Wellington Healthcare (Arden) Ltd

Millvina House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Millvina House is residential care home providing nursing and personal care to 52 people at the time of the inspection. The service is registered to support up to 60 people in one building, located over three floors.

People's experience of using this service and what we found
There were significant concerns with the management of people's health risks. People with diabetes did not always have their health condition well managed which put them at an increased risk of harm. The provider took action during the inspection to ensure there was appropriate clinical oversight of these concerns and reduced the risk to people.

Medicines were not always managed safely. People's prescribed medicines were not always available to be administered and medicines records were not always completed accurately.

There were not always enough staff to meet people's needs. Systems to determine safe staffing levels were not completed consistently and not always accurate. The provider responded to our concerns during the inspection and employed extra day and night care staff to support safe staffing levels. However, on day three of the inspection we again raised concerns about staffing levels on one of the units.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. One person had been subject to the use of restraint without the proper legal authority to deprive them of their liberty. Staff had been completing this practice without the knowledge of managers. This practice was not care planned to ensure it was in the persons best interests and safe to ensure the person was not subject to avoidable harm. The provider stopped this practice immediately once we raised the concern.

Accidents and incidents were recorded, although this was inconsistent and did not always show appropriate action had been taken. Safeguarding referrals had not always been made when needed after incidents occurred. Analysis of incidents was not robust enough to ensure learning could be implemented at the earliest opportunity to prevent reoccurrence.

People's nutritional and hydration needs were not always recorded appropriately in their plans of care and food charts did not always evidence people had received an appropriate diet. However, staff were aware of people's individual needs regarding this and we were assured people were receiving diets appropriate for them.

There was ineffective oversight of staff training. Not all staff had completed training deemed mandatory by the provider. There was a system in place to monitor training, but this was not effective.

There was a lack of leadership, oversight and governance in the home. Audits were not completed consistently, and when they had been completed, they did not always identify the issues we found at this inspection, such as with medicines and care plans. The manager made the decision to leave their role during the inspection. The provider employed a new manager after the inspection.

Relatives were mostly happy with the care their loved ones received. However, some felt there was a lack of communication with the manager at the home.

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

Rating at last inspection
This service was registered with us on 01/04/2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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 COVID-19 and other infection outbreaks effectively.

We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services across Merseyside. To understand the experience of social care Providers and people who use social care services, we asked a range of questions in relation to accessing urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

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 the assessment, management and mitigation of risk, staffing, safeguarding processes and governance and oversight of the service.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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.

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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Millvina House

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
On day one the inspection was carried out by two inspectors and a medicines inspector. On the second day it was carried out by two inspectors and a medicines inspector. The third day was carried out by an inspector and a medicines inspector.

An Expert by Experience made phone calls on day one. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Millvina House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Millvina House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since their registration. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 relatives about their experience of the care provided. We spoke with 10 members of staff including the manager, nurses, senior care workers, care workers 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 10 people's care records, and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. 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.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were exposed to serious risk of harm due to a lack of person-centred risk assessment. Risk assessments were not always accurate or reflective of people's current needs or detailed enough to guide staff on safely supporting people.
- Risks regarding the management of diabetes were poorly managed. People were exposed to a significant risk of avoidable harm as their health needs were not assessed adequately or managed safely. Blood glucose monitoring was not completed regularly to ensure people were safe. Where elevated blood glucose levels had been identified appropriate action was not always taken to ensure they were protected from harm.
- People were not always supported to access appropriate healthcare advice when concerns with their health were noted. One person had elevated blood glucose levels for over a month, but no referrals had been made to the diabetic team for a review.
- Hazardous substances were not always stored securely. We found multiple rooms containing substances hazardous to health accessible to people living at the home.
- Incidents and accidents were recorded, although we found gaps in the recording of these. The manager told us staff recorded incidents in multiple places and did not always follow the providers policy on incident recording. It was not always clear what action had been taken to manage the risks to people after incidents occurred.
- Analysis of incidents was not completed which meant opportunities for learning and reducing the risk of recurrence were missed.

The provider had failed to robustly assess risks relating to health, safety and welfare of people. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to reduce the risk of harm to people. All doors were fitted with a secure lock where needed, care plans were updated and people were referred to healthcare specialists for a review of their needs.

Using medicines safely

- Medicines Administration Records (MAR) were not always completed fully so we could not be sure medicines had been given.
- Medicines were not always administered as prescribed. One person was prescribed a high dose of antibiotics to treat an infection. The incorrect dose was administered for six days.
- There was not always a sufficient supply of medicines available. One person prescribed a medicine to

treat diabetes did not have this medicine available during the inspection. It was also noted the home had only received enough medicine to administer 15 doses of the medication to the person, but 20 had been recorded as being administered. Records were not clear enough to establish how this error had happened.

Medicines were not managed safely which placed people at 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.

During the course of the inspection the provider mitigated some of the risk by providing additional clinical support to oversee medicines management.

Systems and processes to safeguard people from the risk of abuse
● Staff were not always following local safeguarding procedures. Not all incidents had been referred to the local safeguarding team when needed.
● Some staff had been using a form of restraint on one person. This had not been care planned or followed any appropriate processes to ensure it was safe, proportionate and that the persons human rights were upheld. The manager and regional manager told us they were not aware this practice was taking place. This practice was immediately stopped once we raised the concern to the nominated individual.

The provider had failed to ensure appropriate processes were followed to prevent the abuse and improper treatment of people. 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.

● Relatives told us they felt their loved ones were safe at the home. Comments included, "I'd say it's safe. I can feel they [people] are really loved."

Staffing and recruitment
● There were not enough suitably qualified staff to support people. We raised this concern during the first day of inspection and the provider responded by adding one additional care staff of a day and one of a night. However, we raised further concerns regarding staffing levels for a different unit during day three of the inspection.
● Staff told us staffing levels were unsafe. One staff member said, "Staffing levels are too low. People are at risk."
● Staff administering medicines were interrupted multiple times as there were not enough staff to support with tasks. During the course of the inspection, we saw a senior care worker have to stop medicines to support someone in distress and to support someone who was at risk of falling.
● The dependency tool used to support the calculation of safe staffing levels was not completed accurately or updated when people's needs changed.

There were not enough suitably qualified, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment procedures were safe. Pre-employment checks were completed on all staff before they started employment.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We observed friends and relatives visiting their loved ones during the inspection. Relatives told us that there were no restrictions on visiting and described how this was done safely by completing COVID-19 lateral flow tests prior to the visit and the use of PPE during the visit.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Consent to care and treatment was mostly gained in line with the principles of the MCA. However, one person subject to the use of restraint had not had processes followed to ensure this was lawful under the MCA. This is reported on further in the safe domain.
- DoLS were applied for appropriately to keep people safe from harm.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;
- Referrals to appropriate healthcare professionals were not always made in a timely way.
- Oral health risk assessments were completed, but care plans were not always in place or detailed enough to ensure people's oral health needs could be met.

Supporting people to eat and drink enough to maintain a balanced diet
- Nutrition and hydration support needs were assessed. However, it was not always clear from the records if people received the required level of support.
- People's care records did not always contain relevant or up to date nutrition and hydration information and areas of risk were not always monitored. For example, one person was to be supported with thickened

fluids due to swallowing difficulties, but the care plan stated the incorrect information regarding the level of thickener required. We checked the persons drinks and found they were thickened to the correct level.

Staff support: induction, training, skills and experience
● Training records showed not all staff had completed training deemed mandatory by the provider. However, staff told us they received appropriate training and felt competent in their roles. The regional manager was addressing training issues during the inspection.
● Some staff told us they did not always complete an appropriate induction. There were not always records to show how staff had been inducted to the home.
● Some staff told us there was minimal support from the provider and manager. Supervision records showed not all staff had received appropriate supervision. However, staff did tell us they were able to raise concerns to the manager.
● Our conversations with staff demonstrated they were skilled and knew people well.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's care needs had not always been completed in detail. Some care plans lacked detail around specific needs and did not always reflect information in other records. This meant people were at risk of not having their needs safely and effectively met. During the inspection the provider was reviewing and updating care plans.

Adapting service, design, decoration to meet people's needs
● The home was purpose built and nicely decorated and well maintained.
● Some equipment was in use to support people to move around the home independently, for example zimmer frames.
● There was directional signage in place to support people living with dementia to move safely and as freely as possible in the home.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Care delivered to people was mostly task focussed. Some staff told us they were short staffed, and this impacted on the support they could offer people. One staff member told us they did not always get to support people with their planned repositioning needs due to being short staffed. Records also showed gaps in repositioning.
- Where people expressed distressed behaviours there were sometimes a lack of management plans to guide staff in supporting people in a dignified and respectful manner.
- Staff were kind in their response to people and their approach was observed to be patient.
- We spoke with people's relatives who told us they thought the service was caring and focused on people. Comments included, "Yes, they [staff] are absolutely kind and caring. Some communication is not great. If [person] is agitated they phone the family."

Respecting and promoting people's privacy, dignity and independence

- Some relatives told us their loved one's personal possessions had not always been looked after or respected which had resulted in items going missing.
- People's privacy and dignity was promoted and respected.
- We observed staff were speaking to people kindly, knocking on doors, and asking them if they needed help throughout the duration of our inspection.

Supporting people to express their views and be involved in making decisions about their care

- People were not always supported to express their views and be involved in decision making regarding their care.
- Staff did encourage people to express day to day wishes, such as which food they wanted to eat.
- Most relatives told us they had been involved in care planning in some way.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences.
- Care plans improved throughout the duration of our inspection. However, we were initially concerned due to the lack of information about people with high risk nursing needs.
- Some care plans lacked person specific information. One person's care plan stated they could become distressed and staff were to reassure the person in these instances. There was no mention of how to reassure this person.
- Care plans were regularly reviewed. However, they had not always been updated in a timely way to reflect people's changing needs.

The provider failed to ensure records regarding people's assessed needs were accurate and well maintained. This is a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were identified in support plans, however, there was limited information to guide staff on how to support people.

Improving care quality in response to complaints or concerns

- A complaints system was in place and displayed in the service. Complaints had not always been responded to appropriately. The provider was aware of issues with complaints being responded to and was taking action.
- Relatives told us they would feel comfortable raising a concern but told us their concerns had not always been taken seriously.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- An activities programme was in place and there were dedicated staff to provide social activity for people.

However, at times we observed people sat for lengthy periods of time with very little interaction. Staff did their best to engage people with singing or watching films.

● Relatives told us people were able to use the garden and there were some activities at times. For example, relatives told us there had been an Easter egg hunt which people enjoyed.

● Relatives told us they were happy with the care their family members received and they were kept up to date about important changes in people's physical health.

End of life care and support

● Care files contained information regarding advanced care planning. These plans were reviewed and discussed with relatives when appropriate.

● People had been able to remain at the service for the end of their lives and staff had supported them according to their expressed wishes.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- Gaps in governance and quality assurance measures meant people were exposed to unnecessary risk and avoidable harm. Risks relating to the health and well-being of the people living at the home were not always effectively assessed, monitored or mitigated. The provider was aware of some of these issues and was taking steps to address these.
- Processes to determine the deployment of staff were ineffective. People's assessment of dependency was often out of date and inaccurate and calculation of people's needs had not always taken place to ensure staffing levels were safe.
- There was a lack of understanding about roles and responsibilities across all staff levels.
- Records to document the care people had received were not always well-maintained.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- Systems and processes to assess and monitor the safety and quality of the service were ineffective. Not all the concerns found at this inspection had been identified by the managers or provider's monitoring processes.

The provider had failed to effectively assess, monitor and improve the quality and safety of the service provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager was aware of what events they needed to notify CQC about. They had submitted notifications in line with legal requirements.

Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Referrals to other healthcare professionals were not always made in a timely way to ensure the best support for people.
- Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.
- Staff told us there was inconsistent support from management. Some felt the manager was supportive, but others felt concerns raised were not dealt with. Staff told us they felt the provider had failed to communicate effectively with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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

● Staff told us there was poor engagement from the provider. One staff member commented, "It's poor communication with the provider. We have no meetings. They just leave us to get on with it with no support."

● There were systems in place to gather feedback from people and their relatives. However, relatives told us they did not always receive a response to feedback and they felt feedback was "brushed under the carpet".

● Managers and staff understood their legal responsibility to be open and honest with people.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not always followed. One person wa subject to restraint without proper processes to ensure this was safe.

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 not always appropriate numbers of staff to ensure people were safe.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to peoples health and welfare were not being managed safely. people were placed at increased risk of harm. Medicines were not always managed safely.

The enforcement action we took:

warning notice

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	Governance processes were not effective to ensure the safe running of the service.

The enforcement action we took:

warning notice