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

Summary of findings

Overall summary

About the service
Millvina House is a residential care home providing nursing and personal care to 42 people at the time of the inspection. The service is registered to support up to 60 people in 1 building, located over 3 floors.

People's experience of using this service and what we found
There were some significant concerns with the management of people's health risks. Diabetes management had improved since the last inspection however, some people with diabetes did not always have enough information recorded in their care plans to ensure their condition was being managed safely. This put them at an increased risk of harm.

Medicines were not always managed safely. Some people were not being prescribed paracetamol safely, and some prescribed medicines were not always available to be administered.

Systems to determine safe staffing levels were in place, however the calculations for November were inaccurate. The provider responded to our concerns during the inspection and amended this system. However, staff told us, and our observations showed, there were not always enough staff on duty to meet people's needs.

Accidents and incidents were recorded. However, not enough mitigation had been taken and we were concerned for people on 1 to 1 care who had sustained previous injuries due to being left alone for periods of time. Safeguarding referrals had been made when needed after incidents occurred.

Although care plans were personalised, there were gaps in monitoring records, such as repositioning charts, so we could not always be sure people were getting the correct care in accordance with their assessed needs.

Leadership, governance and oversight in the home required further improvement and systems were not yet imbedded to ensure effective auditing processes. Audits were being completed however, they did not always identify the issues we found at this inspection, such as with medicines and risks assessments and records. There was no registered manager in post at the time of our inspection. The provider employed a new manager after the inspection.

Relatives were mostly happy with the care their loved ones received. However, some felt staffing needed to be improved.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 inadequate– (published 1 July 2022).

Why we inspected
We carried out an unannounced inspection of this service between 31 March and 25 April 2022. Breaches of legal requirements were found. We issued two Warning Notices in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider completed an action plan to show what they would do and by when to improve staffing levels and safeguarding procedures.

We undertook this inspection to check whether the Warning Notices we previously served had been met. We also needed to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive 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 COVID-19 and other infection outbreaks effectively.

For the key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Millvina House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the assessment, management and mitigation of risk, staffing, and governance of the service.

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 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
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 1 the inspection was carried out by 3 inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day it was carried out by 3 inspectors and an interim inspection manager who supported the inspection remotely. The third day was carried out by an inspector who looked at records off site remotely.

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 last inspection. 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 had completed 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 5 relatives about their experience of the care provided. We spoke with 7 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 14 people's care records, and multiple medication records. We looked at 4 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.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained the same. 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

At our last inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because they had failed to robustly assess and identify risks, placing people at risk of harm.

Whilst we acknowledge that some information contained within risk assessments was more in-depth and informative at this inspection, we still found people were as risk of unsafe care. Therefore, the provider remained in breach of regulation 12.

- Not all risk assessments contained enough information or mitigation to help keep people safe.
- People with diabetes who required insulin were not always getting the correct level of support from staff. For example, care notes for 1 person indicated they were not having their blood sugar levels checked at the correct times. Another person had conflicting remedial action for staff to follow if their blood sugar levels were above their target. This meant we could not always be sure they were being supported safely.
- People were at risk from weight loss. Risk assessments and care plan reviews for 2 people had not identified changes in their weight, therefore no additional mitigation was put in place to prevent further weight loss. One person who required weekly weight checks had a gap of 6 weeks before they were weighed again. This put them at risk of malnutrition. Another person had only consumed their target fluid level twice in 11 days. This placed them at risk of dehydration. Their risk assessment review had not been updated to reflect this.
- Records did not show that people were not getting the regular pressure relief they required. One person was assessed as requiring pressure relief every 2- to hours. Records suggested they had not been repositioned for 8 hours on 1 occasion, leaving them at risk of further pressure area breakdown. Staff told us they did not always have time to reposition people in line with their care plans.
- People who were assessed as requiring 1 to 1 care were not always getting this. This left them exposed to avoidable harm. On day 1 of our inspection we observed 3 people who spent time alone while their 1 to 1 staff were engaged in other tasks.
- Risk analysis was being completed. However, it did not always have sufficient remedial action. For example, a recent incident had occurred where someone had come to harm while they were with their 1 to 1 staff member. One of the actions when this had been analysed was to never leave the person alone. We observed the person alone numerous times on day 1 of our inspection. This meant learning opportunities, despite being highlighted, were not being implemented effectively.

The provider had failed to implement effective risk assessments and learning opportunities. This placed

people at risk of avoidable 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.

The provider responded immediately and after our inspection to ensure areas of risk we highlighted were mitigated. However, we are not assured at this time that risks to people will be consistently and effectively assessed and mitigated as the provider had not identified these concerns themselves.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement regarding the management of medicines and was still in breach of this regulation.

● The provider had introduced an electronic Medicines Administration Record (eMAR) system, which we identified some concerns with. We found 5 people who did not have all of their medicines copied onto the eMAR from the paper MAR. This resulted in them missing some of their medicines. In addition, doses of insulin were not always written on the eMAR. This meant there was an increased risk of drug errors.
● We found 5 people had not been given some of their medicines as they were out of stock.
● Medicines were not always given as prescribed. We found 5 people had either missed or been given the incorrect doses for some of their medicines.
● We found 7 people had been given some of their paracetamol doses without leaving a four-hour gap, which is not safe.
● Medicines were mostly stored securely in locked treatment rooms. However, we did observe open tubs of thickener stored unsafely in cupboards and within reach of people.

We found medicines were not managed safely across the home. This was a continued breach of regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We escalated our concerns to the provider and they responded the next day to ensure risks were mitigated and it was now safer for people using the new eMAR system. However, we are not assured at this time that medicines will be consistently and effectively managed as the provider had not identified all of the medicines concerns we identified at the time of our inspection.

Staffing and recruitment

At our last inspection, 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. We found during this inspection not enough improvement had been made and the provider remained in breach of this regulation.

● Staff we spoke with during our inspection told us there was not enough staff. One staff member said, "There is not enough staff, staff struggle, they are overworked, people are not getting pressure care.". Another staff member said, "There are not enough staff, people aren't getting 100% care they need." We spoke to relatives who told us medication was delayed due to their not being enough staff to get the prescription.
● Rotas were completed using a dependency tool and a formula which calculated how many staff were needed. When we checked this on day 1, we found the formula was not working. We escalated this to the

interim home manager. They rectified this immediately, however 1 staff member told us the dependency does not always take into account everything the staff have to do for people.
● On day 1 of our inspection we observed staff leaving people in lounges for long periods of time unassisted, and call bells which rang for more than 5 minutes before staff attended to help people.

These examples demonstrate a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited and selected following a robust recruitment process. New staff were subject to checks on their character and Disclosure and Barring (DBS) checks. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

During our last inspection the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure appropriate processes were followed to prevent the abuse and improper treatment of people.

At this inspection, the provider had made enough improvement and was no longer in breach of regulation.

● People told us they felt safe at the home. Comments included: "Yes I feel safe here, they are all ok, you can have a laugh" and "I love it here. I would never leave." A relative told us, "Yes I feel that dad is very safe here."
● Staff were aware of safeguarding processes and how to escalate concerns regarding abuse.
● Where required, safeguarding referrals had mostly been made in timely way. We did highlight 1 exception during our inspection, however this was dealt with straight away.

Preventing and controlling infection
● Infection prevention and control procedures were mostly effectively managed.
● Some staff were not wearing face masks on day 1 of our inspection. This had not been risk assessed in line with guidance. When we retuned for day 2, this had improved.
● The home was mostly visibly clean. However we did observe some unclean areas, which we checked again on day 2 and found they were now clean.
●The provider was safely facilitating visiting for people and there were no restrictions on visiting.
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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● Where required, people had DoLS assessments in place, and had undergone a best interest process for more important decisions and choices.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection, the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure records regarding people's assessed needs were accurate and well maintained.

At this inspection the provider had made some improvements with regards to people's care plans, which were mostly detailed and informative, however there was still some improvement needed with regards to some record keeping.

- The quality and content of the care plans we viewed at this inspection with regards to people with high nursing needs had improved, and there was detailed person-centred information about each person recorded in their care plans. However, more robust scrutiny was required to ensure all records were completed accurately to make sure people were having their assessed needs met.
- Despite most of the care plans being regularly reviewed in line with the providers quality assurance processes, they still had not always been updated in a timely way to reflect people's changing needs. For example, 1 person had lost a lot of weight recently, however, the last 3 reviews on their care plan stated they 'continued to gain weight.' This meant information did not reflect the person's current needs.
- Repositioning charts, food charts and blood monitoring information were not always documented in people's records correctly and in line with people's assessed needs.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's preferred methods of communication were clearly recorded in their care plans.
- Information could be made available in different formats to help support people's understanding, such as large print.

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

- There was a timetable of activities available for people at Millvina to partake in if they wished.

● People's families could visit them when they wanted to.
● Our observations showed however, that staff did not have time to sit and chat with people, and people mostly sat on their own in the lounges or their bedrooms. For example, when we observed lunchtime, it was rushed, and people were not engaged in conversation with staff. Staff completed task led duties, such as helping people to eat, but there was no relaxed atmosphere.

Improving care quality in response to complaints or concerns
● A complaints system was in place and displayed in the service.
● Some people told us they felt the managers did not always listen to them.

End of life care and support
● Care files contained information regarding advanced care planning. These plans were reviewed and discussed with relatives when appropriate and updated when needed.
● People had been able to remain at the service for the end of their lives and staff had supported them to exercise this choice.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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

At our last inspection the provider had failed to effectively assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, not enough improvement had been made and the provider was still in breach of this regulation.

● Systems and documentation to assess and monitor the safety and quality of the service had improved since our last inspection. However, they still required further time and improvement for their effectiveness to be embedded in the service. This was because not all the concerns found at this inspection had been identified by the managers or provider's monitoring processes.
● Despite some risk analysis being completed, the necessary steps to ensure people were safe were not always being taken. For example, on day 1, we observed people who required 1 to 1 care being left on their own for periods of time, even though they had already previously had falls or injuries.
● Information in people's care plans, monitoring charts and daily notes were not always being checked to ensure people were getting the correct care and support which met their needs. For example, an audit had identified some changes needed to 1 person's care plan, however the care plan had been reviewed without the information being added. There were also numerous gaps in peoples reposition charts which had not been highlighted through audits.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 home did not have a registered manager when we inspected. We have since been updated that a manager is starting and will be registering with CQC.
● People did not always achieve good outcomes due to the shortfalls we found in relation to the safety of people at the home. We did however see some improvement in relation to the personalisation of care plans.

● The provider was responsive between day 1 and 2 of the inspection in terms of gathering information for CQC to provide assurances around some of risks to peoples health and well-being.
● The provider had notified CQC of reportable occurrences by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics ; Working in partnership with others
● Referrals were made to other agencies when needed, such as diabetic specialists. However, people's care plans and risk assessments were not always updated with the advice received.
● Staff told us they felt management did not always listen when they raised concerns around staffing. The staff we spoke with told us they felt there was a 'blame' culture in the home.
● Team meetings took place, and minutes were available for us to view.