

MNP Complete Care Limited

Millfield House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Millfield House is a residential care home providing personal care to 8 people at the time of the inspection. Some people using the service had physical and learning disabilities and other conditions such as Cerebral Palsy, Head Injury, MS and the effects of Stroke. The service can support up to 8 people.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found

People and their relatives told us they were happy with the support they received. Staff knew people very well, and there was a low turnover of staff. However, guidance for staff was not always as detailed as it could be and did not inform staff on actions to take to mitigate risks to people. We identified these concerns at our previous inspection; however action had not been effective at addressing these concerns. We discussed this with the registered manager, who was aware and was in the process of updating care plans and risk assessments.

Right Support: Model of Care and setting that maximises people's choice, control and independence

The service (or staff) supported people to have the maximum possible choice, control and independence be independent and they had control over their own lives. Staff supported people to achieve their aspirations and goals. Staff supported people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had enough appropriately skilled staff to meet people's needs and keep them safe. People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs. People received care that supported their needs and aspirations, was focused on their quality of life, and followed best practice.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

People led inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff. Staff turnover was very low, which supported people to receive consistent care from staff who knew them well. People's quality of life was enhanced by the service's culture of improvement and inclusivity.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 1 August 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. You can see what action we have asked the provider to take at the end of this full report.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to good based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Millfield House on our website at www.cqc.org.uk.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led

Details are in our well-led findings below.

Requires Improvement ●

Millfield House

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by one inspector.

Service and service type

Millfield House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Millfield House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 4 people and three people's relatives about their experience of the service. We observed staff interactions with people in the communal areas. We spoke with 4 members of staff including the registered manager and carers. We reviewed a range of records. This included 3 people's care plans and multiple medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits.

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to manage risks to people's health and welfare. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12

- At our last inspection guidance for staff did not provide sufficient information on action to take around risks to people. At this inspection some care plans and risk assessments still lacked detail, for example one person's care plan detailed they were at risk of choking, and how to mitigate the risk, but did not detail what to do if the person choked. Staff we spoke with were aware of how to support the person, but consideration had not been given for example to if people should receive back slaps, and how this should be done safely to people using wheelchairs.
- Some people lived with epilepsy. Although this was well managed, and staff understood how to support them, their care plan lacked detail and guidance for staff to follow. For example, one person's care plan detailed what kind of seizures they had, but not what this looked like for the person, or action to take whilst the person was having a seizure, for example to keep them comfortable and remove anything that could cause them to injure themselves.
- Some people needed support to transfer. Guidance was not in place to inform staff how best to do this. Staff we spoke with had a good understanding of people's needs, however, should the service need to use agency staff, guidance was not available to inform staff how to support people safely.
- Some people lived with diabetes. Guidance for staff was not clear what was their responsibilities, and what was managed by the district nurses. There was also no guidance in place to inform staff on what signs to look out for if they were concerned the person's blood sugars were at an unsafe level and action to take. Staff we spoke with told us people's diabetes was well controlled, and showed good understanding of how to support people, however, guidance in place was not sufficient to inform new staff, or agency staff.
- We shared concerns with the lack of guidance in place with the registered manager, and they took action to review and update care plans.

We found no evidence that people had been harmed however, the registered persons had failed to do all that is reasonably practicable to mitigate risks to people. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People lived safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well.
- Checks were completed on the environment and equipment used to ensure it was safe for people. Regular checks were completed on hoists and wheelchairs to ensure they were safe to be used.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
- Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe.

Using medicines safely

At our last inspection the provider had failed to ensure the safe and proper management of medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 12

- At the last inspection we found medicine counts did not match with medicine administration records (MAR), and we could not be assured people received their medicines as prescribed. At this inspection we found all medicine counts matched with MAR. There was a system in place to ensure medicine counts were completed daily.
- There were now clear protocols in place when people left the service and needed to take their medicines with them. Staff we spoke with understood there was a signing in and out sheet for medicines.
- People could take their medicines in private when appropriate and safe to do so.
- People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely.

Systems and processes to safeguard people from the risk of abuse

- People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.
- Staff had received training in safeguarding people and understood their roles and responsibilities. Staff told us if they had concerns, "I would report it straight away. At the end of the day that's our job, we need to look after them and if we are not doing that, it needs to be reported."
- The registered manager understood their responsibilities to report any safeguarding issues to the local authority safeguarding team.

Staffing and recruitment

- The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. People engaged in different activities and told us of the activities they liked to do with other people or one-to-one with staff.
- The registered manager used a dependency tool to support their decision making around staffing numbers. Staff and people told us there was enough staff, one staff told us, "Yeah I really do. They are really good with covering with agency when needed."
- Checks were completed on staff before they started working with people. This included obtaining two references from the staff members past employers.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- People told us their relatives were able to visit them as often as they wanted and they had been supported to maintain contact with them during the height of the pandemic.

Learning lessons when things go wrong

- Incidents and accidents were logged by staff and actions taken to reduce risks to people were clearly documented. For example, when one person caught their arm on the corner of the table, and sustained an injury, the registered manager ordered guards for the table to prevent the incident re-occurring.
- When incidents occurred, the registered manager reviewed people's histories to identify patterns and trends. For example, when one person expressed feelings or had an emotional reaction, the registered manager was able to identify the trigger to the change in their behaviour. The registered manager then ensured all relevant healthcare professionals were involved to ensure that the person received the support they needed.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personalised care specific to their needs and preferences. All the people we spoke with, and their relatives were happy with the support staff provided.
- Staff spoke knowledgably about tailoring the level of support to individual's needs. A relative told us, "The staff at Millfield have been very diligent and supportive in helping him adjust."
- Support focused on people's quality of life outcomes and people's outcomes were regularly monitored and adapted as a person went through their life. People had goals they set and worked towards with the support of staff. For example, one person was developing life skills, and was able to make hot drinks using an adapted kettle and had made their own pizza.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Staff ensured people had access to information in formats they could understand.
- People used different methods to communicate, and staff understood the way each individual communicated. For example, one person repeated the same word, with different meanings. Staff were patient with them, and went through different things the person was communicating, until they indicated that they were right.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were encouraged and motivated by staff to reach their goals and aspirations. People were supported by staff to try new things and to develop their skills.
- The registered manager told us how they were supporting people to make friends outside of the home to develop more relationships. They told us, "It's small steps, but we are getting there, it would be good for them."
- People were supported to participate in their chosen social and leisure interests on a regular basis. People told us they enjoyed taking part in a wide range of activities including going to local clubs and taking part in music sessions.

Improving care quality in response to complaints or concerns

- People told us they knew how to raise concerns, and they felt confident the registered manager would act on them. One person told us, "Yes we could go to her, and it's important actually."
- Relatives we spoke with told us they knew how to make a complaint but had not needed to raise any concerns.
- There was a complaints process in place, which was in an accessible format for people.
- Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At our last inspection, we identified guidance for staff was not sufficient to inform them of risks to people and how to mitigate them. At this inspection, we found guidance continued to not provide the necessary information.
- Care plans and risk assessments were not explicit to inform staff on actions to take to mitigate risks to choking, diabetes, epilepsy and when supporting people to transfer. Staff we spoke with, had the skills and experience to support people; most staff had worked at the service for years, and knew people well, including any risks to their health, and how best to mitigate them however guidance was not in place for new staff, or agency staff.
- The registered manager was aware that care plans needed reviewing and took action when we shared our concerns about the guidance in place not being sufficient. However, action had not been proactive in addressing the lack of guidance and implementing it. Lessons had not been learnt from our previous inspection. When we highlighted issues to the registered manager, they were proactive, and implemented and amended guidance for staff.

The registered persons had failed to effectively assess, monitor and improve the quality of the services provided. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other checks and audits were completed and identified issues. For example, the registered manager identified that staff needed to complete fire safety training; staff were reminded and training was booked in.
- The registered manager had the skills, knowledge and experience to perform their role and a clear understanding of people's needs and had oversight of the services they managed.
- People had positive feedback about the registered manager. One person told us how supportive they the registered manager had been to them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish.

- People and their relatives gave positive feedback about the service. One person told us, "It's very nice actually, staff are really nice. We are happy, and that's really important."
- Staff felt respected, supported and valued by senior staff which supported a positive and improvement-driven culture. One staff member told us, "I love it. It's one of the best jobs I've ever had. The staff team are really good. Our team are really good."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider sought feedback from people and those important to them and used the feedback to develop the service.
- Feedback had been collated from all the providers services, and therefore the registered manager was not able to establish if feedback was specific about their service. All future feedback requests are to be sent for each service individually to allow the relevant registered manager to make any improvements identified.
- People were engaged in regular resident meetings. People discussed any goals they wanted to work towards, or activities they wanted to take part in. One person mentioned they wanted to get a passport to travel to France, which they had been supported to do.
- Staff had regular meetings where they were able to give feedback on the service and make suggestions for improvements. Staff we spoke with were all positive about their roles and said that the registered manager was open and always available to provide support.
- Staff worked in partnership with other agencies to provide joined up care to people. The district nurses visited regularly to support people with their health needs, and people received support from the mental health team, and GP.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities in line with the duty of candour. The duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The registered manager was open and honest with people and their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that is reasonably practicable to mitigate risks to people.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality of the services provided.