

Mr & Mrs J Fieldhouse

Millfields Residential Care Home

Inspection report

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Date of inspection visit:
22 November 2016
24 November 2016

Date of publication:
18 January 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 22 and 24 November 2016 and was unannounced. The service had been inspected on 31 May and 2 June 2016 and we found the registered provider had not ensured the premises and equipment were safe, the administration of medicines was not safe and they were not assessing, detecting or controlling the spread of infections. In addition, the registered provider did not seek consent to care and treatment from the relevant persons, and people were not treated with dignity and respect. They had not ensured the premises and equipment were clean, secure suitable, properly used, properly maintained or appropriately located. We also found the registered provider did not have effective systems in place to assess, monitor, and improve the safety of the service and there were insufficient numbers of staff to meet people's needs or safeguard people from abuse. At this inspection we found improvements had been made at Millfields with an action plan in place to achieve further required improvements.

Millfields Residential Care Home provides accommodation, personal care and support for up to 38 older people, some of whom might also have a physical disability and / or dementia. On the day of our inspection there were 30 people living at Millfields 27 people were living there permanently and three people were staying on a temporary basis.

There was no registered manager at the location. 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. Day to day management was provided by the operations manager until a new registered manager was recruited.

At our previous inspection we found the service was not providing safe care and treatment as the registered provider had not ensured the premises and equipment were safe or clean. We also found issues with the safe administration of medicines. At this inspection we found significant improvements in the cleanliness of the environment and equipment had been cleaned and some items replaced. The registered provider was planning a programme of refurbishments, to be completed once a decision had been made by the Commission in relation to the enforcement action being taken against the provider.

We found improvements in the management of medicines had been made. Medication was administered appropriately and all staff who administered medication had received training and had been assessed as competent to administer medicines. Further improvements were required around the recording of the administration of creams and some 'as required' medicines.

Standardised risk assessments had been undertaken for those people at risk of malnutrition and pressure sores. The home completed risk assessments when other risks such as choking, medication, fire and falls had been identified. Moving and handling risk assessments and care plans had improved from the previous inspection although further improvements were on-going. One person who was at the home for a temporary respite stay had not had their risks adequately assessed and recorded in relation to the method staff were to

follow due to their fluctuating abilities.

People and relatives told us there had been a lack of staff over the weekend and the previous few days. It was not clear whether this was as a result of the vomiting bug at the home which had affected both staff and people living there. The operations manager told us they had changed the roles of staff to make more effective use of staff at busy times and they would look again at the deployment of staff. They did not use a dependency tool which could provide evidence staffing levels were appropriate to meet people's needs although they agreed to implement one.

Accidents and incidents were recorded and the operations manager analysed these in order to determine themes and reduce the risk of further incidents.

Staff undertook a thorough induction when they first started working in the home and we saw this was evidenced in the staff files we reviewed. Staff completed the Care Certificate and the operations manager was the assessor for the certificate. Staff received on-going supervision, appraisal and training to ensure they had the skills to perform in their roles.

We found the service was not adequately recording the monitoring food and fluid intake for a person at risk of malnutrition and hydration.

The home had a plan in place for refurbishments to modernise the home including making it more dementia friendly to improve the wellbeing of the people living there.

At the previous inspection we found the service was not compliant with the Mental Capacity Act 2005. Since this inspection, the operations manager had undertaken the two stage mental capacity assessment in relation to medicines, finance arrangements and consent to live at the service. Most people had capacity to consent to day to day care if they were supported to make decisions such as what to wear and what to eat. The operations manager had written to relatives of people living at the service in relation to lasting powers of attorney and requested a copy of the paperwork. They told us they would implement a system to ensure all staff were aware of what decisions they could make on behalf of people who lacked capacity and those whose family members had the authority to do so.

We found all the staff to be caring in their approach to the people who lived there and staff treated people with dignity and respect. Staff knew the people they supported very well and were keen for people to feel they were at home.

There had been improvements in the record keeping at the service but we still found some records which lacked detail to promote safe and person centred care. This demonstrated a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found a significant improvement in the audits undertaken at the service and these audits demonstrated the service was monitoring and improving the quality of the service provided. The service regularly sought feedback from people using the service and their relatives to inform improvements at the home.

There was no registered manager at the home and the operations manager was providing day to day management. They were providing leadership and management to staff and recognised this needed to be sustained once a new registered manager was in post to ensure the service continued to improve.

You can see what action we told the provider to take at the back of the full version of the report.

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 always safe

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Whilst some risk assessments were detailed, more detailed information was required to ensure risks to people were at the lowest possible level.

Improvements had been made to the cleanliness of the home and to the safety of the environment but these were on-going and the home was waiting to start a plan of refurbishment and improvements.

People reported to us there had not been enough staff, particularly at weekends.

Is the service effective?

Requires Improvement ●

The service was not always effective

The service had appropriately referred to the local authority people were deprived of their liberty under the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards. We found decision specific capacity assessments in place for those people lacking capacity around certain decisions such as finance, medicines and around the decision to live at the home.

Staff were receiving regular training, supervision and appraisal to ensure they developed in their role.

People enjoyed the food but one person at risk of malnutrition did not have their food and fluid intake recorded adequately.

Is the service caring?

Good ●

The service was caring

People told us staff were caring, compassionate and kind.

Staff knew how to ensure privacy, dignity and confidentiality were protected at all times.

Staff recognised the importance of keeping people independent in their daily lives.

Is the service responsive?

The service was not always responsive

Updated care plans contained information to enable staff to deliver person centred care and contained information about people's preferences and views. However, not all care plans had yet been updated and one care plan for a person on a temporary stay had not been completed in detail.

People were provided with some activities that were meaningful to them and the service was working on their activity programme to ensure they provided activities which people enjoyed.

Complaints were analysed to ensure lessons were learnt and to improve care provided.

Requires Improvement ●

Is the service well-led?

The service was not always well led

There was no registered manager in place. The operations manager was providing day to day support and had implemented system to monitor the quality of the service provided. They had an action plan in place to drive improvements.

The registered provider was involving people and relatives in the running of the service and seeking feedback to improve the service provided.

The operations manager was working hard to improve the morale of the staff and to encourage better practice through reflection, team meetings and supervision.

Requires Improvement ●

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 22 and 24 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors 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.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the operations manager, the deputy manager, three members of care staff, one domestic staff, and two kitchen staff. We spoke with six people who lived at the home, two relatives and a visiting community nurse. We reviewed five care records in detail and medicines administration records. We looked at the records in relation to the servicing and maintenance of equipment and refurbishment of the environment.

Is the service safe?

Our findings

People living at Millfields told us they felt safe. One person said, "I feel very safe here. I think it's lovely here." Another person on a temporary stay told us, "I would be happy to come back if I had to as I go home tomorrow. I didn't know care homes were like this. The one my [relative] is in is not like this." A further person said, "Yes if I need anything I just ask." One relative who told us their relation was safe at Millfields said, "What you are seeing today is what it's like all the time. I sometimes get here early and they don't know I'm in the room and I can listen to them and see how they are with the other folks. You are seeing them just how they are all the time."

At our previous inspection we were concerned about the safety of people living at Millfields as the front door was not locked. At this inspection the door was locked at all times and visitors and staff were required to ring the doorbell to gain access or request staff open the door to let people out. There remained one fire door out of the dining room which could be opened and the home had ordered a fire door alarm to alert staff to any unauthorised entry or exit. This alarm would ensure the fire door remained effective in the event of an emergency situation.

All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. The operations manager told us team leaders reported safeguarding and were now required to report any safeguarding incidents to the operations manager so they could investigate. The operations manager had notified us of all recent safeguarding incidents and had provided us with an analysis of each event. This had not always happened prior to our last inspection. This meant the registered provider was meeting the regulation in relation to notifying us about incidents at the service.

We asked people who lived at Millfields whether there were enough staff to care for them safely and respond to their call bells. One person told us, "There should be a bit more staff. Yesterday was awful there were hardly any staff here." And another person told us, "There wasn't enough staff on this weekend." A further person told us, "The staff come into my room once a day as that is all I want them to. When I ring it depends on how busy they are but usually they come fast enough." One relative told us, "Usually it is fine but staff have been thin on the ground with the bug that has been going round." We raised these concerns with the operations manager who told us staff in addition to people using the service had succumbed to a sickness and vomiting bug but staff had been brought in from one of their other homes.

We asked the registered manager how they calculated staffing levels. They did not use a dependency tool but said they worked out how many people required two care staff or whether people required additional support because they exhibited behaviours that challenged others. They had recently changed roles in relation to staff supporting lunches to enable the kitchen staff to serve whilst care staff supported people. They had also changed the role of the team leader and senior carer to enable the team leader to be out on the floor supervising and observing staff and supporting people as required. They told us that four staff in the morning, four in the afternoon and three staff during the night were adequate for the 30 people at the service but this would be increased if the number of people living there increased. In addition to these numbers, the operations manager and deputy manager were at the home during the week although not at

weekends. We also noted on occasions at a weekend there had been less staff identified on the rotas we had been provided with, which generally tied in with people's comments about there being less visible staffing at a weekend. There were short periods of time late afternoon during our inspection when people in the communal lounge were left without staff and we raised this with the operation manager, who agreed to analyse the deployment of staff to ensure people were not left unsupervised and staff did not take their breaks together.

We looked at how the service managed risk to ensure people living at Millfields were safe. The operations manager told us their responsibility was "to make sure we are accurately managing and assessing risk of all the people, visitors and residents and to minimise risks." We found standardised risk assessments such as a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished and are at risk of malnutrition. We also found moving and handling risk assessments, falls risk assessments and infection control risk assessments in the files we reviewed. We found some good moving and handling care plans in the care plans that had been updated but the information in those that had not been updated lacked essential detail. For example, for one person who had fluctuating abilities there was a lack of detail to ensure staff did not continue to use a handling belts when this was no longer appropriate and the person required the use of a hoist.

One person who had been discharged from hospital with a discharge letter stating they had an unsafe swallow reaction did not have a choking risk assessment in place. However, their nutrition and diet care plan referenced they were on a pureed diet and they had referred back to the Speech and Language Therapist for a reassessment as this person had expressed a wish to eat sandwiches. Staff were appropriately supporting this person to eat, however, they needed to ensure there was a risk assessment in place in relation to choking to ensure all risks around eating were recorded, reviewed and communicated in accordance with best practice.

The operations manager told us hourly checks were made during the night to check people were safe. They showed us a new form which required staff to complete the exact time of the check rather than a tick box, this enabled the registered provider to audit these checks were being carried out and the time correlated with any incidents.

Each person had a Personal Emergency Evacuation Plan (PEEP) in place to enable staff to assist people to evacuate the building if necessary. We looked at the PEEP's as there had been a concern at the last inspection that in the event of a fire there would not be enough staff to evacuate people at the service. The deputy manager told us they had a horizontal evacuation system with zoned areas with six people in each zone. If there was a requirement for evacuation, people would be moved to the safest horizontal zone as indicated on the fire board.

We found issues with the administration of medicines at our last inspection. We checked for improvements during this inspection. Medication was administered appropriately and all staff who administered medication had received training and had been assessed as competent to administer medicines. Medicines were stored and ordered safely. We observed the morning medicines round and observed the staff who administer medicines did this in a caring and compassionate way, getting down to the level of the person, and explaining what the medicines were for. They removed their personal protective equipment (PPE) gloves and washed their hands after every administration. They checked tablets in the monitored dosage system against the medicines administration record (MAR) and signed the MAR sheet after the administration. At our last inspection we found the administration of creams was not always recorded on the sheets kept in people's rooms. The system had been changed so that the person administering medicines recorded on the MAR sheet that the creams had been administered. However as they were not

the person who was present when the cream was applied, they could not be certain it had been applied as prescribed. We brought this to the attention of the operations manager to look at a more robust system for recording the application of creams. We also found a small number of the protocols for the 'as and when' medicines lacked detailed information or were missing, but this had been rectified by the second day of inspection.

At our previous inspection we found accidents and incidents had not been analysed to determine the cause, or identify any trends. We found at this inspection we saw analysis of accidents and incidents had been implemented. For example, in October 2016 there had been eight falls and although there were no themes in relation to time or place of the fall, the operations manager had identified a person required a different dining room chair with arms and reminders for one person to use their buzzer to call for assistance. They had also identified poor post fall documentation and had implemented new paperwork which had improved the documentation. This demonstrated the service was analysing and implementing systems to improve this aspect of safety at the service.

At our last inspection we raised significant concerns in relation to the cleanliness of the environment. This had improved significantly at this inspection with additional cleaning staff and more rigorous systems in place to monitor cleanliness. The home employed three cleaning staff between 8 am and 12 am with one member of staff remaining till 3 pm. Although we were told this pattern could change if staff were on leave. We found the service had liquid soap, paper hand towels and alcohol gel in all the communal areas and in the bedroom areas. The cleaning staff had a daily cleaning routine checklist which was countersigned by management. The operations manager undertook a daily walk around at the service to ensure it was clean. Night staff also completed a cleaning schedule with the staff member initialling the check had been undertaken rather than just ticking it had been done, to enable the auditor to identify who had undertaken the task. This would complete the audit trail, and enable feedback to staff if there were any issues. At our previous inspection we found stained carpets and chairs. At this inspection although furniture was still marked, it had been steam cleaned. The carpet in the main communal lounge had been replaced and other carpets were to be changed as part of a refurbishment programme and quotes had been requested in readiness to start this work. We found one member of staff wearing rings and another who was not in clothes which were bare below the elbows. We raised this with the operations manager as this was not in accordance with the company's own policy on dress code and presented a risk in relation to infection control.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, a review of people's employment history and two references received for each person. DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

Is the service effective?

Our findings

We asked people at Millfields about their meal time experience and about the choice of food on offer. One person said, "Yes, I get what I want to eat. I'm a vegetarian so don't eat any meat" Another person said, "I get fruit and veg whenever I want it." One person said, "We get two choices of food at meal times. It's lovely. We asked people whether food was available outside of regular mealtimes and one person told us, "Yes, I don't always want food when everyone else is having it." And in relation to drinks, one person said, "Yes they come round with tea and coffee or I can have what I want if I ask."

Thirteen people ate their meals in the communal dining room whilst others ate in their bedrooms and one person chose to eat sandwiches sitting on a corridor. The operations manager told us there had been a recent change in mealtimes and kitchen staff now served people their meal rather than the care staff. This enabled care staff to spend more time supporting people to eat. We observed the meal time experience and noted people were offered choice and supported appropriately to eat and drink in the communal dining area. We saw people were supported with meals in their own rooms. At our previous inspection we found there was an issue with the accurate recording of people's food and drink intake as entries had been missed in the monitoring charts. At this inspection we found one person's records had not been updated on the day of our inspection nor was the amount they had been drinking totalled to give an indication of how much they had drank that day or on the 20 November 2016. We raised this with the operations manager who spoke with the key worker who should have recorded the intake that day, they confirmed it was a recording issue rather than a neglect of duty, and the issue would be addressed further in supervision. This person's daily records often referred to 'small food and fluid intake' or 'good fluid intake' but there was no reference to what a good fluid intake was or the amount taken.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We 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.

Staff had either had training in the Mental Capacity Act 2005 or had been booked onto a course. We asked staff about their understanding of the Mental Capacity Act. We asked one member of staff how they supported decision making. They said, "When helping to get dressed, I would ask first what they wanted to wear. If they can't choose I would go to the wardrobe and ask whether they'd like to wear this or that. If they couldn't choose I would look through the care plan to see what they liked to wear. If they liked to wear a dress. We'd ask the family what they liked to wear." This demonstrated the staff member was aware they were required to support decision making, but also the importance of consulting others to obtain the person's preferences once capacity had been lost and they could no longer express their wishes.

During our inspection we reviewed the capacity section in the care files of four people to ensure they were compliant with the MCA. The two stage capacity assessment had been completed correctly in relation to the deprivation of liberty and there were decision specific capacity assessments in relation to self-administration of medicines, capacity to consent to live at Millfields and around finances. The recording of best interest decisions did not contain information as to who had been consulted in relation to the decision and the operation manager agreed to ensure a new form reflected this. The operations manager had contacted all relatives to check whether they had lasting power of attorney for their relation. They had recorded whether this was in relation to health and welfare or property and finance. Most were for property and finance. As not all staff were aware who had a lasting power of attorney for health and welfare, the operations manager advised they would implement a system so all staff were fully aware who was able to consent on their relations behalf in relation to care decisions.

People received care and support from staff who knew them well and who had the skills and training to meet their needs. Staff confirmed they undertook a thorough induction when they first started working in the home and we saw this was evidenced in the staff files we reviewed. Staff completed the Care Certificate and the operations manager was the assessor for the certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

The home utilised an external training provider to support staff development and also undertook some training in house. We looked at the training matrix and could see the records of training showed us a range of learning opportunities were provided for all staff. This included mandatory training in safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards, moving and handling of people, equality and diversity, fire, health and safety and infection control

Care staff told us they had received regular supervision and we saw evidence to support staff were regularly supervised and received an annual appraisal. Regular supervision of staff is essential to ensure the people at the home are provided with the highest standard of care.

We observed handover between shifts which involved staff discussing each person at the service and any updates required for the later team to support the person such as hospital appointments or whether the person had been unwell that day.

At our last inspection we found that the design and layout of the building was not adapted to the needs of people living with dementia. The lighting in corridors was poor and signage was not dementia friendly. The operations manager showed us dementia friendly signage which was due to be put up at the service and they told us their optician had offered them a selection of signs for people with visual impairments. They had information from Stirling University and were planning to ensure refurbishments accommodated people with sensory and cognitive impairments. At the time of our inspection this aspect of care required improvement. The service also had plans to make a safe outdoor enclosed space for people with dementia as currently there was no enclosed safe outdoor space.

Is the service caring?

Our findings

We asked people living at Millfields if staff were kind and caring towards them. One person said, "Yes they are very nice." Another person said, "Oh yes they are all so lovely." And a further person told us, "I like living here." One relative told us, "Yes they are all really nice. They look after [relative] very well. They have even gone into Ponte and got some slippers for me. They didn't fit so they are taking them back. They are always doing little things, extras, like that.'

People told us there were no restrictions on the times their relations could visit. One person told us their relative visited each day and they had a pizza night on a Thursday which their relative brought in. they said, "It's lovely. A bit like being at home still."

We observed care interactions. Staff were polite and sensitive to people's needs and we observed people were comfortable in the presence of staff. We saw people were appropriately supported with their lunch when required and this was done in a caring and dignified way. The service regularly observed staff during meal times to ensure care was respectful and dignified and this behaviour was clearly embedded in the care we observed.

At our previous inspection we found people had not been provided with care in private. In particular two downstairs toilets had doors that opened inwards and it was not possible to support people without the doors remaining open. We observed these toilets were no longer in use and we were told as part of the refurbishment plan these toilets would be knocked together into one accessible toilet and shower area which would enable care to be provided in private. People we spoke with told us staff maintained their privacy and dignity in the home. This included ensuring all personal care was provided in private, ensuring people were covered during personal care and curtains drawn and doors closed.

Staff told us they supported people to remain independent and improve their independence. One member of staff said, "We try and encourage people to keep walking."

We looked for evidence that the service involved people in their care. We saw recorded evidence the registered provider had spoken with several people using the service on 10 November 2016 to gain their feedback about the service provided. Where action was required, we saw evidence this had been completed. The registered provider had also sought the views of people using the service and had assessed whether people believed the care provided was safe, effective, caring, responsive and well-led. We reviewed this audit and could see the service was seeking feedback and acting on comments in order to improve the quality of service provided.

At our previous inspection we were concerned that the cultural and religious needs of people who used the service were not being met. At this inspection staff told us Pontefract Methodist Church held a monthly Holy Communion Service for people living at Millfields and members from a local chapel visited on a Friday for a cup of tea and a chat. In addition a lay preacher from the Catholic church visited every Sunday although the deputy manager told us they had indicated they would be unavailable for a six week period. We saw people's religious preferences referenced in their care plans. It was recorded in one person's care plan they

had expressed a wish to see the vicar, that they had declined communion when this had been offered. The registered provider had thought about the cultural needs of people by offering culturally appropriate choices of food.

The deputy manager told us no one was on an end of life care pathway. They told us they worked with the district nurses and families at this time and there were no restrictions on visiting. They said they had provided a recliner chair for visiting relatives in the past to enable them to stay with their relation at this time.

Is the service responsive?

Our findings

At our previous inspection we found people's care records lacked detail and contained contradictory and conflicting information which did not always give a clear picture of the person they related to. At this inspection the operations manager told us they were in the process of completely updating people's care files. They had not yet managed to update all the care plans and had focussed on those initially where people had higher level needs such as were at risk of falling. The older care plans were handwritten with subsequent updated care plans following on from the previous care plan, which could lead the carer to read old information before current information. However, the updated care plans were significantly improved and included person centred information to enable staff to care for people in a way the person would choose to have their care provided. The home was in the process of inviting family members to review the care plans where people had consented to contribute to their compilation to ensure they were person centred. This process had started the week of our inspection so it was too early to say if this had been effective but this did demonstrate the service was actively seeking to involve people and their families to improve the quality of the care plans.

We found the respite care plans less complete and one of the files we reviewed contained very sparse information apart from essential risk assessments and care plans. Staff knew the person well and this person had been at the centre of meetings with the local authority to determine whether this person could go home. This person had also not had their fluid and nutritional documentation recorded accurately. The operations manager acknowledged they needed to ensure the care plans of people staying on a temporary basis reflected their needs and preferences to ensure the service could evidence they were providing safe, and person centred care. This demonstrated a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The operations manager told us they were working with staff to ensure people at the service were offered choice this was at the forefront of the care staff throughout their days. They said they had written a mantra on the white board stating 'choice, choice, choice' to ensure provided. We observed choice offered to people at the service from where they wanted to sit, to what they wanted to eat and people told us they had a choice of what time to get up in the morning. This had been a concern at the last inspection and the improvements demonstrated the registered provider had recognised the importance of offering choice to people at the service in order to provide care that was responsive to their needs.

Lack of meaningful activities had been highlighted as an issue at our last inspection and we did not observe planned activities taking place during our inspection. Music was playing and some people were watching television. Recording of activities was irregular in the care records reviewed giving an indication that some people had not undertaken any activities. The operations manager was aware they needed to improve the activities provided and told us they were advertising for an additional activities coordinator. They would be supported to develop and expand the role through membership of the Wakefield Local Authority activity coordinators group.

The operations manager told us an activity coordinator was employed three days a week at the service but they had not been that week due to the outbreak of diarrhoea and vomiting. This was to ensure the virus was not passed to people and staff living at the registered providers other homes in the area. They told us staff supported people with activities at other times. We saw minutes of a meeting held by the activities coordinator with people using the service dated 26 October 2016. Most of the discussion was about Christmas events with a party and carol service proposed. From this meeting the activities coordinator had drawn up a plan of Christmas activities with individuals and groups invited to events such as a Mix and Mingle on 16 December 2016 and various choirs and carol singing events organised.

The operations manager told us they had read the National Institute for Health and Care Excellence (NICE) guidelines in relation to mental wellbeing in Care Homes and would be addressing this aspect of care at the home. They had already had discussions with family members to arrange to meet with the management at the home so they could find out what activities people might have liked to engaged with before they lost the ability to communicate this to those around them. The operations manager told us of one person who was a keen photographer and they had planned to bring in their own photography equipment to undertake this activity with the person.

At this inspection we found there had been two complaints since the service had previously been inspected. We could see the complaints had been investigated and where it had been possible (as one was not within the remit of the location) had been acted upon, investigated; a meeting was held with the complainant and concluded to the satisfaction of the complainant. Following the inspection the operations manager notified us about a third complaint which related to care which had been provided in May 2016. The operations manager was open and honest in relation to this complaint and the care that had been provided and explained to us how systems and processes had been changed to ensure this situation did not arise again and lessons had been learnt. The service also recorded compliments they had received about the service and had received four written compliments since July 2016.

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. 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 operations manager was providing day to day management cover at the service until a new registered manager was appointed. They had provided intense support to improve the quality of service delivery. However, they needed to demonstrate these improvements continued and were sustained once a new registered manager had been appointed. Staff told us that the operations manager had a good relationship with staff and they were approachable, listened to staff and had motivated the team. They also said that they loved working at Millfields and the staff team worked well together.

At our previous inspection we found the systems in place to audit and assess the quality of the service provision had been inadequate in identifying and addressing problems at Millfields. At this inspection we looked to see whether audit and quality assurance systems had been improved and were effective at improving quality. We found the audits in relation to the environment and its cleanliness had been effective with a clear line of responsibility as to who was carrying out the repair and when it had been completed. As a result the environment had significantly improved although further improvements were needed and had been planned. We saw evidence of a care plan audit which looked at daily entries of staff to ensure records were recorded in a person centred way evidencing choice. However, there was no care plan audit to look at the quality of the care plans. We discussed this with the operations manager who agreed to look into this type of audit.

We reviewed the statutory maintenance checks and found all the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) testing of slings and hoists were up to date. The hoists and passenger lift had been tested on 30 September 2016. At our last inspection we found slings which should have been condemned and were no longer suitable to be in use. At this inspection we noted slings had been checked on 12 August 2016 by a specialist engineer and condemned slings were removed. The service had purchased some new slings. We found there was a system in place to ensure slings were individually identified for each person and cross referenced in their moving and handling care plan. This demonstrated the service was ensuring people were meeting safety requirements in relation to moving and handling slings.

We saw evidence of wheelchair decontamination audits and hoist cleaning audits had been signed off by management. Any gaps in cleaning had been investigated and actioned. The cleanliness of both wheelchairs and hoists had been an issue at our last inspection. Significant improvements had been made by the time of this inspection. Emergency lighting system faults had been resolved on 24 May 2016 and all fire safety checks were up to date. Equipment that had failed portable appliance testing had been removed and disposed of and equipment had been retested on 4 October 2016. Weighing scales had been calibrated on 3 June 2016. This demonstrated the service had systems and processes in place which were effective in monitoring this aspect of safe care delivery.

We observed staff and the operations manager interacted well with people living at the service and their relatives. The operations manager had completed observations at meal times and each member of staff was observed as to how they assisted people and we saw these observations had been recorded. This included how staff were seated in relation to the person supported, eye contact, conversation, explanation, reassurance, and whether they were rushed or offered drinks at regular intervals. Staff told us the management at the service were approachable and they could influence how the service was provided. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We saw evidence that various staff meetings were held with the different staff groups at the home.

The service sought the views of people using the service and their relatives. One relative told us they felt listened to and when asked if they could influence the quality of service provided told us, 'Yes I feel listened to but haven't needed to influence anything. The registered provider was keeping families informed of the previous Care Quality Commission inspection and what this might mean for the service. We saw the minutes of the relatives meeting held on 3 November 2016 which discussed the various inspections that had taken place, and the outcomes of audits at the service. There had also been a discussion about the Deprivation of Liberty Safeguards and Lasting Powers of Attorney with the offer from the management team of a meeting with them to go through and explain these issues to relatives. A further meeting had been planned for December 2016. Minutes of the meeting were posted on a noticeboard at the entrance of the home with an offer to email these if preferred.

The home had a catalogue of policies and procedures in place which were regularly updated. There were some minor changes required to these to reflect recent changes in legislation. Staff were now required to sign they had read policies to indicate they were aware of their responsibilities in each policy area.

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 17 HSCA RA Regulations 2014 Good governance Contemporaneous records had not always been kept at the service in relation to the care provided to people at the service, in line with their needs and preferences.