Hopscotch Solutions Limited

Millfield House

Inspection report

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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

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

Millfield House provides accommodation and support for eight younger adults who have a learning disability and who live with autism. It is a detached Edwardian House with accommodation for six people in the main house and with a two bedroomed self contained annex that provides accommodation for two people. The service is close to the centre of Colsterworth, Lincolnshire. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection in March 2016, we rated the service good. It was rated good for safe, effective, caring and responsive and requires improvement in well led. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection, the service was rated good in all five domains and good overall.

People were protected from abuse and avoidable harm, by staff who understood their responsibilities for this. Staff identified risks to people's health and safety and managed the risks without unnecessarily restricting people's freedom. Staffing levels were planned to provide agreed levels of support and sufficient staff were available to maintain safe levels of care.

Medicines were managed and administered safely and people received their medicines as prescribed. The premises and environment were well maintained and the required safety checks were completed. Infection prevention and control was effectively managed.

Staff reported incidents and accidents and the registered managers ensured they were reviewed and learning identified to minimise the risk of recurrence.

Care was delivered by staff who were well trained and knowledgeable about people's care and support needs. The registered managers carried out observations of practice and staff were provided with regular supervision and an annual appraisal.

People were provided with a varied and nutritious diet. Most people had very good appetites, however, we discussed the advantages of using a structured nutritional risk assessment when people lost weight.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed.

The service remained caring. People were unable to express themselves verbally, however, we saw they were relaxed and comfortable with staff and had positive relationships with them. Relatives praised staff for their kindness and the way they cared about their family members. They spoke about the staff team's patient and understanding approach.

People continued to receive care that was responsive to their individual needs and wishes. Staff communicated with them very well and offered them choices on an ongoing basis. People had access to a wide range of activities based on their interests and wishes. They led full and active lives. A relative told us they felt their family member had a fantastic quality of life which went beyond anything they could have expected for their family member.

The management team provided good leadership and support for staff. They made themselves available for people and their relatives and treated everyone with fairness and without discrimination. The views of staff and people using the service were actively sought and listened to. Quality audits were completed to monitor the quality of the service provided and promote continuous improvement.

Further information is in the detailed findings below

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service has improved to Good	**Good**

Millfield House

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 was a comprehensive inspection. The inspection took place on 16 January 2019 and was unannounced.

The inspection team consisted of one inspector. Before the inspection, we reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including notifications they had sent us. These are events that happen in the service that the provider is required to tell us about. We considered the last inspection report and information that had been sent to us by other agencies.

Prior to this inspection, we reviewed information that we held about the service, such as notifications. These are events that happen in the service that the provider is required to tell us about. We considered the last inspection report and information that had been sent to us by other agencies. We also contacted commissioners who had a contract with the service.

During the inspection, we spoke by telephone with three relatives of people who used the service, to obtain their views about how well the service was meeting people's needs and wishes. We spent time in the company of people using the service when they were in the communal areas. By observing the care they received we could determine whether or not they were comfortable with the support they were provided with.

There were two registered managers who job shared. We spoke with a registered manager, a team manager, shift leader and three care staff.

We reviewed a range of records about people's care and how the service was managed. This included looking at two people's care records and associated documents. We reviewed records of meetings, staff rotas and staff training records. We also reviewed the quality assurance audits the management team had completed.

Good

Is the service safe?

Our findings

The relatives we spoke with all felt their family member was safe. One relative said, "I have no concerns about (family member's) safety." Another relative said, "I would trust them [staff] with his life."

Processes were in place to protect people from abuse. Staff were aware of the signs of abuse and action they should take if they identified a concern. Staff expressed confidence in the leadership team, to take action if any concerns were identified. There were clearly identified safeguarding leads for each staff team. Staff were aware of how to escalate concerns if they did not feel listened to. Pictorial and easy read information was available for people about adult abuse and bullying and who people could talk to if they had a concern. The registered managers reported safeguarding issues and took the appropriate action in response to these.

Risks to people's health and safety were assessed and reviewed, so they were supported to stay safe while not unnecessarily restricting their freedom. For example, there were risk assessments for assisting a person with personal care, such as shaving and cutting their nails, travelling in vehicles and visiting external venues such as a swimming pool, parks and play equipment and attending medical appointments. Information was provided in the care plans in relation to the person's possible behaviour in these settings and actions staff should take to reduce risks to the safety of the person and others, along with strategies to respond when necessary. Staff were trained to provide safe interventions when people presented with behaviours that might place themselves or others at risk and to manage a person's behaviour in the least restrictive way. Staff told us they were able to recognise triggers to people's behaviour, and used de-escalation techniques and deflection when required, minimising the need for physical intervention. A record was kept of all physical interventions. We observed staff had identified risks to people's safety when they were alone in their rooms, and had made adaptations to the environment when necessary.

Staff completed incident forms when incidents and accidents occurred and the registered manager reviewed these to identify any learning from them.

Staffing levels were set to provide the level of support each person required. Relatives and staff told us they felt there were enough staff to provide the care everyone required. A relative said, "There are enough staff; definitely. I looked at other places for (family member) and nothing compares to this." "There's enough staff to take them out regularly and provide the one to one care (family member) needs." Safe recruitment practices were followed to ensure staff were suitable to work with vulnerable people and those with complex needs. These practices included criminal record checks, obtaining a sufficient number of references from previous employers and proof of identity.

Medicines were stored and managed safely. Two staff administered medicines for each person to ensure they could make the necessary checks and administer peoples' medicines quickly in line with the person's wishes, while maintaining safety. People's medicines record contained a photograph of the person and their date of birth, to aid identification and prevent misadministration. Staff received medicines administration training and had their competency checked regularly. Audits of medicines management were completed

routinely to ensure standards were maintained. An external audit of medicines management had been completed the previous week and the registered manager was aware of the findings and was taking action to address the minor issues identified.

The premises and equipment were maintained to ensure people's safety and the required safety checks were completed regularly. Effective processes were in place for the prevention and control of infection. Two members of staff acted as leads for infection control and attended local authority forums to ensure they were aware of any changes to practice required.

Good

Is the service effective?

Our findings

People's needs and wishes were assessed and care and support was planned effectively. Staff had access to up to date policies and procedures based on current legislation and best practice standards.

Staff were provided with the knowledge and skills to provide effective care. Staff told us they received a comprehensive induction when they started at the service and a wide range of training, applicable to the needs of people they were caring for. The training matrix for the service showed staff were up to date with training requirements. A member of staff said, "The training is excellent, it's amazing." Staff had received additional training in subjects such as autism and the management of epileptic seizures to enable them to respond effectively. Staff received supervision and the registered managers regularly observed the way staff provided support, in order to provide feedback to staff and ensure best practice was followed.

People had access to general and specialist healthcare services and staff acted as people's advocates to ensure services were provided in a way that met their individual needs.

Staff consulted with people to develop a menu based on their choices and to ensure they had a varied and nutritious diet. Staff made extensive use of pictures and symbols when discussing menus, or individual choices on a daily basis. A member of staff explained that one person used the sign for biscuits more generally, to indicate they wanted something to eat, so they would guide them to the picture board to enable to them to choose what they wanted. They said they would offer fruit as snacks first, if people did not express a preference, as some people tended to choose less healthy snacks automatically. A relative told us their family member's diet had changed for the better since they had come to the service. They said their family member ate a greater variety of foods and when visiting the family home would go to the cupboards or fridge and take things out they would like cooking for their meal, something they had never done previously. Staff supported people to be as independent as possible and we observed a person pouring their own drink following encouragement and they took their plates to the kitchen when they had finished their meal.

Staff monitored people's weight on a monthly basis and identified changes in their weight. However, we noted that one person had lost a considerable amount of weight recently and staff had not taken action to review this and identify whether a referral to their GP or dietitian was required. We discussed this with a registered manager and they agreed to address this and said they would consider whether a structured nutritional risk assessment would be helpful in flagging similar issues in the future.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguards (DoLS). We checked that the principles of the MCA and DoLS were followed and we found they were. Staff had a good understanding of the principles, and people were supported wherever possible to make their own decisions. When people lacked capacity to make a decision, decisions were made following the best interest decision making process.

The premises were adapted to meet the needs of the people using them. The home and surrounding gardens were accessible to all and there were a number of areas where people could spend quiet time as well as communal areas. The service had its own transport to enable people to go out either individually or together.

Good

Is the service caring?

Our findings

Relatives we spoke with commented on how happy their family member was at the service and said their family member knew the staff cared about them. One relative said, "They get to know staff and there's a personal connection." They went on to say, "Staff are very committed and very caring; they are very kind." Another relative said, "(Family member) is so happy there; it is their home and they have such a fantastic quality of life."

We observed very positive relationships between people and the staff caring for them. People sought out staff and used gestures to indicate their connection with them. Staff responded warmly and positively and people were relaxed and comfortable with them. We saw staff recognised subtle cues to indicate when a person might need some support or was becoming disturbed and they responded quickly to alleviate any anxiety or distress.

Staff responded flexibly and were sensitive to people's mood and preferences for support. For example, there were times when people preferred to be alone and staff gave them that time, while making sure they were available in case they needed support. At other times they engaged with them positively, chatting with them about things the person was interested in.

Staff maintained people's privacy and dignity. They knocked on people's doors and waited before they went in. We observed a member of staff quickly put a towel around a person as they left their bedroom to go to the bathroom in a state of undress.

People were encouraged to be involved in decisions about their care and support as much as possible and were offered choices. Staff used a variety of ways of identifying each person's wishes including pictures and sign language. A relative said, "(Family member) goes out a lot; they go all over the place, but they have a choice about it." They went on to describe the choice board their relative used to communicate their wishes. Another relative said, "(Family member) is never forced to do anything they don't want." Relatives told us they were involved in the development and review of their family member's care plan and the content of people's care plans reflected the person's preferences and wishes; however, documentation to evidence this was limited.

Good

Is the service responsive?

Our findings

People were supported by staff who provided personalised care based on the person's individual needs and wishes. Staff respected people's personal choices and responded flexibly when people changed their routines or wishes. The provider ensured people were protected under the Equality Act 2010 and the Accessible Information Standard which applies to people who have information or communication needs relating to a disability, impairment or sensory loss.

People's care plans contained detailed information for staff on how best to support them with personal care, eating and drinking, medicines and other day to day activities. Communication care plans described the ways people communicated their wishes non verbally and steps staff could take to better understand their communication. New staff were given time to familiarise themselves with each person's care plans before shadowing and working with more experienced carers. This ensured staff had sufficient information and understanding of each person's needs. A member of staff who had recently commenced work at the service, described how they were learning more signs on a day by day basis, focusing first on the most commonly used signs used by people.

We observed people were encouraged to be as independent as possible and they agreed three goals with staff each month, in steps towards increasing their independence in day to day activities. For example, one person had a goal to increase their independence in their bathing routine. Journals were completed to document the progress they were making. Relatives commented on the impact of this on their family member's independence. For example, one relative said, "I have seen a massive difference since (family member) came here. They have really made progress, it might seem as though they are small things, but it has made such a difference."

People had access to a wide range of activities based on their individual interests. Each person had activities planned each day and for the week ahead displayed on a board in the hall. Staff explained that some people liked to follow a routine and became distressed if this was changed. However, people were able to change their minds about planned activities if they wished. Staff consulted with people at monthly house meetings, about the activities they wanted to participate in and the meals they would like to have on the menu. Staff kept photo books of activities each person was engaged in. Relatives told us they were very impressed with the opportunities their family member had to go out and participate in leisure activities they enjoyed. They spoke about horse riding, swimming, discos, sailing, and walks in the village and local parks. A relative told us the activities offered were age appropriate and spoke about manicures and pampering sessions. There were a range of facilities within the service in the house and garden such as art and craft materials, a trampoline, basket swing and a horticultural area.

Accessible information was displayed throughout the home about how to raise concerns or complaints. A complaints policy was in place and the manager was aware of their responsibility for managing complaints. Relatives told us they had had no reason to make a complaint and they were confident any issues would be addressed and resolved.

There was no one using the service who was nearing the end of their life care and the service did not anticipate needing to provide end of life care in the near future, due to the age and health of people using the service. However, the registered manager said they would support the person, their family and external professionals on an individual basis should this occur in the future.

Good

Is the service well-led?

Our findings

At our last inspection in 2016 we identified we had not been told about the authorisations that had been obtained to deprive people of their liberty. This was rectified following the inspection and at this inspection we were satisfied this requirement was being met.

Two registered managers were in post and shared the responsibilities for the role. 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 ratings from out last inspection in 2016 were displayed in the front entrance to the service and on the provider's website.

Relatives praised the leadership of the service and told us the registered managers were always readily available to discuss issues or new ideas.

The provider and registered managers had values that placed the people at the centre of their service and had clearly defined aims, which included increasing independence, enabling people to make choices about all aspects of their lives, to live rich and active lives, and become part of the community in which they lived. We saw the leadership team and staff were committed to these aims and followed them in practice.

Staff were clear about their roles and responsibilities and there was a clearly defined management structure. Staff told us they received excellent support and feedback, and the management team were fair and consistent in their approach. They said one of the strengths of the service was excellent team work. One person said, "We all have strengths and weaknesses and they play to our skills. We have a no blame culture and if something hasn't been done by someone, another of us will pick it up."

People were engaged in decisions about the service and encouraged to express their views. They contributed to decisions about the décor and furnishings, for example. House meetings were used to obtain people's views on a monthly basis. Staff telephoned relatives regularly to discuss their family member's care plan, obtain any feedback they had and to discuss plans for the future. Relatives felt involved and included. One relative said, "The (registered) managers often ask for our views and share any concerns with us so we can all work together."

Effective systems were in place to monitor the quality of the service and the care provided. A range of monthly and quarterly audits were completed by the registered managers and provider. The registered managers had an action plan to address areas for improvement for the service that included actions identified in the audits.