements. Staff told us people's wishes were always respected. This included where people had expressed a wish not to be resuscitated.

Good

Is the service well-led?

Our findings

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager was registering with the Care Quality Commission (CQC).

The manager and general manager were present throughout the inspection and were available to people who greeted them with familiarity and confidence. We observed good relationships had been forged between management, staff and people. The interactions we observed produced lots of smiles, laughter and appropriate humour.

Staff told us they had confidence in the service and felt it was well managed. Comments included; "[Manager] is fine and lovely. She is approachable and a good listener. This is an honest service", "This is a well-run service" and "[Manager] is lovely, definitely approachable and runs the service well".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the manager and the general manager spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was open and honest. One staff member said, "This is a nice place to work with no culture of blame at all".

The manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care and where improvements were identified, action plans were created to drive improvements. For example, one audit identified 'special instructions' on medicine records required updating. The action plan and medicine records confirmed this action had been completed. The manager was supported by the associate head of CQC compliance who also conducted audits and supported the manager with actions plans. For example, one audit had identified the concerns we found relating to risk assessments reported earlier in this report and plans were in place to address them.

Staff told us learning was shared at staff meetings, briefings and handovers. People's care was discussed and staff could make suggestions or raise issues. One staff member said, "Staff meetings and handovers keep us informed about clients. We also email each other to keep up to date".

The manager sought people's opinions through surveys and meetings. We saw the results of the first survey conducted which were very positive. 'Customer meetings' were held and any issues raised were investigated and action was taken. For example, people discussed alarm pendants, which were rarely used. Following these discussions the manager arranged for all alarms to be tested monthly. This reassured people the alarms were operational.

The manager worked in partnership with external agencies such as GPs, district nurses, social services, Age UK and the local authority. They also attended contract and panel meetings with Oxfordshire County Council.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.