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 42 people in one adapted building. At the time of the inspection there were 20 people living at the service. These were older adults and some people 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 medication was not being managed safely. Medication was not always counted; storage temperatures were not monitored and some prescribed cream were out of date.

Health and safety issues were due to a lack of maintenance work being completed around the home, windows restrictors were not in use and radiators with broken thermostats were hot to touch.

Infection control practices were not always recorded to show that cleaning had been completed. Some equipment was not clean.

Care plans did not always contain the information staff needed to provide effective and safe care for people.

A dependency tool was used to decide staffing levels and an agency had provided cover to manage staffing shortages. However, agency staff were not always able to record the care they had provided due to the lack of inhouse training of the services care planning system.

Systems and processes to monitor and manage the quality and safety of the service had not been followed and audits were either not carried out or not identifying the issues found during this inspection.

Incidents and accidents were investigated to learn lessons but there was a delay in actions being taken which increased the risk of incidents reoccurring. Managers were often needed to provide care meaning some managerial tasks were being overlooked.

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

Rating at last inspection
The last rating for this service was requires improvement (published 8 February 2019). This service has been rated requires improvement for the last two consecutive inspections. The provider was in breach of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We received concerns in relation to infection control and management of falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed to inadequate and is based on the findings at this inspection.

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 and good governance

Please see the action we have told the provider to take at the end of this report.

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
The overall rating for this service is 'Inadequate' and the service is therefore 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 of their 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.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always 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
There were two inspectors who carried out this inspection.

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.

The service did have a manager registered with the Care Quality Commission, however, they had resigned. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced.

We gave short notice of the inspection because the registered manager had recently left and so we could ensure we were aware of any COVID-19 related risks. Inspection activity started on 12 October 2020 and finished on 20 October 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person using the service and five relatives about their experience of the care provided. We spoke with 11 members of staff including the nominated individual, deputy manager, team leader, nurses, care workers, housekeepers, the maintenance man and the chef. 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 ten people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas and care 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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.
At our last inspection we found that risks had not always been assessed and medicines had not always been safely managed. This resulted in a breach of Regulation 12 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 12.

Using medicines safely
- Medicines were not managed or administered in a way that ensured people's safety.
- Medicines were not routinely counted to check people had the correct number of tablets in stock. There were discrepancies in the amount of medicines recorded in some people's Medicine Administration records and the physical stock of medicines in storage. This included medicines for people with Parkinson's and Epilepsy. This could mean people were not receiving their required amount of medicine.
- Storage temperatures for medicines were not being monitored. On the day of the inspection the storage room where medicines were being kept, exceeded the advised maximum temperature of 25 degrees. Staff had not been monitoring this for several months so were unable to determine if the temperature exceeded this on any other days. This could affect the effectiveness of the medicines.
- Prescribed creams had not been marked with an open date, this meant staff did not know how long the cream had been in use and it could have been in use beyond expiry date recommended. This meant people were at risk of having skin creams applied which were ineffective.
- Some protocols were not in place for PRN medicine. PRN medicine is prescribed for people as and when they require it. This meant, staff did not always have guidance to help them decide when to administer this type of medicine, risking inconsistent administration of these medicines.
- Where people were able to decide if they wanted their PRN medicine, staff asked them if they required it. People were given the time they needed to take their medicines safely.
- Records and staff interviews confirmed that competency assessments had not always been carried out annually in areas like medication administration. This meant areas of medication management which needed improvement would not be picked up in a timely manner and errors in medication management may go unnoticed.

Assessing risk, safety monitoring and management
- Risk had not always been appropriately assessed, monitored and acted on. For example, water in some bedrooms was too hot, and no action had been taken to assess the risk of hot water or reduce it. This placed people at risk of harm.
- The home environment was in a state of disrepair, in five areas we found flooring and wires were not

secure which posed a trip hazard and radiator thermostats were broken.
● Two people did not have access to their call bell because one was out of reach or another was broken. This meant people were at an increased risk of incidents or accidents resulting from poor maintenance.
● People had personal emergency evacuation plans in place but these did not reflect people's needs in relation to how to support the person to evacuate the building. This placed people at increased risk of not being evacuated from the building in a timely manner.
● Some people used air pressure mattresses to help prevent sore skin developing. The mattresses had adjustable settings which staff should check daily to ensure they were set according to the person's weight and record this in the person's daily monitoring records. However, the correct setting was not available for staff to see what the mattress should be set at and staff were not recording they had checked them. This meant some people had their mattress set incorrectly which put them at an increased risk of pressure sores developing.
●Some staff lacked knowledge around people's care needs. Records showed some tasks were not being completed as often as necessary. For example, one person's catheter required changing every three days, some staff were unaware of this and records showed it was not being done. This placed the person's health are risk.

The provider failed to ensure they provided safe care and treatment to all service users. This is a continued breach of regulation 12 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Incidents were not always reviewed and learnt from in a timely way. This led to a delay in changes being implemented increasing the risk of incidents happening again.
● Care plans were not always reviewed and updated following incidents. For example, following a fall, a person required a hoist and a sling to help them move safely. Their care plan had been reviewed but did not tell staff what size sling to use and how to fit it correctly. Staff had insufficient information to move the person safely which created a risk of an incident happening again.
● Recent safeguarding incidents had highlighted shortfalls in staff's knowledge around tissue viability care and moving and handling. The training matrix showed prior to the incidents occurring, some staff had not completed training in these areas or had their competency assessed. Staff did not have all the training the provider thought they needed to carry out their role.
● Where a risk of a person presenting behaviours that may challenge had been identified, no care plan was 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.
●Relatives said that staff knew people well. One relative said, "Yes, the fully employed staff, they understand my [relative] very much so."
● Staff knew how to identify and act on the signs and symptoms of abuse and where to go if they needed to report poor practice. One staff member told us "I can air concerns when I need to and am confident something will be done."

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 breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices had not always been followed.
● We looked at two staff files which lacked information on employment history, staff interviews and

inductions. A telephone reference had been accepted for one person without verification of the referee's identity. No risk assessment or additional monitoring of the persons performance was carried out.
● The provider could not assure us that staff had been recruited safely and completed all their induction.
●A dependency tool was used to record people's needs. One person's dependency assessment was inaccurate and underestimated the level of their needs. Due to a number of inaccurate records around people's care needs, we advised the provider to review people's dependency assessments to ensure sufficient staff were in place to meet their needs and staff had accurate information to refer to when providing care.
● We reviewed rotas to see how many staff had worked in the two weeks prior to our inspection. The rotas did not clearly show who had worked and how staffing levels had been maintained. We were informed staffing at night was three carers and two nurses. However, the rota does not show that staffing levels reflected this in practice.
●The home had advertised their vacancies and the provider said they tried to use the same agency staff where possible to cover shifts. However, this was having an impact on record keeping because agency staff did not know how to use their online recording system.
● The provider informed us carrying out managerial tasks was difficult due to the challenges of COVID and it's impact.
● Feedback from relatives acknowledged staffing changes but they were positive about staff's approach. One relative said, "They have had a lot of changes just recently, but prior to COVID, I knew them all really well. They are all very pleasant." The staff we spoke with said there were enough staff to meet people's needs and keep people safe.

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 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection
● We were not assured that the provider was monitoring the cleaning regime within the premises. We found bed rails, safety mats and commodes were soiled. Flooring and tables were worn in some areas making them difficult to clean. Cleaning schedules were in place but there were unexplained gaps where cleaning had not taken place. This placed people at risk of the spread of infection.
● Handwashing signs were missing in communal toilets and bathrooms, where they would have been beneficial to staff and people to prompt them to regularly wash their hands.
● Staff had access to the correct personal protective equipment [PPE] to protect themselves and others from cross contamination. We observed staff using the PPE safely when caring for people. One relative told us "[Staff] are in complete PPE and I can talk to [relative] through the window".
● Safe processes were in place for staff when leaving one area of the home and entering another. This helped to reduce the risk of the spread of infection.
● We were assured the provider was following the most recent government guidance around visiting arrangements and admitting people to the service safely.
● People were being supported to socially distance and access regular testing.
● We were assured that the provider's infection prevention and control policy was up to date.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. 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

- The registered manager had been absent for a few weeks prior to the inspection and the deputy manager was overseeing the service. The nominated individual had maintained contact by phone and worked remotely during the COVID-19 pandemic. The absence of a registered person to oversee the safe running of the home had led to many systems and processes not being followed and tasks not being completed or followed up.
- Audits were not always completed or, where they had, they had not identified risks and concerns. For example, call bell response times had not been reviewed as required. Some records showed call bells were ringing for over 30 minutes, but no audit had been completed to establish the reason for this.
- Where incidents and accidents had occurred, an analysis to help identify trends, patterns and causes had not been completed. The lack of audits and analysis meant, any underlying causes would remain unknown increasing the risk of issues being unresolved.
- Care records showed a lack of pressure relief care, catheter care and support for people with their fluids. Audits of these records had not been completed and discrepancies with the care provided had not been addressed with staff. The provider said this was a recording issue, however, a lack of effective good governance systems meant that people were at an increased risk of not having their care and treatment needs met.
- Testing to ensure the safety of electrical items had not been carried out when it was due in 2019. The provider ensured this was completed during the week following our inspection and no issues were found.
- Supervision of staff performance had not been carried out in line with company policy, some staff had worked several months without a supervision meeting. There had also been a lack of oversight of the management team monitoring the staffs' competence to carry out certain tasks.
- Staff were not always clear about what their responsibilities were and issues with staff performance were not addressed. This led to incomplete tasks and safety issues going unnoticed. For example, staff were not monitoring or recording the settings for people's pressure relieving mattresses, staff were also unaware how often one person's catheter required changing.

Working in partnership with others

- Some referrals to specialist services had not been made in a timely manner. On the day of the inspection we identified a SALT [Speech and language therapist] referral for a person was needed. However, when we checked if it had been completed nine days later, we found it had still not been made. This meant there was

a further delay in accessing specialist support for the person. This put the person at risk of not having their nutritional needs met.
● There were times when staff had not always followed health professional advice which could compromise people's safety. For example, one person was given less thickening agent in their fluids than advised by SALT because the person did not like the texture of their drinks. No further advice had been sought. This meant staff were not providing people with the support they needed in the safest way for them.
● Records did not support the monitoring of people's on-going health. One person's hospital discharge letter instructed staff to change a person's dressings daily. However, this could not be evidenced because staff had not recorded it. The provider assured us this care had been given but due to agency staff being unaware of their online recording system, some care had not been recorded.
The provider failed to ensure that their systems and processes to keep people safe was working effectively and could not assure the Commission they had good governance systems in place. This placed people at risk of harm This is a breach of regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

● Staff communicated with family and relatives and kept them informed of changes in people's health and well-being. One relative told us "If anything different happens they do inform us."
● Staff said they felt if they had concerns about people's health, they could raise them with nursing staff and appropriate action would be taken.
● Regular discussions were held with their local doctor's surgery to review people's health needs. This helped to ensure that any changes in health were referred to the appropriate service so they could be investigated further or treated in a timely manner.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were supported and empowered to use technology to keep in touch with people who were involved in their care. One relative told us "I have done phone calls. They are pretty good with WhatsApp, my [relative] needs assistance during a phone call. It takes a member of staff to support her."
● Staff felt positive about the service and referred to it as a 'home'. One staff member said, "I think it's a good place, it's like a family environment. I feel like staff do really care, we care about each other as well as the residents and we do the best that we can."
● Care staff said they felt able to speak up and were listened to by senior staff. One staff member said, "I feel more involved and get regular feedback on how I'm doing as well." This helped to create a positive environment for people living at the service.

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; Continuous learning and improving care
At our last inspection the provider had failed to notify us of incidents within the service. This was a breach of regulation 18 (Notifications of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Relatives told us they were informed when an incident or accident had occurred.
● When things had gone wrong, an investigation had taken place and people were kept informed of the outcome.
● The investigations carried out, looked to find the root cause of an incident and share the findings with the appropriate people and agencies.

● Information was shared with staff when something went wrong, this helped to create an open and honest culture amongst the staff.
● Additional training was completed following an accident, actions taken included staff competency assessments in moving and handling to reduce the risk of repeat events. However, care plans were not updated with the relevant information to tell staff what equipment they needed to use.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Feedback from people was not requested regularly enough to ensure issues or concerns were picked up and responded to quickly. Relatives were kept informed about individual issues and an online portal was used for people to leave comments. However, feedback to ask relatives how the service was performing was not requested. This meant there was a risk that potential issues would not be resolved and the opportunity to improve from feedback was lost.
● Relatives said they had been kept informed about visiting arrangements and changes at the service by phone and letter during the pandemic. They felt able to contact the service if they had a problem and were satisfied with the outcome. One relative told us "I have raised concerns and they have always been taken seriously."
● Due to the COVID-19 pandemic, government guidance had been followed. For example, visiting had been staggered and prioritised depending on people's circumstances.
● Staff said they felt involved and their ideas were listened to. Some staff had attended weekly governance meetings. This gave staff from each department across the home, the opportunity to share important information about changes in people's needs or changes in government guidance.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure they provided safe care and treatment to all service users. This is a continued breach of regulation 12 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent the risk of abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were an insufficient number of staff with the appropriate training, supervision, knowledge and skills to carry out the necessary duties

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems or processes were not effective in assessing, monitoring and improving the quality and safety of the service. Risks relating to the health, safety and welfare of service users were not mitigated and accurate and complete records of the care and treatment provided to each service user were not consistently kept.

The enforcement action we took:

We issued a warning notice for this regulation