BKR CCH Limited

Millington Springs

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Millington Springs accommodates up to 42 people in one building. At the time of our inspection there were 21 people living at the service, some of whom were living with dementia.

People's experience of using this service and what we found
People were not always supported in a safe way. We found concerns around medicines management and infection control. We also found risks were not always being managed adequately which placed people at increased risk of harm or injury.

The provider had not taken enough action following the last inspection report to ensure systems and processes in place to monitor the safety and quality of the service were being carried out effectively. This meant concerns and issues were not being identified or action was not being taken to rectify them.

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

Rating at last inspection (and update)
The last rating for this service was inadequate (published 19 January 2021) and there were multiple breaches of regulation. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve. The provider did not submit this action plan. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced focussed inspection of this service on 12 October 2020. Breaches of legal requirements were found around safe care and treatment, staffing, safeguarding and good governance.

We undertook this focused inspection to check they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed from inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Millington Springs on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

Millington Springs

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by an inspector, an assistant inspector and a specialist advisor whose specialist area was nursing.

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

At the time of the inspection the service did not have a registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in

this report.

During the inspection
We spoke with one person using the service and observed multiple interactions between staff and people. We spoke with six members of staff including a senior carer, housekeeper, maintenance person, cook, nurse and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at five staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Following the visit to the service we made phone calls to relatives and staff. We spoke with four relatives about their experience of the care provided and we spoke with ten members of staff.

We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to effectively assess and manage risks and medicines had not always been safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not being safely managed.
- There were issues with the documentation around the administration of medicines. These included missing vital information about the people receiving medicines, such as known allergies. Also there were missing protocols around medicines that were taken as and when required (PRN) and missing signatures to evidence medicines had been administered.
- There were concerns around how medicines were being administered covertly and the overuse of PRN medicines without a medicine review being sought.
- A person was supported to receive medicine via a skin patch. There was no documentation in place to record the location of where the patch was being placed or a record of checks that the patch was still in situ. This left the person at risk of skin irritation, inflammation and unnecessary pain.

Assessing risk, safety monitoring and management

- Risk assessing, monitoring, management and mitigation continued to be insufficient and placed people at increased risk of harm.
- There was a lack of sufficient care planning and checks in place for a person being supported with a percutaneous endoscopic gastrostomy (PEG) tube by which they receive their medicines and additional nutrition. This placed the person at increased risk of infection.
- There was a lack of sufficient care planning and checks in place for a person being supported with a catheter. This placed the person at increased risk of harm and did not adhere to current national guidelines.
- At the last inspection concerns were identified around support for people with behaviours that may challenge. These concerns were found to be ongoing at this inspection. Not all staff had completed training to guide them on how to safely support people who present behaviours that may challenge. Where a risk of a person presenting behaviours that may challenge had been identified, care plans were still not in place to provide staff with guidance around how to protect the individual from harming themselves and other people. This placed people at risk of avoidable harm.
- The home was still in a state of disrepair and environmental risks picked up at the last inspection had not

been rectified. Risks such as trip hazards continued to be found, hot water temperatures were still not being addressed and concerns over mattress checks remained. This placed people at increased risk of injury.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection systems were either not in place or robust enough to demonstrate safeguarding was effectively managed. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● The systems in place to review incidents and learn lessons to ensure people were safeguarded from abuse and harm were ongoing.
● Whilst staff were aware of safeguarding processes and people felt safe; accidents, incidents and falls were not reviewed promptly, actions were not being followed through and lessons were not being learnt.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safeguarding was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider failed to ensure there were sufficient numbers of suitably skilled and experienced people to staff the service. This is a breach of regulation 18 (Staffing) of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

●At this inspection we found ongoing concerns around recruitment practices and heavy reliance on agency staff.
● There were not enough competent permanent staff at senior levels to ensure safe delivery of care.
● Whilst staffing levels for care staff were adequate to meet the needs of people, this was only being achieved by high use of agency staff. The risks associated with the use of agency staff included the provider being reliant on the agency to check their competency, particular with nursing staff. There was little assurance from the provider that recruitment for permanent staff was being actively pursued.
● We reviewed five staff files and found gaps in each one. They lacked information around employment history and didn't provide assurance that people were suitable for their roles.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing was effectively managed. This was a continued breach of regulation 18

(Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Preventing and controlling infection

- Adequate infection control measures were not in place.
- Best practice guidelines for preventing the transmission of Covid-19 were not always being followed, staff were observed not always wearing the appropriate personal protective equipment (PPE) and on admission people were not being isolated in line with guidelines. Appropriate disposal of PPE was not always taking place.
- The registered provider was ineffective in ensuring a clean and appropriately maintained environment was provided. This placed people at increased risk of the spread of infection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection control practices were effectively managed. This placed people at potential risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider failed to ensure their systems and processes to keep people safe were working effectively and could not assure the Commission they had good governance systems in place. This was a breach of regulation 17 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At the time of this inspection there was not a registered manager in place. The nominated individual was currently also managing the service and was in the process of applying to become registered manager.
- The nominated individual had not taken enough action to ensure they were now in compliance with the breaches identified at the last inspection. They also had not submitted action plans as required by CQC following the last inspection.
- Audits continued to not always be completed or, where they had, they had not always identified risks and concerns. Where actions had been identified there was no follow up to ensure these actions had been completed. The last inspection identified that call bell response times were not being audited; no call bell audits had taken place since the last inspection.
- The last inspection identified a lack of analysis where incidents and accidents had occurred, this analysis still was not being completed in a timely manner. This meant trends, patterns and causes had not been identified and the underlying causes would remain unknown. This increased the risk of issues being unresolved and people being at risk of further incidents.
- At the last inspection there were concerns over healthcare professional advise not always being followed. At this inspection we found this still to be the case. For example, a specialist dietician gave clear advice around cleaning of a PEG, however the manager was unable to provide evidence to demonstrate this advice had been followed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was effectively managed. This is a continued breach of regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Although we found significant areas of concern staff feedback was mostly positive. Staff said, "I do enjoy working at Millington springs, I feel valued and supported in my role" and "I think all the staff are very hard working and very caring. Everybody tries their hardest."

● We received mixed feedback from people and their relatives. One person told us, "I can't praise this place enough, they've been wonderful. I'm treated like a queen." A relative said, "I have a good relationship with them [staff], can't fault them, at end of day [relative] is really happy, if [relative] is happy then I'm happy."

● However, relatives did voice some concerns over the lack of communication and were unsure about the current management structure.

● At the last inspection it was identified that feedback from relatives had not been sought in a formal way, such as a survey or questionnaire. Since then questionnaires had gone out to residents and their families however responses received had not been analysed and actions had not been taken to address concerns raised.

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

● The provider understood their legal responsibility to be transparent when incidents occurred. They ensured they informed the relevant agencies, such as the local authority and CQC.

● We saw evidence of internal investigations taking place into most incidents; however, they were not always carried out in a timely manner.

● Relatives we spoke with had mixed responses regarding being informed of incidents. One relative said, "They [staff] will ring me and let me know, a couple of times [family member] had to go into hospital and they let me know what's going on." However, another said, "You don't really hear from them very much, I did say to [provider] I do need to know when [family member] falls."