Mellifont Abbey LLP

Mellifont Abbey

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

Mellifont Abbey provides accommodation for up to 23 people who require personal care and have complex mental health needs. On the day of inspection there were 22 people living at the home. The accommodation was arranged in one grade two listed building over three floors. The home was going through some refurbishment; there was a television lounge and main dining room lounge on the ground floor. The home has extensive gardens.

This inspection was unannounced and took place on 22 and 25 September 2015.

The registered manager in post was also the owner of the home. A registered manager is a person who has registered with the Care Quality Commission 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.

Summary of findings

People told us they felt safe but there were risks to their safety. Enough staff did not always support people. The registered manager said a number of staff had recently left to pursue careers; they were recruiting new staff.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and they knew whom to contact externally. However, the provider had not always correctly informed the local authority and CQC about safeguarding. This meant external monitoring of safeguarding could not always be completed.

The recruitment process followed good practice; however, checks to ensure people were of good character and had the correct visa were not always correct. Staff told us they had comprehensive training; there was good understanding of how to support people using their training.

Staff and the registered manager had some understanding about people who lacked capacity to make decisions for themselves. Care plans had not made it clear the consultation process when people lacked capacity or that people had decision specific two-part assessments. When there were decisions to prevent people leaving the home for their safety the correct processes had not always been followed. As a result, there were breaches of people's human rights.

There were some quality assurance procedures in place; the systems did not always identify shortfalls in the home. The registered manager made mistakes because they had not planned effectively for the absence of key staff.

Staff supported people to see a wide range of health and social care professionals to help with their care; this was important because many people had complex needs. Staff supported and respected the choices made by people. The medication processes in the home were good.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if people did not want what was on the menu to ensure preferences were met. Staff encouraged people with specific dietary needs to eat appropriately in a caring and respectful way.

People and their relatives thought the staff were kind and caring; we observed positive interactions. The privacy and dignity of people was respected and people were encouraged to make choices throughout their day.

There were detailed care plans for all individuals including spiritual and cultural information. These plans had a person centred approach to them; this means that people were central to their care and any decisions made. The needs of the people were reflected within the plans; they were responsive to people's changes. Staff had good knowledge about the care plans.

People knew how to complain and there were good systems in place to manage the complaints. The registered manager demonstrated a good understanding of how to respond to complaints including future learning.

The registered manager had a clear vision for the home and had some systems in place to communicate this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We made a recommendation about the provider seeking advice around employing people overseas from agencies such as the United Kingdom Border Agency.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were not always enough staff to meet the needs of the people that used the service.

Staff understood how to keep people safe and who to tell if they had concerns about people's safety.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff

People's medication was stored and administered correctly.

Is the service effective?

Requires improvement

The service was not always effective.

The registered manager and staff demonstrated some understanding about making best interest decisions on behalf of someone who did not have capacity. However, they did not follow the code of conduct for making important decisions.

Even though people were kept safe with a locked door, people were at risk of their human rights being breached because the correct procedures were not being followed.

Staff had training to meet the needs of people they supported.

People were supported appropriately to eat and drink, but the menus did not always reflect people's choices.

There was contact and access to other health and social care professionals to make sure people's needs were met.

Is the service caring?

Good

This service was caring.

People told us that they were well looked after and we saw that the staff were caring.

People were involved in making some choices about their care.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive

There were activities in the home that were personalised to people's interests.

Summary of findings

People did receive care and support in line with care plans and staff were familiar with them.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

The service was not always well-led.

The service had quality assurance systems in place but they did not always identify shortfalls.

The registered manager had a strong vision for the home and some staff were effectively supported.

The registered manager kept their knowledge and skills up to date so they could provide effective support for the people.

Requires improvement

Mellifont Abbey

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 25 September 2015 and was unannounced. An adult social care inspector and an expert carried it out 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.

Before the inspection, the provider had not been requested to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR information during the inspection. We looked at other information we held about the home and spoke to health and social care professionals before the inspection visit.

We spoke with nine people that lived at the home. We spoke with the registered manager and five members of staff. We spoke with three visitors and with five health and social care professionals.

We looked at four people's care records and observed care and support in communal areas. 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 looked at eight staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints file and a selection of the provider's policies.

Requires improvement

Is the service safe?

Our findings

Staffing arrangements did not always ensure people were kept safe. For example, staff giving out medicines were constantly disturbed due to there not being enough staff available. This meant there was a risk medicine error could occur. People were also left for long periods without having any interactions with staff which left them at risk of social isolation. People and relatives raised concerns about the staffing levels. One person told us' "It is a bit short staffed". Another person said, "They keep grabbing him [the activities coordinator] to take people to doctor's appointments". A relative said, "[The home] had been short staffed last Sunday"; the rota showed there was a shift that needed covering. Following the inspection the provider explained the activities coordinator took people to doctors appointments because they feel safe with them; they often go for coffee or do some shopping afterwards.

On the first day of our inspection, we saw long periods where people waited for interaction from a member of staff. There were three people in the dining room who had no interaction from staff for 40 minutes. Some people struggled to communicate or ask for help from staff; in the room, there were not staff present to check on them. We spoke to the registered manager who said staff were observing people from a distance. At lunchtime, the interactions were task based until the activities coordinator sat with three of the residents. During a medication round the deputy manager had been interrupted at least three times by people, call bells and staff; they were wearing a do not disturb tabard. Another staff member was already attending to a person. The interruptions included answering call bells and activating the finger print entry system on the front door. This meant they were distracted from administering medication to people; some people needed medication at a specific time to ensure it was the most effective. The deputy manager had to keep answering the door because there had been a problem adding new members of staff to the entrance system. One of the reasons they kept being disturbed during the medicine round was because there were not enough experienced staff.

On the second day, there were more staff which meant staff had more time to spend with people. The rotas identified some shifts that needed covering by staff or agency staff and the registered manager was aware they needed more staff. The registered manager said a number of staff had recently left due to career choices. As a result, the registered manager was recruiting new staff; incomplete checks delayed the new staff starting work. We saw evidence that this process was occurring. Whilst the recruitment process was ongoing, staff completing the medication round were unable to focus on the task without interruptions and the activity coordinator was unable to ensure activities were taking place consistently.

Risks of abuse to people were reduced because there was an effective recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. However, the registered manager had not completed the required annual checks for staff from overseas. These are to ensure people have the correct qualifications and documentation to work legally in the country. As a result for not completing the correct checks one person had an out of date visa. We spoke with the registered manager who resolved this during our inspection. The registered manager confirmed they would continue to complete the correct checks for staff members from overseas.

Staff told us, and records confirmed that all staff had received training in how to recognise and report abuse. Staff had an understanding of what may constitute abuse and how to report it. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant professionals to make sure issues were fully investigated and people were protected. However, there were occasions when the registered manager had not passed on concerns about safety to all the necessary authorities including CQC. One person had left the building six times unsupported. The registered manager had actively contacted and had meetings with external health and social care professionals to reduce the risks to this person. However, they had not informed the local safeguarding team and CQC of all the incidents that had led to the person harming themselves or being at risk of harm. This meant external agencies were unable to monitor the provider's actions and ensure they had followed correct procedures to reduce risks to people.

People told us they felt safe; one person when asked if they felt safe said, "Yes I feel safe". Another person said "Oh yeah" when they were asked if they felt safe at the home. A relative said "I wouldn't go away unless I was happy they [their loved one] were well looked after". The health and

Requires improvement

Is the service safe?

social care professionals we spoke with all agreed that the home was safe. We saw the home was proactive in keeping people safe; they had effectively identified and managed risks. Care plans contained risks assessments, which outlined measures that enabled people to participate in activities with minimum risks. The registered manager managed risks using a system to identify ongoing risks and those that were no longer a constant concern. This meant the registered manager was reviewing and updating risk assessments. When an accident or incident had occurred, new risks had been updated on the risk assessments.

People's medicines were administered by senior staff that had received training. There were secure storage facilities for medicines. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. Despite some medication being signed in by the deputy manager and registered manager a mistake had occurred with the quantities. We spoke with the deputy manager who rectified the problem during the inspection. We looked at records relating to medicines that required additional security and recording. These medicines were stored securely and clear records were in place. We checked records against stocks held and found them to be correct. This meant the home was managing medication to keep people safe.

We recommend the provider should seek advice around employing people overseas from agencies such as the United Kingdom Border Agency.

Requires improvement

Is the service effective?

Our findings

Staff had some understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. .

Some people who lived in the home were able to make decisions about the care or treatment they received. Some people at the home were unable to make certain decisions about their care and treatment; people had not had detailed capacity assessments and if they lacked capacity a best interest decisions. For example, one person required special monitoring but there was no record in their care plan of how staff had reached the decision or that a MCA or best interests decision had been completed The registered manager said that one of the other health and social care professionals had completed this, but the home did not have copies.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. At the entrance of the home there was a finger print lock; only staff had the ability to use this lock. We saw people asking and being let out by staff. However, the registered manager and staff told us that three people were unable to ask or leave unsupervised. At the time of the inspection, there was one application to restrict a person's liberty under DoLS. The registered manager told us two further people should have had applications completed to ensure breaches of their human rights did not occur. This meant the protection of people's human rights had not happened because the provider had not followed the correct procedures when people lacked capacity and were subject to continuous staff supervision. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care from staff that had not always been appropriately supervised to ensure that they are able to carry out their roles effectively. Staff were not clear how often they should have supervisions; they explained the registered manager was the only person that carried out supervisions and appraisals. The provider's supervision policy states that staff should receive six supervisions a year. One member of staff thought supervisions should happen every six months and another member of staff said they should receive supervision every four to six months. We looked in staff files and there was little written evidence of supervisions. Staff said they felt supported by the manager and were able to go to them with concerns. The registered manager said there was not always enough time for them to do everything.

People received a diet in line with their assessed nutritional needs and wishes. One person said the "Food is OK" and explained that they do get choice. Another person said, "The food is not bad at all". A third person told us they "Enjoy the food". We saw the deputy manager went around people and had a long discussion with them about what food they would like the next day. We spoke with the chef who understood the different needs of the people and their dietary requirements; for example, some people had medical conditions that required low fat food. Another person required a soft diet; they received this at meal times. However, for over two-years the home had the same eight-week rotating menus. We asked the registered manager how much input people had into the current menus. The registered manager explained they were in the process of redoing the menus with people's involvement so it reflected their choices. Following the inspection we were told the home has a Christmas menu, summer menu, chef's special of the day and bonfire night menu.

At lunch time people were able to choose where they ate their meal. During a lunchtime observation, most staff interactions were task based with people. However, the activity coordinator sat with people and had many positive interactions. We spoke with the registered manager who explained that some people like to sit alone and not receive interactions from the staff; people appeared relaxed during the meal.

The registered manager told us people were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. There was a focus on trying to introduce the new care certificate for new staff. The care certificate is an identified set of

Requires improvement

Is the service effective?

standards that health and social care workers adhere to in their daily working life. A staff member told us their induction included taking information home to read and coming back to talk through the material.

There was a training system in place; a member of staff said, "There is loads of training. All training is really good compared to my old job". The registered manager explained they were sourcing specific care training for members of staff to meet their learning needs. Members of staff confirmed they had been involved in these discussions. A health and social care professional told us they were liaising with the home to deliver training for staff to reflect the needs of the people. This meant the registered manager was identifying staff needs to ensure they were trained to deliver effective support to people.

People with complex needs lived at the home; the home arranged for people to see health care professionals according to their individual needs. A relative said, "[The home] got doctors and the district nurse in quickly when it was needed". To meet the needs of individuals a range of health and social care professionals were involved. We spoke with some health and social care professionals that regularly attended the home who were positive about the way the home supported people as part of a team. One health and social professional said, "There was lots of joined up working". We saw a person had received some dentistry treatment; their health needs had been identified and appropriate action had been taken. This meant the health needs of people living at the home had been considered and when required the home sourced appropriate professionals.

Good

Is the service caring?

Our findings

People said kind and caring staff supported them. One person told us that the staff were supportive and "Very professional". Other people said "They look after them terrifically" and "Any problems I get, they help me." Another person said, "Everyone treats me very well". A relative told us "The difference in [relative] has been amazing" when talking about the positive effect the staff and home have had. Another relative said, "Staff come quickly when they [the resident] call them". Health and social care professionals were positive about the interactions they had seen between the staff and people.

We saw staff have positive interactions with people. A person approached a member of staff complaining about their shoes; the member of staff offered immediate support. Another member of staff went round to everyone asking if they would like a cup of tea. Throughout the inspection, the registered manager took time to talk with people and make sure they were alright. We observed people were happy in the home and felt supported.

People's privacy was respected and all personal care was provided in private. We observed members of staff knocking on people's doors prior entering the room. When people were supported with personal care action was taken to ensure a person's dignity was respected. During the inspection, a person moved in to be with their loved one. A separate lounge area meant they had more privacy.

People told us they were able to have visitors at any time. A person told us "My [relative] comes to see me two or three times a week. I like [relative's name] coming". We saw some people had visitors; they chose where to sit with their visitors. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private.

People made choices about where they wished to spend their time and their preferences were respected and actioned. One person told us "They respect my choices". A relative said, "[My relative] is involved in choice. We are really pleased". Some people preferred not to socialise in the lounge areas and spent time in their rooms. Some people told us they preferred to stay in their rooms. We saw people moving freely around the home. The registered manager told us that some people in the home wanted pets in the home; there were two cats living there.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us, they did so in a respectful and compassionate way. Care files were kept securely to ensure people's confidentiality; people could see their file if they wanted. Sometimes it was necessary for confidential papers to be sent to other agencies such as the local authority and CQC. We found an occasion when a new member of staff did not send paperwork as securely as they should. The registered manager explained that this staff member was new to sending this type of paperwork; they explained the correct process to this member of staff.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about all aspects of their day-to-day lives. Staff had excellent knowledge of the people they were supporting. They were familiar with their care plans, needs and choices. This meant they were able to provide individualised care for people. People, their relatives and the health and social care professionals agreed that care was responsive to their needs.

People were able to take part in a range of activities according to their interests with the support of the activities coordinator. A person spoke with us about a trip to a museum with old tractors and artefacts. Another person said, "I play scrabble sometimes". A relative told us that their loved one enjoyed painting in their room. We spoke to the activities coordinator who took activities to people that chose to stay in their room. They said they would play the piano to one person who would recognise the tunes. The activity coordinator had only been in post a short time. They were aware of people's preferences already and were sourcing more activities. The registered manager told us about a plan for a potting shed on site so people could participate in gardening.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. A range of health and social care professionals were contacted to ensure people's complex needs could be met by the home. People and their loved ones were able to have input into which bedroom they had. One couple had an area of the home where they had a small sitting room next to their bedroom.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected people's wishes. There were updates to people's support and care plans in relation to changes in behaviour and needs. Additional risk assessments were created if the changes were identified that increased the risks. People's cultural and spiritual needs had been considered as well as health and care needs. There were completed monthly reviews and updates; this meant that people requiring information about a person, including new staff, would have the up to date information needed be able to deliver care. Staff asked people about their care through informal discussions and recorded their preferences in their care plans.

People were supported to maintain contact with friends and family. People were supported to use the telephone to make contact with relatives. Another person saw their loved one every fortnight at another care home.

People knew how to make a complaint; one person explained they complain about another person entering their room without permission. They said, "There was a very quick response" to their complaint. The registered manager showed us their complaints file and talked us through how they had managed them. They had dealt with them in a timely manner, including making detailed notes about how they had managed the complaint. One complaint required the provider to write an apology; the registered manager was confident to do this when they knew they had made a mistake. Therefore, the provider handled complaints effectively and the registered manager demonstrated how they had learnt from a particular complaint and how they would prevent the same thing reoccurring.

Requires improvement

Is the service well-led?

Our findings

The home was not always well led; the registered manager did not have enough time because they tried to complete most tasks themselves. A key senior staff member was on maternity leave and the manager had not put structures in place in a timely manner to allow for the shortfalls. There were plans to introduce a new induction process but the person arranging this was the staff member on leave. The registered manager told us that they knew this person was going on leave for months but had only just employed someone to begin doing some of their work. This meant the registered manager was not always acting in a timely manner to changes that occurred in the staffing team there were delays in the completion of audits and new inductions as a result.

Staff told us the registered manager delegated jobs to other staff; they explained the registered manager would use their strengths to decide which tasks they received. However, Staff supervisions were not in line with the provider's policy; the registered manager supervised all staff except two maintenance staff. Staff did not have a forum where they could discuss their performance and support for the people in the home. There had been no changes in the menus for over two years; this meant people had not been involved in designing the menu and they had not considered current needs of people such as their current dietary requirements relating to their health.

There were inconsistencies in the quality assurance procedures and audits; These had not identified shortfalls so no plans put in place to prevent reoccurrence. The procedures were not identifying all errors that had occurred including a mistake in medication. The registered manager said they did not complete a medication audit each month because they signed in the medication. They continued to tell us the member of staff on leave completed some of the audits; the registered manager was completing all of them because they had not delegated them to anyone else. The registered manager had explained that they did not have time for everything. Consequently, the registered manager was not effectively delegating systems to identify shortfalls.

Some issues identified during the inspection were potentially putting people at risk; the local authority and CQC had not received safeguarding notifications and the provider had not completed the correct employment checks for staff. People's human rights were breached and the correct MCA procedures had not been followed. Completed audits did not identify Issues found on the inspection; this meant the processes were not effective at identifying all shortfalls within the home.

This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

The registered manager had a clear vision for the home which was to be as homely as possible and an extension of the family for the people. A relative said "It is like a family." Staff members were clear about the vision; a member of staff said "It is very homely here. Not too Clinical". Another member of staff said "It feels like a big family" when they were talking about working at the home. The registered manager explained staff were always free to bring ideas to them so that they could contribute to the vision and values of the home. The visions and values were communicated to staff mainly through informal methods.

There was a staffing structure in the home, which provided some lines of accountability and responsibility. We spoke with some staff who had just received new job descriptions to help them understand their roles and responsibilities. They described their roles and how they help to provide good quality care to the people living at the home. This meant that some staff knew the lines of accountability with the registered manager in charge. As well as this, the people knew who to go to if they needed advice or support.

All accidents and incidents which occurred in the home were recorded and analysed. New risk assessments were created followed the accidents and incidents. When required external health and social care professionals were identified and brought into the person's care plan. We saw evidence of this approach on a number of occasions with people.

The registered manager kept their skills and knowledge up to date by on-going training and reading. They spoke to us about the importance of keeping their skills up to date so they could deliver bespoke training as part of staff meetings. For example, the registered manager talked about a session they had delivered on supporting people with dementia at meal times. They identified key features such as plate colours and how to prompt people in a dignified way. This meant they were empowering staff to

Requires improvement

Is the service well-led?

have key skills to deliver care to meet the needs of the people that live in the home. They were able to tailor the training to meet specific people's needs within the home. There was some evidence of this at meal times.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not acting in accordance with 2005 Mental Capacity Act when people lacked capacity and had their liberty deprived. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not identifying all the shortfalls in the home and did not mitigate all risks. Regulation 17 (2) (a, b)