Mellifont Abbey LLP

Mellifont Abbey

Inspection report

The High Street
Wookey
Wells
Somerset
BA5 1JX

Tel: 01749672043
Website: www.mellifontabbey.co.uk

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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

About the service
Mellifont Abbey is a residential care home providing personal care of up to 23 people with mental health conditions including dementia. At the time of the inspection there were 20 people living at the home on the first day and 19 people on the second day. One person was in hospital at the time of the inspection.

The home is a large converted building where each person has their own bedroom. There are communal areas on the ground floor including a dining room and lounges. There are extensive gardens and a patio area which is more secure.

People's experience of using this service and what we found
People were not being kept safe when they had a specific health or care need. People's care plans had not been updated when their risks changed. When actions had been identified to mitigate risks, they had not always been actioned. Infection control systems to reduce the risk of infection spreading were not always being followed. Following the inspection we were informed actions were taken to rectify this.

Staff levels were not adequate to keep people safe and meet their needs. Training for staff did not always meet the needs of people and keep them safe. Staff used specialist equipment to support people with limited mobility without suitable training to keep people safe.

Staff had a mixed understanding around safeguarding systems. The provider had not alerted relevant authorities when someone was at risk of potential abuse. People were placed at risk in the event of a fire because fire drills and alarms were not carried out in line with the provider's policies.

Systems to ensure enough staff could safely administer medicines were not in place. Although we did see medicine administration which was in line with a person's preferences. Medicine was stored safely.

The home was not well led. Systems to manage the home were chaotic and documents which should be readily available were not always. Policies were not being followed by staff and the management. Quality assurance systems had failed to identify concerns identified during the inspection.
Throughout the inspection we saw that staff interactions with people were positive and caring.

The provider had strong links with the local community which helped in the early stages of the COVID-19 pandemic.

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 good (published 25 October 2019)

Why we inspected
The inspection was prompted in part due to concerns received about a cumulative range of concerns including staff levels, staff understanding of people's needs and management of the home. As a result, we undertook a focused inspection to review safe and well-led only. A decision was made for us to inspect and examine those risks.
We reviewed the information we held about the service. Due to the current COVID-19 pandemic we felt it was not necessary to inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment including managing risks, staff training in relation to people's needs and inadequate staff trained to administer medicines. We also found concerns around staff levels, protecting people from potential abuse and how effective the management is at the home.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Mellifont Abbey

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.

The inspection was brought forward due to cumulative concerns raising potential risks to people at the home. The second day on site was carried out due to further concerns being received.

Inspection team
This inspection was carried out by two inspectors on the first day and one inspector on the second day.

Service and service type
Mellifont Abbey is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was also one of the directors and owner of the care home.

Notice of inspection
We gave a short period of notice of the first day of inspection because of the current COVID-19 pandemic to ensure everyone's safety. Due to new concerns the second day was carried out unannounced.

What we did before the inspection
Due to the current pandemic the provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals. We used all of this information to plan our inspection.

During the inspection-
We spoke to five people informally during the inspection. To keep them safe we did not spend long with them. We spoke with the registered manager, deputy manager and assistant manager plus five other care staff. 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 reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment.

After the inspection
Due to the pandemic we reviewed a variety of records offsite relating to the management of the service including one care plan, incident and accident records, policies and procedures and rotas. We spoke to two staff and four health and social care professionals on the telephone.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also requested a variety of records within specific time frames. These time frames were not always met.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely;

- People were not being protected from risks which could potentially harm them. One person had been identified as high risk of falls with declining mobility. Despite multiple recent falls their mobility risk assessment had not been updated. Some of these falls had resulted in injury or the attendance of the ambulance service. Staff had suggested ways within incident reports to mitigate the falls; these had not been actioned.
- Another person who had recently lived at the home had a decline in health. It had been noted by multiple health and social care professionals their mobility was declining. No update to the risk assessment from January 2020 had been completed. The risk assessment states, "[Name] appears to have a stable gate and firm on his feet." This was no longer the case.
- People with specific health needs were not being protected from potential harm. Staff had not received adequate training for a person with epilepsy. The training records confirmed this. Risks assessments for people with specific health conditions had not followed current best practice. For example, specialist health professionals had not been consulted. Neither was there clear guidance for staff to minimise the risk of infection spreading.
- Staff had not received training on how to use specialist equipment to help people with mobility issues. This reflected a concern raised prior to the inspection. Staff told us they had been talked through how to use hoists and lifting equipment by other staff who they thought were trained. Training records reflected what we were told and demonstrated staff were being trained in manual handling by an untrained member of staff.
- Systems were not in place to ensure there were adequate numbers of staff trained to administer medicines. The registered manager told us six staff including them were able to administer medicines. For example, one week's rota demonstrated the registered manager off site at night although they were required for administering 'as required' medicine for five nights. However, this did not reflect information we found including issues with medicine administration errors. Staff told us there were not enough trained staff to safely administer medicines for people.
- One medicine error had an identified action of retraining a staff member to mitigate risks of further errors resulting in potential harm to people. This had not been followed up. The registered manager told us the member of staff had not stopped administering medicines to make sure all shifts were covered. The staff member had made two further medicine administration errors for a person.
- Risks protecting people in the event of fires had not always been actioned or carried out in line with the provider's policies. Fire drills were not occurring regularly to ensure all staff and people knew what actions to take. The fire alarm tests were not being completed weekly to check the alarms were working. Audits completed by management stated they had prioritised the safety of people during the pandemic. However, training records stated most staff had not practiced a drill since September 2019.

We found evidence that people had been harmed. Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager told us they had sourced agency staff who were safe to administer medicines whilst they train more staff and retrain others.
● Following the inspection, the registered manager told us they had added additional training for staff and employed someone to manage the staff training.
● We saw that people were supported by staff who knew how to administer their medicines in a personalised way. Medicines were taken to people rather than wheeling around the medicines trolley.
● Storage of medicine was safe including those requiring additional checks and refrigerated medicine.

Preventing and controlling infection
● Prior to the inspection concerns were raised about infection control and prevention during the current COVID-19 pandemic. We found some of the preventative systems to reduce the spread of the pandemic virus were not being followed. On the first day of the inspection, staff and visitors to the home should have had their temperature checked and records taken of their contact details for track and trace; this did not happen. By the second day this had improved because the inspector were asked for their details when entering the home.
● Staff had access to a thermometer. Neither inspector had their temperature checked. Visitors were not witnessed having their temperature checked. One visiting professional confirmed they had not had their temperature taken or contact details recorded when they had been to the home.
● Risks of an infection spreading were increased with some practices witnessed. There was a fingerprint entrance system at the front entrance of the home inside and out. On two occasions when staff were aware they were being observed this was wiped clean. However, on other occasions there was no cleaning of the fingerprint machines which were both in regular use.
● Staff had access to personal protective equipment (PPE) such as gloves, aprons, masks and face shields. During the inspection staff were wearing appropriate PPE for the activities they were completing. Staff told us there were strategic points around the home they could use for fresh PPE. However, on the second day of the inspection one member of staff came into the office without a mask.

We found no evidence that people had been harmed however, the provider was not managing or mitigating the risks of infection effectively. This placed people at risk of harm. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager informed us of a number of actions which were taken to rectify the concerns around infection control found at the inspection.
● The home was being regularly cleaned in line with current guidance. The cleaning staff was very aware of their additional responsibilities required at present. They had access to the appropriate cleaning products and equipment.

Staffing and recruitment
● People were not supported by enough staff to meet their health and care needs to keep them safe. All staff told us this. Staff also told us they had not received enough training to work safely with people and meet their needs. One staff told us about an incident which occurred because of their inexperience.
● There were occasions during the inspection in the communal areas where people lacked interactions from staff. One person asked to go outside, and a staff member informed them they were all busy. Another person paced up and down with nothing to occupy them. People remaining in their bedrooms were not being

frequently checked in line with the incident report falls recommendations. Most staff said they would either go up every hour at best or when a specific task such as a mealtime.
● The registered manager told us they did not understand why staff felt there were not enough of them. They told us there had always been this level of staffing. No dependency tool had been completed by the registered manager to assess a safe level of staffing to meet people's current needs. The registered manager had plans to action this in line with discussions they had with the local authority.

We found no evidence that people had been harmed however, staff were not sufficient in number to meet peoples needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported people the best they could, and all the interactions witnessed were pleasant .
● People had been protected by staff who had been through robust recruitment. Staff had appropriate checks completed prior to starting work. When there was a delay in these coming back the registered manager had taken appropriate steps.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems were in place to review some concerns which could result in risks of abuse to people. However, this approach was not consistently being used. Neither were concerns always being communicated with other professionals in a timely manner.
● One person who had frequent falls was been located at the top of the house despite being assessed as high risk of falls. Staff had been unable to check this person as frequently as they should due to staff levels. They had multiple falls which identified checks should be more frequent. The registered manager was not clear why the person had been placed at the top of the house. They did not appear fully aware of the decision which was made. The local authority had not been made aware of this person's being place at risk of neglect.
● Another person had multiple incidents recorded which the local authority had not been made aware of. Some of these issues had placed the person at risk of potential abuse and harm.
● Staff had a mixed understanding about what constituted safeguarding. Also, of actions which needed to be taken if they were concerned. Some staff after speaking with us realised they should have raised concerns earlier.

There was a failure to safeguard people by not reporting potential abuse. This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider was not sharing information with other organisations in line with their responsibilities to allow them to support and monitor the home. The local authority safeguarding team had not been informed of incidents and accidents which met their threshold for reporting.
- Notifications to CQC were not in line with statutory guidance. Some notifications arrived weeks or months after the incident had occurred. Examples of this were seen during the inspection and prior to the inspection.
- Other incidents which should have been notified to both the local authority safeguarding team and CQC had not been. For example, neither CQC nor the local authority knew about a significant incident involving two people until the inspection.

Statutory notifications had not been made in line with legislation to allow the CQC to monitor the service. This is a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- The home was not well being managed. Management of the home was chaotic. For example, staff and the registered manager were unable to locate records when requested. Staff told us they lacked direction at times when on shift. The registered manager had been shielding, so working from their own home or an office in the garden. No notification had been made to the CQC to inform us of this change, although the registered manager had prepared one and informed us of the change.
- Paperwork and records requested throughout the inspection which should have been readily available were not. The registered manager was asked to send them to us after the site visit and failed to meet the deadlines for us to receive them, in some instances we did not receive them. This included records such as staff rotas and audits of the home.
- We identified serious and widespread shortfalls leading to multiple breaches in regulation. These affected the safety, quality and standard of the service. The shortfalls had not been identified by the provider through their governance systems and rectified as required. The quality assurance systems were ineffective. Audits had not always identified the issues found during the inspection such as the shortfalls in staff training, risk management, incidents involving violence and lack of fire drills.
- The audits were basic and lacked detail; there was no information about which care plans or records were reviewed and what complaints had been received.
- Communication was not effective between senior staff in the home and the registered manager. Also,

actions were reactive rather than proactive. When we shared concerns about things to the registered manager, they told us they were not aware of them. Some concerns led the registered manager to complete their own reviews of people's care plans.

● Staff were not always clear of the management structure or lines of responsibility in the home. The staff referred to different members of the management team for issues. This meant it was not clear who was leading in the home in the registered manager's absence.

● The management and staff were not always following their own policies. For example, around fire safety and moving and handling.

● Prior to this inspection we carried out an Emergency Support Framework (ESF) call as part of CQC's regulatory approach during the pandemic to support and monitor providers. Information we heard from the registered manager during this did not always match concerns found during the inspection. For example, not all infection control prevention measures were being used and positive communication between the management team.

The failure to ensure the quality and safety of service provision through effective governance is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not been receiving regular supervisions. Although most staff felt they were being supported informally by different members of management.

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 management had some understanding of the duty of candour about telling relatives or staff when mistakes have been made. However, we were not assured that the provider had acted with a duty of candour due to the number of safeguarding events that had not been notified to us, and the provider's failure to provide requested information post inspection.

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

● The management and staff were aware of trying to engage with people and their relatives. We saw positive interactions between the registered manager and people in the garden.

● Staff felt they could raise issues with members of the management and felt they would be considered. One member of staff recalled a specific issue which had action taken promptly by a member of the management.

Working in partnership with others

● Mixed views were heard about the partnership working with other health and social care professionals. Some professionals recalled positive working relationships whilst other professionals raised concerns.

● Links with the local community had been positively developed during the pandemic. Letters to people were received from local children and there had been a tea party.

● Local volunteers had been helping produce masks and face shields. Other volunteers had completed shopping in the early stages of the pandemic.