

Wellington Healthcare (Arden) Ltd

Millvina House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

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 one adapted building, located over 3 floors.

People's experience of using this service and what we found

We have made a recommendation about the recording of medicines. This is because although the provider was no longer in breach of regulation, medicines administration records (MARs) were untidy and confusing, and it was not always clear if people had received their medications as prescribed.

We have made a recommendation in relation to records. This is because although care plans were personalised, we identified gaps in monitoring records, such as repositioning charts and food charts. We could not be certain people had received the care interventions reflected in their care plans.

Leadership, governance and oversight was much improved at this inspection. There were still some improvements required in relation to records. We identified concerns with areas of care provision that had not been picked up by the providers routine audits. The provider employed a new management team after the last inspection. People told us they liked the new manager. The new management team and governance processes needed further time to fully embed.

Systems to effectively manage risk assessments had improved. People's care needs and associated risks had been assessed and there was more in-depth information in place to help keep people safe from harm.

Systems to determine safe staffing were in the process of being updated and we received some mixed feedback with regards to staffing levels. Relatives were mostly happy with the care their loved ones received. However, some still felt staffing levels needed to be improved. Our observations found there were generally enough staff to meet people's needs. However, there were still some periods of time where the communal lounges were left unstaffed.

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.

Accidents and incidents were recorded and action was taken to mitigate risk following safety related events. Safeguarding referrals were made when needed.

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

Rating at last inspection and update

The last rating for this service was inadequate (published 21 February 2023)

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

This service has been in Special Measures since 21 February 2023. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

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 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 inadequate to requires improvement based on the findings of this inspection.

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

Enforcement and recommendations

We have identified breaches in relation to good governance at this inspection.

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

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect. 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 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 always safe

Details are in our safe 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 always well-led

Details are in our well-led findings below

Requires Improvement ●

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

The first day of the inspection was carried out by 3 inspectors, 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. The second day was carried out by 1 inspector and the third day was carried out by 1 inspector who remotely reviewed records.

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 the 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 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 6 relatives about their experience of the care provided and 1 person who lived at the home. We spoke with 5 members of staff including the manager, nurses, senior care workers, care workers and the director of quality.

We reviewed a range of records. This included 9 people's care records, and multiple medication records. We looked at 2 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.

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 changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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.

During this inspection, information contained within risk assessments was more in-depth and informative. Therefore, enough improvement had been made and the provider was no longer in breach of regulation 12.

- People's needs had been risk assessed and there was more in-depth information in place to help keep people safe from harm.
- People who required support to manage diabetes were getting the correct levels of intervention when their blood sugars varied beyond the normal range.
- People were getting better levels of intervention when they had unplanned weight loss and this was being discussed during weekly multidisciplinary (MDT) meetings. We did highlight concerns for a person who had experienced weight loss with no remedial action undertaken. The provider addressed this immediately and the person was prescribed supplements to reduce the risk.
- People who were assessed as requiring 1 to 1 care to reduce risks associated with their health conditions were receiving this consistently.
- Risk analysis was completed and there were detailed follow up actions recorded against concerns, incidents and substantiated safeguardings. This ensured lessons were learnt and used to improve service provision. However, we identified further improvement was needed to ensure action were implemented effectively. The provider responded immediately to the concerns to ensure areas of risk were mitigated.

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 made enough improvement and was no longer in breach of regulation 12.

- Medication were safely managed overall. However, further work was needed to improve record keeping.

For example, we found some missing signatures on MARs, and some concerns with the illegibility of paperwork, such as hand written MARs which were confusing.

We recommend the provider reviews their record keeping in relation to medicines administration and takes action accordingly.

- Medicines were administered by staff who had the appropriate skills, knowledge and competence.
- Medicines were stored securely in locked treatment rooms.
- People had PRN (medications needed as and when required) protocols in place.

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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- People told us staffing levels had improved and the management team were continuing to work on some further improvements.
- Some staff told us they still felt rushed at times and felt the senior managers did not always understand how much work they were expected to undertake. One staff member said, "It is definitely better here, but we could always do with more staff." A relative told us, "Sometimes I feel there isn't always enough staff, it's mostly of a night." We shared this feedback with the manager who told us there was a plan in place to implement a new dependency tool and review how staff were deployed.
- 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.

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.

Systems and processes to safeguard people from the risk of abuse

- People and relatives told us they felt safe at the home. A person told us, "Yes I suppose I feel safe." A

relative told us they did not always feel their loved one was safe because they had experienced a fall. We checked this person's care plan and saw this had been reviewed since the fall took place and measures put in place to reduce the risk of recurrence.

- Staff were aware of safeguarding processes and how to escalate concerns regarding abuse.
- When required, safeguarding referrals had been made in timely way.

Preventing and controlling infection

- Infection prevention and control procedures were effectively managed.
- The home was visibly clean throughout.
- The provider facilitated visits for people safely. We were assured there were no restrictions on visiting.

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

- 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.
- When people required nutritional monitoring due to risks associated with malnutrition and diabetes, some records were not fully completed. We identified records that stated, 'had tea' or 'had dinner' and did not detail the quantity and type of food consumed. The poor completion of records made effective monitoring difficult. In addition, records relating to pressure relief were still not being completed in full. While we noted improvement to people's pressure areas and wounds, the failure to keep accurate records meant we could not be fully assured people were receiving the appropriate care interventions as outlined in their care plans.

We recommend the provider reviews their monitoring records and updates their practice to ensure records reflect the level of care given.

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 House to partake in if they wished.
- People were encouraged to keep in touch with their loved ones and families could visit them when they wanted to.
- Our observations showed some better interaction between people and staff, however, this needed to be further improved.

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; however, this was improving. One relative said, "I think the manager is getting better at listening now."

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.

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 has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

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 there was a failure to implement adequate governance systems.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The provider had consulted various health and social care consultants in the development of the new governance system. The newly implemented systems had identified several areas of improvement needed at Millvina House. However, these systems were not fully embedded to demonstrate robust management or consistent improvements of quality.
- The management structure in place was robust, however, the new managers had not been in post long enough to test the effectiveness of the new structures.
- A detailed service improvement action plan was in place to address areas of concern. However, some issues identified at this inspection had not been picked up by the providers systems, such as some missing risk assessments, records lacking information and some issues with recording of medicines.

Despite some level of improvement, governance systems, oversight and records were still not robust which put people at risk of harm. This means the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2008.

The manager and regional manager were responsive during our inspection and took immediate and prompt action in response to some of the issues we found.

- There had been positive changes in the home, such as the refurbishment of the communal floors, with further plans in place to replace other items of furniture.
- People and staff were complimentary about the new manager and the deputy manager, and knew them by name. Staff said they felt the morale was better across the units

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 aware of their legal responsibility to be open and transparent when things went wrong.
- CQC had been notified of significant events which had occurred, in line with the provider's legal obligations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Regular meetings were held with people and family members to enable them to share their views about the service. We saw evidence during our inspection feedback was listened to and acted upon by the manager.
- Staff were kept regularly informed and updated about any important changes to the service and people's needs through handovers and other meetings which took place on the units. The manager attended these to ensure they had oversight of the units.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Some records were lacking information and were not always contemporaneous or accurate. Governance systems were still not always identifying or highlighting issues with service provision.