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Mill House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Mill House is a residential care home providing personal and nursing care to up to 24 people in one adapted building. The service provides support to older people some of who are living with dementia. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found
Risks to people were not safely managed. Risks had not always been assessed or monitored and staff were not consistently provided with guidance to reduce those risks.

People were not receiving safe care. Staff did not have sufficient information to be able to ensure they understood how to manage risks to people from distress and anxiety, falls, pressure injuries and specific health conditions.

Incidents of potential abuse were not investigated and reported to the appropriate body for investigation. Where potential abuse had been identified by staff this had not been acted upon to ensure people were safeguarded from the risk of harm.

There was insufficient staff to ensure people had their needs met when they required support. We saw people were left unsupervised when they should have monitored continually by staff to keep them safe.

The service was not in good repair and there were concerns with infection control measures in place. People's medicines administration was not consistently documented.

When incidents and accidents occurred staff were recording these but there were no actions taken to review these and prevent reoccurrence.

People were not supported to have maximum choice and control of their lives and staff did not 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.

People were supported to access health professional visits however where guidance was given to support people with their health needs this was not always clearly documented within people's care plans.

People did not consistently have their needs assessed and care plans put in place to meet their needs.

Staff training was not consistently up to date and there was inconsistent evidence of checks on staff competency.

There was limited management oversight in the service and quality and safety systems were not robust.

Issues were not always identified in a timely manner which meant actions were not taken leaving people at risk of harm.

Governance systems in place to manage the service had not identified all the concerns we found during the inspection. CQC had not been notified of significant events as required.

People received enough to eat and drink and told us they enjoyed the food. Recruitment processes were safe to ensure only suitable people were employed.

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 February 2022)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to medicines, infection control and staffing. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, protecting people from abuse, consenting to care, staffing and governance at the home 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mill 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 Health and Social Care Act 2008.

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 two inspectors.

Service and service type
Mill 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. Mill House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been appointed and had submitted an application to register.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 1 relative about their experience of the care provided. We spent time in the communal areas observing the support people received. We also spoke with the provider, acting manager, and 4 staff. We looked at the care records for 16 people and multiple medication. We looked at records relating to the management of the service, including policies and audits carried out within the home.

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 requires improvement. At this inspection the rating has changed to 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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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

- Risks to people were not always assessed and mitigated effectively. Where people had risks identified on admission there was no risk assessment and management plan put in place to manage these risks. For example, where people expressed distress or agitation creating risks to themselves and others, there was no guidance for staff on how to support people and minimise the risks. This meant people were left at risk of harm, or harming others.
- Where people were at risk of developing pressure injuries or already had moisture lesions there was no assessment of the risks for people and no management plan in place. Staff had no guidance on how to support people safely. This meant people were left at risk of harm from pressure injuries associated with their skin integrity risks.
- There were no reviews of people's risk assessments and management plans when incidents and accidents happened. There were no actions taken to prevent similar occurrences. For example, where people had falls, these were repeated and there was no review of people's risk assessment or preventative actions taken. This meant people were left at risk of harm from falls.
- People who had plans put in place by a health professional to manage risks to their health did not have the plans followed by staff. For example, where people were on restricted fluids, they were having more than the restricted amount on a regular basis. There was no monitoring system and therefore no action taken to prevent this from reoccurring. This meant people were left at risk of their health deteriorating.
- People were at risk of harm from poorly maintained environments and equipment. Window restrictors were not operating effectively, maintenance of beds hoists, slings and electrical equipment had not been completed when this was due. The lack of oversight and maintenance of equipment and premises left people at risk of harm.
- The provider was not promoting safety through the layout and hygiene practices of the premises. We saw equipment which was not in a good state of repair and paint in the home was chipped. This meant surfaces would not be easily cleaned and could pose risks to people from cross infection.

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of

people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had taken action to mitigate the immediate risks to people living at the service.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from potential abuse. Injuries to people such as bruising, grazes and lumps had been identified by staff and documented in body maps by staff. There was no oversight of these incidents and none of them had been investigated or reported to another body. This meant people were left at risk of harm from potential abuse.
- Where people had been subject to physical abuse from other people living at the home this had been documented but not reported to the appropriate body for investigation and action. This meant people were left at risk of harm.
- Staff had received safeguarding training. However, there was no evidence staff were competent in following safeguarding procedures to safeguard people who had been potentially subjected to abuse.
- There was no oversight system in place to review incidents and ensure they were investigated by an appropriate body to protect people from harm.

Systems in place had failed to ensure people were protected from abuse and neglect leaving people at risk. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

- People were not consistently supported by enough staff. We saw periods where people were left in communal lounges without staff present and no access to call for help from staff if they needed it.
- When buzzers were activated, staff had to leave people who were in receipt of personal care to answer the buzzer. This meant people did not consistently have their needs met at the time they needed it.
- The manager was using a dependency tool to determine how many staff should be in place to support people based on their needs. However, this had pages missing and had not been used effectively. This meant there may not be enough staff to meet people's needs.

Using medicines safely

- Medicines were not always stored safely. Medicines needs to be stored at the correct temperature, checks were not in place to ensure the temperature of the medicines room and fridge were correct. People may not have had medicines which had not been stored at the correct temperature administered. This meant people were at risk of having medicines which were not effective.
- Medicines administration records were not consistently completed. We saw some signatures were missed by staff. We established from checks on the medicines stock people had received their medicines.
- People who had 'as required' medicines prescribed had guidance in place to show staff when this should be administered.

Preventing and controlling infection

- We were not fully assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were not fully assured that the provider's infection prevention and control policy was up to date
- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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 responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
People were able to receive visitors freely to the home.

Inadequate

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's rights were not consistently protected in line with the MCA. Where people had impairments which indicated they may lack capacity to consent to their care there were no MCA assessments in place or information about how decisions had been made in people's best interests.
- Where people had restrictions in place such as bed rails there had been no assessment of their capacity to consent to these and no decisions made in their best interest. This meant people had restrictions in place which may not be in their best interests.
- The manager had not assessed people's capacity to consent to their care and there were no applications made to the authorising body when people were having their liberty restricted. For example, with the use closed-circuit television (CCTV). This meant people were subject to restrictions which had not been lawfully authorised.

Systems had not been established to ensure all the requirements of the MCA were met which placed people at risk of not having their rights protected. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not consistently have their needs and choices assessed. Where people had come into the

home for a short stay period, we found there was no care plan in place to guide staff on how to meet their needs. This meant people were at risk of not having their needs and choices met.
● Assessments and care plans were not reviewed when people's needs changed. This meant we could not be sure people were having the care they needed.

Staff support: induction, training, skills and experience
● Staff received an induction and training, however there were no checks on staff competency to ensure they understood how to apply the training. This meant people were at risk of not having their needs met effectively.
● Where staff had received medicines training there was no checks on whether staff were competent in administering medicines to people. This meant people were left at risk of not having their medicines administered effectively.
● Staff had received safeguarding training; however, we found the policies and procedures to safeguard abuse were not followed. This meant where incidents occurred the policies and procedures were not followed to safeguard people.
● Manual handling training had been delivered to staff, however we found staff were not following peoples care plans when equipment was used. This meant people were at risk of harm from unsafe practice.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not consistently supported to follow advice on their fluid intake. Where people had been advised to restrict fluid by a health professional this was not followed by staff consistently.
● People told us they enjoyed their meals and had access to a choice of food and drinks, our observations supported this.

Staff working with other agencies to provide consistent, effective, timely care
● Staff did not have accurate guidance on how to meet people's care. This meant people were at risk of receiving inconsistent care and support.
● People did not always receive timely care as staff were not always available to support them when they needed it.

Adapting service, design, decoration to meet people's needs
● The building required internal repair and redecoration. The communal areas had poorly decorated rooms which left people at risk of cross infection.
● There were adaptations in place for people's physical needs such has handrails, however there were no adaptations in place to support people living with dementia at the home. This meant people living with dementia did not have access to an environment designed to meet their specific needs.

Supporting people to live healthier lives, access healthcare services and support
● People did not consistently have access to healthcare services and support to help meet their needs. This meant staff did not always have information and guidance to support people with their specific needs.
●Where people were anxious and distressed which resulted in them placing themselves and others at risk of harm there had been no referral to appropriate health care professionals for advice and support.
●Where people had fallen there was no referral to local falls prevention specialists to help prevent future falls. This meant people were left at risk of harm.

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 requires improvement. At this inspection the rating has changed 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; Continuous learning and improving care; Working in partnership with others

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 17 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

- There was a lack of oversight of the quality of care provided. The systems in place to identify and address areas of concern with the service were either not in place or not effective in driving improvements. The provider had not identified the concerns we found at this inspection which left people at risk of harm.
- There was no system in place to ensure accurate assessment of risks for people in the home. This meant some people did not have their risks assessed and plans put in place to meet them, others did not have these updated when incidents occurred. This left people at risk of harm.
- Oversight systems had failed to ensure the principles of the MCA were followed. This meant people were left at risk of being unlawfully deprived of their liberty and decisions taken which may not be in their best interests.
- The system to assess how many staff were needed was not effectively used. This meant people were not consistently supported by enough staff.
- There was no oversight of accidents and incidents which occurred in the home. There were no systems to learn when things went wrong. People were having reoccurring incidents and accidents and were exposed to continued harm.
- Checks were not in place to ensure the premises and equipment were maintained. This meant people were using equipment which may be ineffective or unsafe and they were exposed to the risk of harm. For example, window restrictors were not fitted correctly, and electrical equipment had not been tested and maintained.
- There was a lack of engagement with other agencies. We found people had not been referred to other bodies when their health needs required it. For example, where people had anxiety and distress which placed them and others at risk of harm.
- The systems in place to ensure staff were suitably skilled had failed to ensure staff competency was checked following training. This meant staff were not consistently following procedures with manual handling, safeguarding and medicines administration.

● The system in place to ensure people were safeguarded from abuse had failed to ensure incidents were reported to the appropriate body. Incidents were happening and being reported by staff, but these were not escalated for investigation. This meant people were left at risk of experiencing abuse.

Systems had not been established to identify areas for improvement and take action to keep people safe placing people at risk of continued harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had addressed the immediate concerns and put oversight systems in place to monitor the service.

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

● People were not supported in a person-centred way. Staff were not given guidance on how to support people effectively in their care plans and in some cases care plans were not provided for staff. This meant people were not receiving person-centred care.
●People's views were sought about the service, using surveys. However, there were no actions taken to address the issues which were identified, and no analysis completed to drive change.
● Care plans lacked details about peoples protected characteristics which meant people may not be receiving care which met their needs and preferences.

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 was not consistently informing relevant people when things went wrong or there were incidents.
● There was no oversight system to ensure relevant agencies were informed when people sustained injuries.

● Notifications were not always submitted as required by the CQC.