Millfield James Limited

7 Eworth Close

Inspection report

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Date of inspection visit:
06 September 2017
08 September 2017

Date of publication:
12 October 2017

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

The inspection took place on 6 September 2017 and was unannounced. We visited to complete the inspection on 8 September and this visit was announced. 7 Eworth Close offers accommodation and personal care for up to six people with learning disabilities.

The service was last inspected on 6 and 12 February 2016. During that inspection we found safeguarding adult procedures were not always followed. We found people had not been involved in decisions about managing their diet. People's capacity to make specific decisions had not been assessed. Best interest decisions were not made and the least restrictive option used. Deprivation of Liberty Safeguards (DoLS) applications had not made to the supervisory body. People had little autonomy and their care plans were not developed in a manner that respected their rights. They lacked detail and were not individualised.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. We asked the provider to send us a report saying what action they were going to take. The provider had told us that they would complete all the actions required to meet the regulations by the end of October 2016. During this inspection we found that the provider was meeting the regulations.

The service had a registered manager in place. 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 day to day running of 7 Eworth Close was overseen by a manager based at the house.

People who used the service felt safe and relatives had confidence in the ability of staff to keep people safe. Staff had received training on safeguarding adults and understood their responsibilities. Risks had been appropriately assessed and control measures in place to minimise the risks.

People received their medicines as prescribed. Staff had training and were checked to ensure they continued to be competent when administering medicines.

Recruitment processes were designed to ensure only suitable staff were selected to work with people. There were sufficient numbers of staff to meet the needs of people who currently used the service.

New staff were supported with an induction when they commenced work in the service, including shadowing opportunities. Relevant training had been received such as managing medicines, food hygiene, health and safety and first aid.

Staff were supported through annual appraisals and meetings with staff took place as per the company policy. Staff told us that they felt supported by the manager and that communication was effective.

Staff were aware of their duties under the Mental Capacity Act 2005. They obtained people's consent before carrying out care tasks and followed legal requirements where people did not have the capacity to consent to their care.

People who used the service and relatives consistently told us staff were caring, patient and upheld people's dignity. People confirmed staff encouraged them to maintain and improve their independence on a day-to-day basis.

People felt consulted and listened to about how their care would be delivered. Care plans were personalised and centred on people's preferences, views and experiences as well as their care and support needs.

People who used the service knew how to complain. Complaints were investigated and responses given which were satisfactory to the complainant.

The manager and staff were described in positive terms by people who used the service and relatives.

The manager had worked hard to improve the service since the last inspection. This had resulted in an improved service for people. Auditing and quality assurance systems were improving to enable the provider to identify trends.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe.

Medicines administration training took place with observations to ensure staff competence.

Potential risks were identified, monitored and managed to minimise harm.

Staff received safeguarding training and understood their responsibilities to report concerns.

There were enough staff. Checks were completed to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff had received a range of training relevant to the needs of people in the service and had regular meetings with their manager to gain support.

People were cared for in line with the principles of the Mental Capacity Act 2005.

People were supported to have a healthy diet and their wellbeing maintained with relevant health checks.

Is the service caring?

Good

The service was caring.

People had positive and caring relationships with the staff that supported them.

People were treated with dignity and respect.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's care records were individualised and they had been involved in developing them.

People were given opportunities to express whether they were unhappy about anything. We saw this was responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The established staff team ensured a person centred service with a positive culture.

The manager had ensured a good overview of the quality of the service and monitored this effectively.

Auditing and quality assurance processes were in place.

People who used the service and staff had confidence about the leadership of the service.

7 Eworth Close

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.

The inspection took place on 6 September 2017 and was unannounced. We completed the inspection on the 8 September 2017. The inspection team consisted of one inspector. Before our inspection we reviewed all the information we held about the service. The provider had submitted a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. We also contacted four health and social care professionals for feedback.

During the inspection we reviewed three people's care information, looked at three staff records, policies, procedures, auditing and feedback from people. We spoke with three people who used the service and one relative. We spoke with the provider, the nominated individual, the manager and two members of staff.

Good

Is the service safe?

Our findings

At the previous CQC inspection in February 2016 we identified concerns that people's risk assessments lacked detailed guidance for staff on how to manage identified risks. During this inspection we found the provider had made improvements.

People had risk assessments in place specific to their individual needs. For example, accessing the local community, use of public transport and safe relationships. Risk management plans were put in place to minimise harm and maintain people's safety, but also to maintain and promote independence. Risk assessments were reviewed regularly, or when a change occurred. For example, a person was increasing their independence and starting to use public transport. We saw a risk assessment about supporting a person to do more trips without support. For example, starting with a trip to the post box and then extending this to the local supermarket with measures in place to ensure the person's safety.

There were generic risk assessments completed to ensure a safe environment. For example, fire, hot water, kitchen, hazardous substances. This meant the environment had been assessed to maximise safety and minimise the chance of accidents.

People who used the service told us they felt safe. One person said, "Yes I'm safe here, my money is kept upstairs safely. I can always get it when I want." A health professional told us, "Yes, I feel that staff are effective at keeping the people in their care safe. This is with regards to risk management and safety around epilepsy, being alone in the community, supporting people to take their medication correctly and raising concern when needed, i.e. with concerns related to capacity and consent."

People were protected from the risk of harm because care workers knew how to recognise signs of potential abuse and how to report their concerns appropriately. Up to date information on local safeguarding procedures was clearly displayed. Safeguarding training was delivered as part of the provider's induction and staff received refresher training on this topic. When we spoke with staff they were clear about their safeguarding responsibilities and how they could raise concerns. A member of staff told us, "People are safe here. They have a safe environment, it's a small home and small staff team so that helps ensure people are kept safe." Another said, "Yes I know about whistleblowing and would not hesitate to do so if needed. I have done so before in previous roles. I'm aware of safeguarding and people's vulnerability." We also saw that where there were safeguarding concerns referrals had been made to the appropriate body.

Medicines were managed safely and people received their medicines as prescribed. We saw that medicines were stored in a designated locked cupboard. We examined the Medicine Administration Record (MAR) and saw that there were no gaps in the recordings. Medicines were clearly labelled and stored separately to ensure people received their correct medication. We saw records and staff told us that all staff had received training in the safe management of medicines. We saw that staff's competency to administer medicines was checked regularly. One person told us, "Staff help me with tablets. I have them in bed then have a shower. Then they do my creams and eye drops."

The manager had arranged some face to face refresher training on medicines for staff the week following the inspection. Where specialist training was needed we saw that staff were provided with the training before administering the medicine. For example, a specific epilepsy rescue medicine needed to be signed off by a health specialist before staff could administer the medicine. The management of this medicine was carefully audited on a daily basis and signed out by two staff when the person left the premises and needed the medicine with them.

We saw that people's medicines were reviewed regularly to ensure their behaviour was not controlled by excessive or inappropriate use of medicines. For example, a person had their medication reduced due to side effects. Medicines were audited weekly to check stock quantities and were in date. We saw an independent medicines audit was completed and pharmacy advice reports completed.

Some people had been prescribed medicines to be administered on an 'as required' or occasional basis (PRN). We saw that guidance was provided within Medicines Administration Records (MAR) on how PRN medicines should be administered, should people require it. The provider maintained records of when these medicines were administered and the reasons for their administration

People and care staff said they felt staffing levels were sufficient to ensure people received their care safely and on time. People told us they always had a member of staff to support them when needed. Staff told us they felt there were adequate staff. On call staff were provided with a folder with useful information and telephone numbers to ensure they could respond swiftly if needed.

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with potentially vulnerable adults.

People were protected from the spread of infection. Staff ensured the kitchen remained clean and free from potential cross infection. The provider adhered to food safety standards and ensured the food was kept at appropriate temperatures and prepared safely.

Regular checks and tests, such as gas, electricity, water safety, fire drills, weekly fire alarm tests and external checks of firefighting equipment, were completed to promote and maintain safety in the service. A grab folder contained essential information about people and services in the event of having to evacuate the premises urgently.

There were robust contingency plans in place in case of an untoward event. The contingency plan assessed the risk of such events as fire or bad weather conditions and how the service would continue in the event of these occurring.

Good

Is the service effective?

Our findings

At the previous CQC inspection in February 2016 we identified concerns that people were not always involved in decisions about maintaining a healthy diet. Applications had not been made to the supervisory body under the Deprivation of Liberty Safeguards (DoLS) and in line with the principles of the Mental Capacity Act 2005. This meant the sanctions imposed restricted people and were unauthorised. We also found referrals were not always made to the relevant bodies for people who alleged physical abuse by other people living in the home. These issues were a breach of Regulations 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, we asked the provider to send us a report stating what action they were going to take. At this inspection we found the provider had made improvements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The provider had procedures and processes in place to prevent people being subjected to unnecessary or disproportionate restraint around food. People in the service were keen to maintain a healthy diet but at times had difficulties around portion control. In order to assist this, staff had undertaken a mental capacity assessment alongside a social care professional. Where a person was deemed not have capacity to consider the effect of an unhealthy diet, a referral had been made to a dietician. We saw a best interest decision had been made in conjunction with a health professional. This was to support the person to enjoy healthy foods alongside balancing having treats in line with their choices. We saw that an application had been made in relation to this area of the person's care to the supervisory body for a Deprivation of Liberty Safeguards (DoLS). DoLs ensure that people are only deprived of their liberty when this is in their best interests and legally authorised under the MCA. We saw measures in place to monitor the application including support from a dietician and regular reviews. In the care files we reviewed we saw people had consented to the care planned.

One person had the support of an independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

People's needs were met by staff that had relevant skills, competencies and knowledge. People said that staff were well-trained and knew their needs. One person said, "[Staff] do what you want to do. They are very good." A member of care staff said, "Training is good for a reminder, and important when working with the

same group of people for a long time. Keeps you refreshed and more alert to be aware of anything." A health professional commented, "Staff regularly attend training provided by the local learning disability health team. This has included epilepsy management and healthy eating. My experience with the team gives clear evidence that they have knowledge/ training in supporting people with learning disabilities and autism. I have delivered training for epilepsy management and the administration of rescue medication for prolonged seizures."

We looked at the training records which showed staff had completed a range of training courses which included: health and safety, moving and handling, first aid, safeguarding adults, the Mental Capacity Act, and infection control. The manager said face to face medicines training was booked in the following week to refresh knowledge. A member of staff told us, "I am currently doing a [national care qualification]. I've also done Safe Handling of Medicines at Swindon College."

New staff undertook an induction comprising a mix of training, shadowing and observing more experienced staff. Staff told us the training covered all areas of the role and was relevant.

Staff told us they felt supported by the manager. Staff told us they had annual appraisal meetings and supervision meetings. We saw records on staff files that they had discussed their roles and responsibilities. For example, upcoming training and completing a national qualification. We saw notes on a staff's records providing positive feedback to the staff member about them being well liked by people they worked with. A member of staff told us, "I have regular supervision and my appraisal is due soon. I feel I can discuss any issues or any support needed."

People's health was optimised as the service ensured relevant health professionals were consulted when needed. For example, we saw that people had been supported to attend health appointments such as an annual health review with their GP, having a flu injection, attending the hearing clinic and attending the dentist and opticians when needed. Where people had health professionals involved to support their mental health, such as psychiatrists and psychologists, we saw that meetings had taken place to review people's care and support. We saw other health professionals such as learning disability nurse and dietitian were involved in people's care. We received feedback that the service had sought advice about epilepsy, weight management and capacity around safe relationships to enable positive risk management.

Staff had received food hygiene training as part of their induction. We saw people were involved in menu planning to reflect their individual tastes. People were supported to maintain a healthy diet to improve and maintain their health. A member of staff said, "Everyone makes their own choices alongside being supported with healthy eating. Some help with portion control is needed. People pick their own treats and fruit is always available if people are hungry." One health professional commented, "The staff team are very skilled in supporting people with nutrition and weight monitoring. They have successfully supported [person] to reduce their weight significantly through diet and exercise. This has increased their life expectancy and reduced the risk of significant co-morbidities."

Good

Is the service caring?

Our findings

At the previous CQC inspection in February 2016 we identified concerns that people had little autonomy and their care plans were not developed in a manner that respected their rights. This issue was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, we asked the provider to send us a report stating what action they were going to take. At this inspection we found the provider had made improvements.

People told us they were involved in the planning of their care and could voice their views on how their care should be delivered. In order to facilitate communication, most information was provided in a format that was easy to read, with symbols and pictures. Three people at the service showed us their records which contained their preferences and had drawings and photographs of people or things that were important to them. People were supported to make choices and decisions about their care. The choices included ways of spending their day, places to go, times to go to bed and to get up.

People gave consistently positive feedback about the caring attitudes of staff. Comments included, "Really nice, I like the staff" and "Really brilliant, they take me out." A health professional commented, "I feel that the staff team are long standing and know the clients very well, I feel that they care very much for each person and communicate with each individual in a person centred way, i.e. using signs/ gestures when needed."

The service was small and there was an established care team who all got on well. This ensured a continuity of care for people with staff they knew well. This meant care staff knew people and their needs thoroughly which enabled them to support people in line with their needs, preferences and wishes. On both days of the inspection, we observed very caring and positive interactions between people and staff. We observed all the people in the service being at ease with staff and enjoying appropriate banter and jokes. There was a lot of laughter and a homely atmosphere. We also observed close friendships between people and discussions about past and upcoming holidays and activities, such as going to the boxing club. A member of staff told us of their enjoyment working with people in the service commenting, "I enjoy making a difference. I took [person] to a show and seeing the enjoyment on their face was more enjoyable than the show for me."

People's independence had been promoted and we saw people were encouraged to do as much as they could for themselves. For example, when we arrived for the inspection, two people were preparing their packed lunch. A health professional told us, "They have worked towards a resident safely accessing the bus to attend a day centre, assessing capacity, risk and ability. This has taken a long time but has resulted in increased independence."

People felt secure when being supported with personal care by staff, who behaved in a respectful manner. People told us they were treated with dignity. One person told us, "They are always kind to me." Staff told us that treating people well was important. A member of staff said, "When we do personal care we always ensure their dignity is maintained. For example we make sure the doors are shut if doing personal care and remind people to close the door if they are in the toilet."

People's wishes around what they wanted in the event of their death had been sensitively recorded. This captured information such as who was the next of kin, where they wished to be cared for, what sort of burial and choice of music and flowers to reflect their life.

People's rooms were personalised and reflected their individual interests and taste. The walls of the communal areas were decorated with photographs of people. People had chosen which pictures were to be displayed.

We saw that records containing people's personal information were kept in the main office which was locked. This meant people's sensitive information was treated confidentially.

Good

Is the service responsive?

Our findings

At the previous CQC inspection in February 2017 we identified concerns that care plans lacked detail and people were not at the centre of their care. People's likes and dislikes and their preferred routines were not gathered to develop person centred care plans. Staff lacked an understanding of person centred approach to care and treatment. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, we asked the provider to send us a report stating what action they were going to take. At this inspection we found the provider had made improvements.

The service had involved people in developing their care plans which reflected what was important to them. Staff showed an in-depth knowledge and understanding of people's care and support needs. All the staff members we talked to were able to describe the care needs of each person they provided with support. This included individual ways of communicating with people, people's preferences and routines. This meant that staff were able to offer very individualised care.

Care files contained sufficient information for carers to undertake the necessary tasks as well as including information which was person centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. This meant that staff could build up a rapport with the person and know what was important to them. We saw care plans described how people wanted to receive care. For example, one person's care plan stated they liked to be independent. A member of care staff told us how important it was for the person to do as much for themselves as they could and wanted. We reviewed a sample of daily notes and found them to be sufficiently detailed regarding the tasks the carer had undertaken. We saw that tasks on the care plan had been completed and recorded.

People's care files were reviewed monthly. People who used the service and staff confirmed they took part in regular reviews. The manager had arranged care reviews for all people in the service, involving the person, their relatives and the authority that had commissioned the person's service. This ensured an objective review of the person's support needs.

People were involved in activities including keep fit (at a local boxing club), attending community activities, baking, and holidays. We saw people had individual hobbies such as doing jigsaws or knitting. One person liked to write to royalty and proudly showed us the responses they had received from Buckingham Palace. There were also photographs of visits to London to see the Palace. Some people also attended a local college to attend Learning for Life. This provides free training for people who have a disability and carers aged over 18 living within Swindon and Wiltshire.

One relative said they were impressed by the manager and her approach, stating, "[Person] is being enabled to bake and has been out collecting berries for fruit crumbles. We hope that [manager] will receive all the support she needs to enable her to meet her clear ambitions to provide all residents with happy, fulfilling and purposeful lives." Another relative had sent in a letter stating "[Person] is thriving in an environment where she has events to look forward to. It has put my mind at rest knowing [person] is in capable hands

with staff who care about her. The staff are all excellent and I appreciate their hard work and effort."

People told us they enjoyed their social life. Comments included; "I am going on holiday for a week to see my [relative]. Will bring cupcakes back with me!" We also saw that holidays had been arranged. One person said "I like the shows, discos and bands and free food!" People had the choice to have separate holidays if they wished or to go with people they got on well with.

The provider had a complaints policy in place. Everyone we spoke with was aware of how to make a complaint and confident they could do so if necessary. There was easy read information displayed stating how people could make a complaint. We heard that the manager was introducing one to one meetings with each person to ensure they had an opportunity to express any concerns in a private manner. We saw one complaint where a person was unhappy about another person's behaviour towards them. We saw a meeting had been arranged between the two people and a complaints procedure offered to the complainant. We saw the record of the meeting and how the issue had been satisfactorily resolved with mutual agreement. We asked staff how people could raise a complaint. One member of staff said "People have regular meetings with manager. People are very forthcoming in their views."

Good

Is the service well-led?

Our findings

At the CQC inspection in February 2016 the provider did not have a thorough system of monitoring the effectiveness of the service. For example, auditing information such as care plans to ensure they were complete and accurate. People's risk assessments did not provide sufficient guidance for care staff to follow. Safeguarding referrals had not been made to the relevant bodies. The principles of the MCA had not been adhered to. This meant the quality and effectiveness of the service was not being managed adequately. At this inspection we found improvements had been made.

There was a manager in the service and an overall registered manager who oversaw two services. The manager was proposing to make an application to CQC to become the registered manager for the service. We saw that the manager had put in place systems to audit and monitor the service to ensure it was effective and safe. We observed improvements to systems to assess the quality of care. A range of audits had been introduced which had been designed to monitor the quality of the service and to identify areas in which improvements were required. The system included audits including, medicines, health and safety and care files. We also saw quality audits undertaken by an external consultant which covered all areas of the service. As a result of the audits, the provider and manager had a good overview of the quality of the service and any actions needed to improve quality or safety.

People, staff and relatives told us the manager was effective and supportive. A relative told us, "Prior to [manager] appointment as manager there were some causes for concern. We felt that although the house was safe, clean and comfortable, it was generally lacking in stimulation. Following [manager's] installation improvements have become evident. She has spent a good deal of time building a detailed understanding of the things that would contribute to the happiness, wellbeing and sense of purpose of each resident" and "[Manager] faced quite a significant challenge and she has risen to it. In the vast majority of cases she has brought the staff with her and the general atmosphere of the home is much better." A staff member said, "She's brilliant. Very supportive around [personal development]. Will always help. We work well as a team. [Manager] good at having difficult conversations and manages well." Another said, "What can I say, intelligent and confident – a good manager."

We found morale to be good amongst the staff and all staff we spoke with displayed a positive, caring attitude. It was clear in the observations and responses from people we spoke with throughout the inspection that the culture was very caring, focussing on delivering good standards of care. One staff commented, "I love working in this small environment. I feel like a person not a number as it is a very personal service and flexible". Another said, "The service is run as people's home, not a care home."

Regular staff meetings were held and recorded. These took place at varying times to ensure staff on all shifts had a chance to attend. We saw issues discussed such as people's reviews that were taking place and also staff development.

Due to the size of the service, the manager also carried out the same work as care staff. This enabled them to observe the operating of the service in detail. Staff were able to contribute to developing the care and

support provided to people through this daily interaction, and within formal feedback given to the manager.

People, where able, had completed the Annual Quality Assurance Questionnaire which reflected that they were happy with their support. Families also completed the Annual Quality Assurance Questionnaires which reflected positive relationships. Families were contacted regularly to update them on their family member's well-being. A health care professional said, "[Service] Communicate well and are always open and honest, and easy to contact."

Accidents and incidents at the service were recorded and monitored. For example, a person fell when walking to café. The person's mobility was reassessed and a risk assessment put in place to ensure vigilance to reduce occurrence. The manager reviewed these to detect any trends, patterns or possible causes of the incidents. This meant the provider had a system in place that identified risks to people who use the service.

The manager understood their legal responsibilities and ensured that the local authority's safeguarding team and the CQC were notified of incidents that had to be reported and maintained records of these for monitoring purposes. The provider had completed a Provider Information Return (PIR) and sent it to us.

Policies and procedures were detailed and gave adequate information to staff, people who use the service and their relatives, and were fit for purpose. We saw that they had been reviewed and that a system was in place for ensuring staff had read and understood them.