Mountfield House Care Home

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Inspection report

286 Penn Road
Wolverhampton
West Midlands
WV4 4AD
Tel: 01902 330017
Website:

Date of inspection visit: 17 and 18 December 2014
Date of publication: 25/03/2015

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on the 17 and 18 December 2014 and was unannounced. At our last inspection on the 6 November 2013 the regulations inspected were met

Mountfield House Care Home is registered to provide accommodation and support for 14 older adults with dementia, mental health, physical disability and sensory impairment. On the day of our inspection there were 14 people living in the home and there was a registered manager in post. 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.

People we spoke with told us they felt safe. The relatives we spoke with told us that people were safe within the home. Our observations were that people were happy and staff interacted with people in a loving and caring manner. Staff we spoke with were able to explain the

Summary of findings

actions they would take to ensure people were kept safe from harm. Records showed that staff had received the appropriate safeguarding training to know how to keep people safe.

We found that where people were administered medicines 'as required', there was not an individual protocol in place to guide staff as to when these medicines should be given where they are not prescribed. This would reduce any potential risks to people's safety.

We found that staff were not always available to support people when needed. Our observations were that during meal times people in the dining room who needed help to get their food cut up by staff had to wait. This was due to staff having to support people in the lounge area to eat and there being no staff available in the dining room area. This meant people would not get the support they needed when they needed it.

We found that the provider had the appropriate medicine procedures in place so staff had the skills and knowledge to administer medicines safely. We found that where people needed medicines on an 'as required basis' rather than a regular daily regime there was a protocol in place to advise staff. However the process was a general process and did not give specific guidance to staff as to people's medicine needs on an individual basis. So where people may have specific risks these may not be identified.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. CQC is required by law to monitor the operation on the DoLS and to report on what we find. We found that people's rights were not being protected in line with the legislation. Staff we spoke with had not had any training and where people who lacked capacity were unable to give consent or their liberty was being restricted the appropriate actions had not been taken.

People we spoke with told us how lovely the meals were and that they were able to decide on what meals they had. Our observations did not identify how easy it was for people to get hot and cold drinks. However, people and relatives we spoke with told us they could get a drink whenever they wanted one.

People and relatives we spoke with told us that staff were respecting the dignity, privacy and independence of people. Staff were able to explain how people's dignity was being respected in how they supported people.

We found from our observations that people were not being interacted with on a regular basis either through staff communicating with them or through activities that were identified within the care records as part of the preferences or interest. People were left for over an hour at time throughout the day with no stimulation or just left to sit and sleep. On arrival to the home this was very apparent as staff were busy supporting people to get up and the member of staff in the lounge was busy administering medicines. It was unclear as to how much importance was given to people being mentally stimulated on a regular basis as part of their identified preferences in their care records.

People and relatives we spoke with told us that although they had not been given a copy of the complaints process they knew how to complain. They told us that they had not had cause to complain. Records identified there was a process in place and where complaints had been received they were being investigated and the appropriate record kept of the outcomes/action taken. We found that monitoring of trends to improve the service to people was ongoing.

People and relatives we spoke with told us the service was well led. The staff we spoke with confirmed they were able to get support from the registered manager when needed. We found that systems were in place to communicate with people, relatives and staff, however improvements were still needed in how the service was audited in terms of delivering a good quality service. You can see what action we told the provider to take at the back of the full version of the report.

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

We found that some areas of the service were not safe.

We found that people were not always able to get the support they needed from staff when they needed it during meal times.

Staff knew how to keep people safe and the action they would take where people were at risk of harm.

The appropriate guidance was not in place to ensure people's safety when they needed medicines as required that were not prescribed.

Is the service effective?

Requires Improvement

We found that some areas of the service were not effective.

We found that staff did not have the information, skills or knowledge required to ensure people's liberty was not being restricted. Staff had not had the appropriate training in the mental capacity act or the deprivation of liberty safeguarding.

We found that people were offered a choice of meal.

Staff knew how to ensure people's support needs were being met and where people needed support from health care professionals this was being done.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were kind and caring. Our observations of staff interaction with people were that staff showed an understanding of people's support needs and aided them appropriately.

People told us that their dignity and privacy was respected by staff. Our observation did not confirm this, we saw someone being supported by a chiropodist inappropriately in the lounge area.

Relatives told us they were involved in the decisions about their loved ones and that communication with staff was good.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found that the appropriate documentation was in place so staff knew how people's support needs should be met. Staff told us they were able to access records as needed. Our observations confirmed this.

People and relatives told us they were able to share concerns they had with staff when they wanted. It was unclear how people could do this that had a lack of capacity.

Summary of findings

We found that people were unable to get regular stimulation as part of their identified preferences and interests.

People and relatives told us they had not been given a copy of the complaints process, but knew who to speak with anyway.

Is the service well-led?

The service was not always well led.

We found that the environment in the home was homely and the registered manager and staff were approachable and friendly. People and relatives we spoke with told us the home was well led and that they were happy.

We found that monitoring systems/audits were in place but they were not always effective to ensure the quality of the service or to determine where improvements were required.

Requires Improvement

Mountfield House Care Home

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.

Our inspection took place on 17 and 18 December 2014 and was unannounced. The inspection was conducted by one inspector.

Before the inspection, we asked the provider 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. They did not return a PIR and we took this into account when we made the judgements in this report. To plan our inspection we reviewed information we held about the home, this included notifications received from the provider about deaths, accidents/incidents, safeguarding alerts which they are required to send us by law.

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 communicate with us.

On the day of our inspection there were 14 people living in the home, only two people were able to speak with us. The other 12 were unable to share their views verbally due to their communication needs so we observed how they were supported. We spoke with one relative who was visiting the home, three members of staff, the registered manager and two further relatives by telephone after the inspection. We looked at the care records for two people, the recruitment and training records for two members of staff and records used for the management of the service; for example, staff duty rosters, accident records and records used for auditing the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with felt safe living within the home. One person said, "I do feel safe living in the home". One relative said, "I do feel [My Relative] they are safe living here. I have seen how staff are with her, very caring and know what they are doing. The way they talk to her". Our observations were that staff were seen checking on people throughout the day. There were a number of people in their bedrooms and staff were seen going to check that they were okay as part of ensuring their safety. Staff we spoke with were able to explain the action they would take if they saw people at risk of harm and how they would keep people safe. They confirmed they had received the appropriate training in safeguarding and the records we saw confirmed this. People could be assured that were a situation to arise staff would know what to do to keep them safe and the process to follow in reporting any safeguarding concerns. There had been no safeguarding alerts raised by staff as no situations had arisen since the last inspection.

The provider had a dependency system in place to determine the levels of staff that were needed to ensure people's needs were met safely. However, too much reliance was given to this system and not enough monitoring was being done to increase staff where the need was apparent during meal times and when people were being administered their medicines. We found there was only two staff left to support people in the home when the senior was administering medicines. Relatives we spoke with told us there was enough staff to meet people's needs. One person we spoke with said, "There is enough staff, but at times I am left waiting for support". The staff we spoke with felt there were enough staff working within the home. Our observations at meal times were that people had to wait for staff to support them. This was due to staff having to leave the dining area to take meals to people who were in their bedrooms and support other people to eat in the lounge area. While staff where doing these tasks there were no staff available to support or check on people in the dining area. During medicine administration we saw that where someone needed two members of staff to support them outside of the lounge area this would impact upon people and leave the lounge area with no staff to support or check on the remaining people while senior staff were administering medicines.

The staff we spoke with told us they had completed a Disclosure and Barring Service (DBS) check before being employed. This check was carried out to ensure that staff were able to work with people and they would not be put at risk of harm. The provider also had a declaration process in place so that staff suitability to work with vulnerable adults could be continually checked. Records we saw confirmed this. This would give people assurance that the staff supporting them were appropriately checked and recruited.

Records showed that risk assessments were undertaken as part of identifying risks to people's safety and how any risks should be managed as part of supporting them. For example where health care professionals gave advice to how people's meals should be provided, we saw that this was being done. Where people were at risk of falls we saw that the appropriate actions were recorded to keep people safe. Staff we spoke with had an understanding of the risks to people and how they were to be managed.

People we spoke with were happy with how their medicines were being administered. One person said, "My medicines are always on time". One relative said, "They do better here than in hospital".

We found that there was a medication policy in place to support staff in administering medicines. However, we found that when people needed medicines 'as and when required' there was only a generic protocol in place to guide staff and this protocol did not take account of people's individual needs. An individual 'as and when required' medicine protocol would highlight each person's needs so staff would have better guidance as to when these medicines could be given where they were not prescribed. We spoke to the registered manager about this and they agreed to put a protocol in place for each individual.

We found that the Medication Administration Record (MAR) being used to record when people were given medicines were completed consistently. Staff we spoke with told us that they were only able to administer medicines once they had received training and that their competency to administer medicines was checked. Records we saw confirmed this. Where people were administered controlled drugs, the provider had the appropriate recording system in place and the drugs were being locked away as required. Our observations of the administration of

Requires Improvement

Is the service safe?

medicines did not identify any concerns that would put people at risk of poor medication. Staff administering medicines and recorded when people had their medicines after they had been given them.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with were unable to explain the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) and what the impact would be on people who lacked capacity. They also confirmed they had not received any training in either area. We observed people who lacked capacity, we saw that their consent was being sought however; due to their capacity levels we were unsure at the time as to whether they were able to give consent. Where people may have wanted to leave the home and were unable to do so due to their lack of capacity we saw no evidence that people's capacity was being assessed.

We observed staff on one occasion talking over someone who lacked capacity. Staff could have involved the person to hold a positive conversation with them, allowing them to contribute to the discussion rather than talking over them.

People's restrictions were limited for their safety, but we saw no DoLS assessments in place. The provider had not made contact with the supervisory body for clarity as to whether a DoLS application would be required. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. This meant that the provider had not followed the requirements of the DoLS. Arrangements in place did not ensure that the provider had taken steps to ensure the legislation was appropriately applied and people's rights upheld.

This was a breach of regulation 11 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One relative said, "Staff understand and are aware of all [My Relative's] needs". Our observation of staff were that they knew how to support people and were able to explain to us the appropriate actions they would take in a number of situations to ensure people were supported. This showed that the member of staff concerned did not understand the person's care needs. The staff we spoke with told us they had regular access to training, supervision, and were able to attend staff meetings. We saw no evidence of an appraisal system in place and staff were not able to confirm whether this took place. The register manager confirmed that staff were able to get appraisals every eight weeks. The information from staff and the manager was conflicting; this could mean that staff were unclear as to what an appraisal was. The training records showed that while training was being offered there were gaps in some training areas which would enhance the skills and knowledge of staff.

People told us they were able to get a choice of meal. One person said, "The meals are lovely, I have no complaints". We saw that a menu was in place and displayed in the dining room. However where it was displayed behind the Christmas tree did not make it easily visible to people. They would only be able to see what was available when they entered the dining area. One person said, "I do get a choice of meals and drink". The cook explained they would go round on a daily basis gathering people's meal choices. One person said, "You can have whatever you want for breakfast". People confirmed the cook would check what they wanted to eat. We were unclear from our observations how frequently people were able to get a hot or cold drink outside of the main meal times. The cook confirmed people would get a hot/cold drink with their breakfast and lunch and again mid-morning and in the afternoon. One person we were speaking with at the time was asked if they wanted a cup of tea outside of the meal times however, we did not see anyone else with a drink. Relatives we spoke with told us people were able to get a drink whenever they wanted. During meal times we saw people being supported to eat their meals where this support was needed. The majority of staff were seen to be gentle, supportive and kind when assisting people to eat. We saw an example of poor practice where a member of staff was not being so supportive. The person they were assisting to eat their lunch were not being spoken with or even communicated with to establish if they were ready for another spoonful of food.

Records showed that a nutritional screening tool was being used to monitor people's nutritional needs on a regular basis. Where people were identified with a nutritional risk the appropriate action was being taken. The cook had the appropriate skills and knowledge having confirmed they had received the appropriate nutritional training. This enabled them to be able to meet people's needs where

Requires Improvement

Is the service effective?

they were diagnosed as a diabetic or needed food supplements, which would have been agreed through a dietician. This would ensure people were able to maintain a balance diet.

One person we spoke with told us they were able to see a doctor when they wanted. Relatives confirmed their relative was able to get medical assistance when needed.

We observed someone being supported by a chiropodist during our visit. Records showed that people were able to see a dentist or their doctor when needed and a health check form was being completed to record these appointments. This meant that people had access to health professionals where needed.

Good

Is the service caring?

Our findings

A person we spoke with said, “Staff are nice, cheerful and happy”. A relative said, “Staff do know how to support mum, she is drinking and moving around since moving into the home”. Our observations were that there was a warm feeling in the home amongst the staff and people.

The atmosphere was relaxed and staff greeted people with a smile and welcome. People and relatives we spoke with told us how caring the staff were. One relative said, “They [My Relative] always have a smile on their face, so I know they are happy”. When staff had time they would talk with people and we heard people respond back in a confident and happy manner. The staff we spoke with had a good understanding of the care needs of people and how people should be supported; they knew where the care records were and were able to access them as and when required. One person we observed had very dry skin on their legs and staff had no guidance as to when and how cream should be applied. This meant where people needed support this may not always be available if staff were unclear as to what people’s needs were.

One person said, “I am able to make decisions about the care I receive”. Our observations were that people who had capacity were able to make their own decisions as to how they were supported and when they went to bed. Staff were observed asking people a range of questions related to the care they subsequently received. People were also able to talk with staff when they wanted. Staff were seen telling someone what time of the day it was, so they were able to know when their relative would arrive. Staff spoke slowly when required so people could understand and used body language skills to help people understand. For example, pointing at the time on the clock to help illustrate what they were saying. People who were unable to make decisions had their relatives involved in the decision making process. We saw a number of relatives visiting the home on the day of the inspection which showed that people were able to have visitors. One relative said, “I am kept regularly informed about [My Relative’s] changing support needs”. Relatives told us they could visit the home when they wanted.

People were seen walking around the home as they wanted and were not restricted to any particular part of the home. People did however spend most of their time in the lounge area with a few people choosing to stay in their bedrooms. This meant that people had the choice as to where they spent their time.

We found that people were able to spend time privately where they wanted; most people choose to stay in their bedrooms. People we spoke with told us it was their choice to spend most of their time in their bedroom. One person we spoke with said, “My privacy, dignity and independence are respected by the staff”. We saw staff promoting people’s dignity when they supported them to the toilet. The staff we spoke with were able to explain how people’s dignity and privacy were being respected in their everyday support of people. However, we saw someone being supported in the entrance area of the lounge to have their feet cared for by a chiropodist, and their dignity was not being considered or other people around them in the lounge at the time. The provider confirmed action would be taken to ensure this situation did not happen in future as a way of promoting people’s dignity.

We found that people’s independence was promoted. People were able to support themselves where they were able with little support from staff. One person said, “Staff only supported me when I need it”. One relative said, “They [My Relative] are able to do what they can to keep their independence”. This meant that people’s independence was being respected wherever possible.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said, "I do not remember being involved in the assessment process". The relatives we spoke with all told us they were involved in the assessment process as part of establishing their relative's needs. We found that where people's needs changed staff responded appropriately by involving people or their relatives as part of the decision making process. The support people received was responsive to their needs. People were able to go to bed and get up when they wanted. Records showed that people's needs were identified so that staff would know what their needs were and how to meet them. One relative told us that since their relative came to live at the home they had improved.

We found that people's preferences and interests were not always being met as identified in their care records. Our observations on arrival to the home were that people were not being stimulated as much as they should be. People were not all able to remember when lunch time was or even what they had chosen for lunch. We saw no evidence within the environment of the home to show how people were being supported to remember daily events like lunch time or take part in their interests as a way of supporting their memory loss. Staff were not proactively interacting with people in a range of ways to help stimulate them. People were sitting in the lounge either sleeping or just looking around at each other, while staff moved in and out of the lounge carrying out tasks. For large parts of the day people were not able to take part in the interests identified in their care records. On the afternoon we saw that there were some activities taking place as part of offering people some stimulation, but this was not person centred and was more general activities aimed at everyone in the lounge as a group rather than anything more specific to people's interest. One person told us they were able to go out with their relative, as described in their care records another person said, "I would love to play bingo". We found that staff were required to do activities with people as well as their care role, there was no dedicated person responsible for doing activities with people. It was not evident from what we saw that people were regularly involved in decision's about the activities they took part in.

We found that there was displayed in the home pictures of activities that had taken place previously, but this did not show whether it was activities people wanted to do and there was no evidence shown to us to verify this. Staff we spoke with told us that activities did take place and gave the example of a man who visited the home weekly to do exercise with people, but accepted activities could be more frequent.

Relatives told us they were kept informed of people's support needs, and were able to share any concern they had. People we spoke with told us staff discussed concerns with them, but we saw no records of reviews that had taken place to show the outcome of reviews or any discussions about people's changing needs. There was no evidence of regular relative meetings or the involvement of people in decisions related to how the home was managed and quality of the service provided to them.

People told us they were able to share concerns they had about the service and they knew who to raise concerns with if they had concerns or a complaint. They also confirmed they were never given a copy of the complaints process, but never had anything to complain about. Relatives we spoke with confirmed this. Record showed that a complaints process was in place and complaints that had been dealt with previously had been logged appropriately and actions/outcomes identified as part of how the provider used the process to improve services to people. This meant that where people had to make a complaint there was a process in place to deal with them appropriately.

Requires Improvement

Is the service well-led?

Our findings

People and relatives we spoke with told us the home was well run and that the manager and staff were very 'Friendly' and 'Kind'. One person said, "Normally I do not see the manager". One relative said, "The manager is usually around taking an interest in people's needs and aware of what is going on in the home". The staff we spoke with told us that the manager was supportive and available when needed. Our observations were that the registered manager was available to talk with people and support staff. The home was welcoming and friendly and people were happy and well-presented and spoke to us willingly and with ease where they were able.

There was a deputy manager available to cover the home when the manager was not present. The deputy manager knew where everything was and was able to answer our questions on arrival to the home. Staff we spoke with were aware of the management structure and who was in charge of the home on a day by day basis or when the registered manager was on holiday.

The registered manager was also the provider/owner and any decisions that needed to be made on a daily basis could be immediately taken without having to seek someone else's approval. This meant that where there were implications for people's support these decisions could be taken immediately by the registered manager.

We found that the provider had a whistleblowing policy which staff were aware of and able to tell us about. Staff knew what the policy was for and how it was to be used where there were concerns about how people were supported or potential risk.

We found that audits were carried out to monitor the quality of the service people received but they were not all effective. For example, the audits carried out on the window within the home did not detect that window restrictors were not in place. We found that windows were being locked rather than being restricted. This meant that people were unable to open their bedroom windows where they wanted to.

We found that incidents and accidents within the home were being recorded appropriately following a clear written process. Where accidents or incidents took place they were monitored for trends so any improvements to the quality of the service people received could be taken. The records we saw confirmed this.

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. We were informed by the registered manager that the form was not received. We have confirmed that the email details we have are still correct and there is an expectation that the PIR is completed in future. We found that there had been no recently notifiable events to us; however the registered manager was aware of the legal requirement to notify use of any deaths, accidents, or situations where people were put at harm.

We found that the provider was not implementing the provisions of the Mental Capacity Act 2005 (MCA). Staff had not received the appropriate training to aid their skills and understanding of the MCA.

We found that people had limited access to activities and appropriate stimulation as part of the preferences and interest identified in their care records. Whilst there was evidence displayed in the home of activities that had taken place, it was not clear what people's involvement was in the decision making process.

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 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 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.**