Millfield Lodge Care Home Limited

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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

We carried out this unannounced inspection of Millfield Lodge Care Home Limited on 4 July and 1 and 9 August 2017.

At the previous inspection on 12 and 20 April 2017 the service was rated as 'Requires Improvement'. We found four breaches of legal requirements. These were in relation to the safeguarding of people, people's care records, the governance of the service and incidents, such as serious injuries, not being reported to us.

As a result of our concerns we imposed additional conditions on the provider's registration. We required the service to not admit any more people without our written permission. We also required information to be sent to us on a monthly basis to show us how the service was assessing and monitoring the safety and quality of the service being provided to people.

After this inspection we received further concerns about the service and we undertook this inspection. This report only covers our findings in relation to the concerns reported to us, to those requirements and the enforcement actions we took.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Millfield Lodge Care Home Limited on our website at www.cqc.org.uk.

Millfield Lodge Care Home Limited is registered to provide accommodation and nursing care for up to 31 people. At the time of our inspection there were 16 people living at the service on the 4 July 2017 and 11 people on 1 and 9 August 2017. The service is a single storey premises located on the outskirts of Gamlingay with accessible garden areas. The service has communal lounges and dining areas. All bedrooms are single rooms with an en-suite toilet and washbasin facilities in 27 of these.

A registered manager was not currently in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The management of the service was being overseen by a nursing management agency. They were assisting with the day to day running of this service. However, on 8 August 2017, they informed us that they were withdrawing their services due to the registered provider not being willing to support the actions needed to make the required improvements. People were not always safely supported with the management, administration and recording of their prescribed medicines. The premises were not safe and actions previously identified and made known to the registered provider had not been acted upon.

Where people had been identified as being at risk, assessments such as those for skin integrity had been completed. However, where these risks had been identified, the registered provider was not supporting

people in a safe way or adhering to health care professionals' advice and guidance. This put people at serious risk of harm.

There were no systems or processes to ensure that the service provided was safe, or well led. The registered provider was unable to demonstrate the skills, knowledge or ability to make the urgent changes that were required to make the service safe.

A sufficient number of staff with the right skills could not be assured to be in place to meet people's assessed needs. There was not always a nurse on duty to carry out the health care tasks that people needed. This placed people's health and welfare at serious risk.

Where accidents and incidents had occurred, these had not always been acted upon and reported to the appropriate authorities. Also, the registered provider had repeatedly not responded to the local authority's request for investigations and information about previous incidents. This meant that the registered provider missed opportunities to identify or learn lessons and this put other people at risk of the same, or similar, risk of harm.

Although people's care plans had been reviewed, full information about the needs of people were not available to staff. This was because the registered provider had removed information from the service.

Some improvements had been made to the governance arrangements in the service and this had been entirely due to the consultant nursing agency's input. However, the registered provider's lack of openness, honesty and candour put people at serious risk of harm.

At this inspection we found serious breaches of Regulations 5, 12, 13, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These breaches were assessed by CQC as extreme, as the seriousness of the concerns meant that unless we took the action we believed people would/potentially be at risk of harm.

The provider had 28 days to appeal against this decision to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. This period has now passed and we can report on the decision that had been ratified by a judge and the action we took.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. No representations were made.

At this inspection we found there had been further deterioration in the service provision. The overall rating for this provider is 'Inadequate'. On 10 August 2017 CQC used its urgent powers to keep people safe. This means that it can no longer provide any regulated activities and is closed.

Other stakeholders including the local authority supported people and relatives to find other homes or alternative care arrangements. On 10 August 2017, all 11 people using the service were safely moved from this service.

You can see the enforcement action we took at the end of this report.

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

The premises were dangerous and had been poorly maintained. A serious risk of fire existed and a failure to act on known risks increased a risk of fire and put people's lives in danger.

The service did not have adequate arrangements in place for the proper and safe management of medicines.

The service did not have sufficient staff employed to meet people's needs safely.

Is the service well-led?

Inadequate

The service was not well-led

Governance and quality assurance procedures in place were not effective in driving improvements that were urgently required.

A registered manager had not been in post for over two years. This limited the provider's ability to drive, or sustain, improvements that were required.

There were no systems or processes in the service to ensure that the service provided was safe or well-led.

Millfield Lodge Care Home Limited

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Millfield Lodge Care Home Limited on 4 July, 1 and 9 August 2017. This inspection was undertaken to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 12 and 20 April 2017, had been made.

It was also in response to concerns reported to us about the safety of people who lived at the service. We inspected the service against two of the five questions we ask about services: is the service safe? And; is the service well-led?

This focused inspection was undertaken by two inspectors on 4 July 2017 and two inspectors and an inspection manager on 1 and 9 August 2017.

As part of our inspection planning we requested information from those organisations who commission care at the service. We looked at this and other information we hold about the service, which included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law. We also requested and received details about the provider's financial viability.

During the inspection we spoke with three people living in the service. We also spoke with the nominated individual. This is the person who has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the service provided. This was as well as speaking with the deputy manager, two staff from the nursing management agency, a nursing consultant, a nurse, one senior care staff, two care staff and the chef. We also spoke with a visiting pest controller and a member of the fire service.

We observed how people were cared for to help us understand the experience of people who could not talk with us.

We looked at 11 people's care records, medication administration records and records in relation to the management of the service, including records of accidents and incidents.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Millfield Lodge Care Home Limited on 12 and 20 April 2017 we found that people were not safe because action had not been taken to minimise risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of this we imposed a condition on the provider's registration to not admit any more people to the service. During this focused inspection of 4 July, 1 and 9 August 2017 we identified on-going and new concerns about people's safety.

On 4 July 2017 we found that not all people's medications were being administered as prescribed. We looked at the amount of medication in stock. We checked to see if this tallied with the amount of medication that had been received at the beginning of the medication cycle and what had been recorded as administered. We carried this out for four different people. We found that the records did not accurately tally with the amount of medication left in stock for all four people. For the 25 tablets that we checked, 19 of them did not tally with the records. We found that tablets had either been signed as administered but were still in stock or tablets were missing. There were no processes in place that had identified the issues with the administration of medication. Failure for people to receive their medicines as prescribed could have a serious effect on their health and welfare.

When we returned on 1 August 2017 we found some improvements had been made. However, the internal audit undertaken by the nursing management agency team showed that not all people were being supported to take their medication as prescribed in a safe and consistent way. We also found that a patch for pain relief was not being administered in accordance with the manufacturer's instructions. This could cause damage to the person's skin. In addition, the details for the application of this medication had not been completed for the period 20 July to 1 August 2017. This meant that there was a risk of harm as the person did not have their prescribed medications appropriately administered or recorded by staff.

We received information from the nursing management agency team that the provider's nominated individual did not take the appropriate action when a person's pressure sore was identified. The nominated individual who was also a nurse did not ensure that the correct dressing was applied to the pressure sore to aid healing and to prevent further deterioration. Information about the pressure sore had also been removed by the nominated individual from the persons care plan. This meant that staff and other healthcare professionals were not able to compare the wound state to assess healing or deterioration.

We found that one person's pressure mattress was on the wrong setting for the person's weight. This had not been identified even though the record checking the pressure mattress had been regularly completed. This placed the person at risk of developing a pressure sore. We also found that the nurse on duty on 4 July 2017 was not aware that one person had a dressing on their leg. This put people at risk of not receiving the health care they needed.

During the inspection on the 9 August 2017 we found that there was only enough food in the service to last until breakfast on the 11 August 2017. Staff told us that they had no means to purchase any more food as the

payment system they normally used has been removed. The staff on shift stated that they had to purchase milk for breakfast for the following day out of their own money. Had people remained in the service after the 11 August 2017 this would have placed their health and welfare at risk.

This was a breach of Regulation 12 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of safeguarding incidents that had occurred in the service. The local authority had requested on many occasions that the nominated individual provided further information about these. At the time of our inspection there were still seven incidents where further information was required. This meant that the opportunity to identify or learn lessons was missed and this put other people at risk of the same, or similar, risk of harm.

This was a breach of Regulation 13 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

During the visit on the 1 August 2017 the visiting pest control expert made us aware of a significant fire risk in the service. They told us and showed us that there were about 100 bin bags of clothing and paperwork in the loft. They stated that they had reported their concerns to the nominated individual on at least two previous occasions. They told us that it was a considerable fire risk as there were also rodents in the loft which could chew through electrical wires. Because of the bin bags they could not access the loft and therefore could not effectively set traps.

As a result of the concerns we alerted the fire safety officer who immediately attended the service. They gave clear instructions to the nominated individual on how to minimise the risk of fire for people. The fire safety officer stated that the action had to be completed within 48 hours due to the seriousness of the risk.

The fire safety officer returned to the service on 4 August 2017 and undertook an audit. He found that the loft space was now clear. However, the fixed electrical wiring throughout the building was in urgent need of attention to ensure that it was safe. The fire safety office issued an improvement notice for actions such as fire monitoring equipment; fire separation within the loft space; and holes and gaps through walls and floors that needed to be made safe in order to prevent the spread of heat and smoke. The nominated individual had also not acted on previous concerns from the Fire Service. This put people at very serious risk in the event of a fire occurring.

In addition, we found that staff on duty on the night of 1 August 2017 had not had fire safety training since February 2016. The lack of access to records had prevented the nursing agency team from being aware of this risk.

This was a breach of Regulation 15 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 9 August 2017 we found that as of 10 August 2017 there would be no nurses employed in the service. Only the nurses working in the service were trained to administer the medication. This meant that from the 10 August 2017 we could not be confident that people would receive the right medication as prescribed. The nurses were also responsible for completing other nursing tasks such as wound care. Some people's care plans stated that due to their physical and mental health they needed a nurse to monitor their wellbeing. Without a nurse on duty this level of monitoring would not be available. This placed people health and welfare at serious risk.

In addition, due to a lack of payment to staffing agencies there would be no care staff cover for the following week's night shift. People's health, safety and wellbeing were therefore put at serious risk of harm.

This was a breach of Regulation 18 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection on 12 and 20 April 2017 we found that the governance and quality assurance systems were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that we had not been informed about events that, by law, the provider is required to inform us about. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

As a result of these concerns we imposed two conditions on the provider's registration. They were required to submit governance records to us each month and were not to admit any more people to the service. We hoped that these conditions would assist the service to improve.

During this focused inspection of 4 July, 1 and 9 August 2017 we found that the quality and standard of governance at the service had deteriorated further.

The person who we registered as the manager left the service in November 2014. Since that date six further managers had been employed but they all left the service before applying to be registered. Another person employed at the servicer did apply to be registered as the manager but they left the service before their application had been completely processed. This lack of consistency limited the provider's ability to make or sustain any improvements.

Three different consultancy companies had been used in the service during the last three months. However all three consultants had withdrawn their support. This was because they had not been able to make the required improvements due to the lack of support from the nominated individual.

Concerns raised about the service had not been acted on. This put people at risk of harm and showed us that the nominated individual did not act on the concerns of other agencies when they should have done. The lack of a robust and effective systems to ensure the service was carried on effectively, safely and with good governance put people's health, safety and wellbeing at serious risk.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there had been some improvements in the way the service was being supported. This had been entirely as a result of the local authority's support in identifying a nursing management agency to support the service to improve. This agency was currently doing their best under challenging circumstances to improve the quality of care that people received. They were however, being severely hindered by the nominated individual's reluctance to cooperate with them.

This hindrance included, but was not limited to, not having access to people's finances and records as well as not having any information about staff supervisions, training and competencies. The nominated individual removed information from the service including the service's computer and fire and electrical

certificates. This seriously limited the nursing management agency's ability to manage the service safely and effectively. The nominated individual's failure to provide access to computer records also restricted the nursing management agency's ability to be able to manage any unknown risks to people, relatives, staff and visitors.

On 7 August 2017 we informed the nominated individual that they must return all records to the service. When a computer was returned to the service it did not contain any records nor did it provide access to any e-mails. In addition, on 9 August 2017 we found that the payment system for buying and supplying food to the service had been cancelled by the provider. We found that there was no fresh milk and only sufficient food for two days. There was only sufficient protective clothing and equipment for staff for about five days. This was because payments to a protective clothing supplier had become overdue despite attempts by them to obtain payment.

As a result of what we were told, what we saw and the information we were provided with by local authorities and the nursing management agency we determined that the nominated individual was not of good character and not a fit and proper person. This was because of their failure to fully cooperate with the nursing management agency that had agreed to support them. This was despite the nominated individual, on 5 July 2017, thanking the local authority "for introducing (name of agency) care team to us." The nominated individual had said, "They are truly a committed management and nursing team. We had a very focussed productive meeting today for moving forward, and working to an improvement plan."

Three staff members told us that when the nominated individual was not at the service everything ran much more smoothly and they could get on with providing care rather than doing less important tasks. One said, "With [name of agency] here it the atmosphere is so calm and relaxed. They have been so supportive." Another staff told us that if the management agency left then so would they as the nominated individual was constantly interfering with the day to day running of the service and would not let managers manage it A third staff member said, "That's why the managers never stay as they are not allowed to manage."

This was a breach of Regulation 5 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested information about the financial viability of the registered provider. When we received this we found that there were serious concerns. We found the registered provider owed several organisations a significant amount of money. In one case this had resulted in a visit by bailiffs to the service to seek recovery of a debt. A payment plan set up by the registered provider had also been defaulted on. This put the service at serious financial risk.

On 9 August 2017 we found that the payment system for buying and supplying food to the service had been cancelled by the provider. We found that there was no fresh milk and only sufficient food for two days. There was only sufficient protective clothing and equipment for staff for about five days. This was because payments to a protective clothing supplier had become overdue despite attempts by them to obtain payment.

The deputy manager told us, "All staff want is to do a good job - they are really passionate. I've never met such a good team." However, without the full cooperation of the registered provider, the ability to make the necessary changes to the service had not been possible due to limitations placed on staff and the nursing agency. A member of the agency team said, "I have never had such a difficult provider to deal with despite all our efforts to work together."

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 5 HSCA RA Regulations 2014 Fit and proper persons: directors The Nominated Individual was not a fit and proper person to carry on the service. This was because they had not cooperated with the nursing agency they had commissioned and they had not provided information when requested to the local safeguarding authority. This was also because they had removed records and equipment from the service as well as preventing access to people's finances, staff training and supervision records.

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.

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 Not all people were safely administered their medicines as prescribed. This put them at risk of harm as well as not benefiting as well as intended from the desired outcome as intended.

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.

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 People could not be assured that they were kept safe. This was because the provider had not investigated and provided information about previous events to the local safeguarding authority.

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not kept as safe as the should have been. Actions had not been taken to ensure that the risk of fire occurring was minimized.

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance of the service was not as effective as it should have been. Actions to improve the service to keep people safe had not been acted upon

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.

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 Insufficient, and a lack of suitably skilled and competent, staff meant people's care needs were not being met.

The enforcement action we took:

As a result of our serious concerns about people's safety we applied to a magistrates court, and were granted authority to cancel the provider's registration.