Mrs Hazel Teresa Boam

Masson House

Inspection report

86 Derby Road
Matlock Bath
Matlock
Derbyshire
DE4 3PY

Tel: 01629258010

Date of inspection visit:
08 November 2023

Date of publication:
19 December 2023

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Masson House is a residential care home providing accommodation and personal care to up to 17 people. The service primarily provides support to older adults but can also support people over the age of 18. At the time of our inspection there were 12 people using the service. The care home is a large adapted domestic style building, which also has a purpose-built ground floor extension.

People's experience of using this service and what we found
The purpose of this inspection was to check whether the provider had complied with the conditions we had imposed on their registration with CQC, which took effect on 3 October 2023. We had imposed conditions because we found the provider needed to take urgent improvement action to keep people safe from harm. In this inspection we found the provider had not complied with the conditions and people continued to be at risk of harm.

The provider had not complied with the condition on their registration which stated they should send us evidence of their process and procedure for reviewing incidents and identifying safeguarding concerns. This meant people were still at risk of potential abuse and neglect.

The provider had not complied with the condition on their registration which required them to send us written confirmation that all sinks, baths, and showers, to which people had access, had appropriate thermostatic mixing valves fitted to ensure the hot water was at a safe temperature. This meant people were still at risk of harm from scalding.

The provider had not complied with the condition on their registration which required them to send us written confirmation that all radiators and associated pipework had appropriate covers in place that were securely attached to the wall. This was to prevent people encountering hot surfaces which may cause burns.

The provider had not complied with the condition on their registration which required them to send us written confirmation of their plans for repairing or replacing the lift. The lift was broken, and the provider told us it could not be easily repaired. This meant people could not use the lift to travel from the ground floor to their upper floor bedrooms.

The provider had not complied with the condition on their registration which required them to provide us with written details of their procedures for identifying, and addressing, environmental safety issues at Masson House; which impacted on the health and safety of the people who lived there. This included details of the timescales for completion of remedial works and who would be responsible for completing them.

The provider had not complied with the condition on their registration which required them to carry out a Legionella risk assessment and a fire risk assessment at Masson House. Additionally, the provider was required to send us confirmation those risk assessments had been completed, and a copy of their action

plan to show how and when identified improvement actions would be completed. This meant people continued to be at potentially increased risk of harm from Legionella infections and fire.

The provider had not complied with the condition on their registration which required them to determine people's individual capacity to consent to receive care and treatment from Masson House; and to request any necessary DoLS authorisations. This meant there was an increased risk that people may have been subject to unlawful care and treatment.

The provider had not complied with the condition on their registration which required them to send us written evidence that people's care plans had been reviewed. The provider was also required to evidence how that review information had been used to calculate the numbers of suitably trained staff required to meet the care needs of people. This meant there was an increased risk that people would not receive safe and appropriate care.

The provider had not complied with the condition on their registration which required them to instruct a suitably qualified, and independent, nurse or pharmacist, to undertake oversight of medicines management at the care home. Additionally, the provider was required to send us copies of their monthly medicine quality audits but had not done so. This meant people continued to be at risk of harm from poorly managed medicines.

The provider had not complied with the condition on their registration which instructed the provider must not admit any new service users or readmit current service users to Masson House (if they should have been admitted into hospital for example), without the prior written permission of the Care Quality Commission. This meant we were not assured that people were able to be supported safely by the provider.

People were not supported to have maximum choice and control of their lives and the provider did not have suitable processes in place to ensure potential restrictions on people's liberty were legally authorised and in their best interests; the policies, systems, and practice in the service did not take into account the requirements of the Mental Capacity Act 2005.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

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

Rating at last inspection and update
The service was last rated Inadequate and was placed into special measures. The inspection report was published on the CQC website on 15 November 2023.

The previous inspection site visits had taken place on 23 and 24 August 2023, and 5 and 28 September 2023. The inspection report was completed, and a final copy shared with the provider, on 6 November 2023 before final publication on the CQC website.

As a result of the findings, from that previous inspection, CQC imposed urgent conditions on the provider's registration on 3 October 2023.

Why we inspected
We undertook this targeted inspection, on 8 November 2023, to check whether the provider had complied with the urgent conditions we had imposed on their registration on 3 October 2023. A condition of registration places a limit or a restriction on what a provider can do. It may be linked to a location, regulated activity, service type, or specific activity.

In this case the imposed conditions restricted the admission, or readmission, of people to the care home; and a requirement that the provider send us satisfactory evidence of specified improvement actions having been completed, by the dates listed in the conditions notice.

We use targeted inspections to follow up on concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Masson House on our website at www.cqc.org.uk.

Enforcement
We have identified ongoing breaches in relation to medicines management, health and safety, consent, staffing, and the management of the service.

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, which will help inform when we next inspect.

The overall rating for this service remains 'Inadequate' and the service therefore continues to be 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 six 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 of their 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?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Masson House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and had previously provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the urgent conditions we had imposed on their registration on 3 October 2023, in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of 2 inspectors and an Operations Manager. The inspectors carried out the onsite inspection activity. The Operations Manager was offsite and supported the inspection by reviewing copies of people's medicine administration records obtained by the inspectors.

Service and service type
Masson House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Masson House is a care home which does not provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager was also the provider and owner of the care home.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

As part of the urgent conditions applied to the provider's registration, the provider had already sent us some documents showing what changes they stated they had made at the care home. We reviewed those before completing the inspection. We also obtained feedback on the care home from the Local Authority Adult social care team. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and discussed with them the requirements of the urgent conditions applied to the provider's registration. We checked the care home environment and sought evidence that the conditions had been complied with. We spoke with 5 people who use the service about their experience of living at the care home. We checked various rooms of the care home and also reviewed people's medicine administration records. We observed staff interactions with people.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had complied with the urgent conditions we had imposed on their registration with CQC. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found the provider's systems and processes failed to safeguard people from the risk of abuse and improper treatment. This placed people at increased risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- We had imposed a condition on the provider's registration which required them to evidence their process and procedure for reviewing incidents and identifying potential safeguarding concerns. Additionally, they were required to provide evidence to us that they had properly recorded safeguarding matters, escalated the issues to the Local Authority safeguarding team and CQC where appropriate, and that lessons were learned from incidents.
- The provider sent us no evidence of their revised policy or procedures, and could not evidence that incident reviews had taken place. Additionally, we found incidents had occurred, in which people had been harmed, and no incident reports had been completed by the provider's staff.
- The provider's incident recording and review procedures continued to be ineffective, and the provider had failed to comply with the condition which we had imposed on their registration. Therefore, we could not be assured the provider was operating a safe incident and safeguarding system to record, alert the relevant agencies, investigate, and keep people safe from abuse or improper treatment.

Assessing risk, safety monitoring and management
At our last inspection we found the provider failed to adequately assess the risks to the health and safety of service users receiving care. They also failed to take action to mitigate any such risks as far as is reasonably practicable. This placed people at increased risk of harm. This was a breach of regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- We had imposed a condition on the provider's registration which required them to send us written

confirmation that all sinks, baths , and showers, to which people had access, had appropriate thermostatic mixing valves (TMVs) fitted and that they did not release hot water which exceeded a safe temperature.
● The provider had sent us their action plan, and hot water risk assessment. However, during the inspection we found the provider had reduced the temperature of the hot water output from the boiler to all the hot water outlets in the main building. This meant there was no hot water available for people to use to wash themselves at their bedroom sinks.
● The action of the provider, in reducing the temperature of the water leaving the boiler, potentially increased the risk of Legionella infection; as the hot water circulating through the care home main building pipework was at too low a temperature to inhibit the potential growth of Legionella bacteria.
● Legionella is a type of bacteria which in some circumstances can lead to a potentially fatal form of pneumonia. People's risk of susceptibility to infection increases with age, and some people who have chronic health conditions may be at increased risk.
● In the care home extension part of the building we found hot water at a communal shower room sink was at an unsafe temperature. This posed a risk of scalding to people.
● The provider told us they had not fitted TMVs to all the outlets which needed them and could not tell us by when the installation work would be completed.
● The provider failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would not continue to place people at risk of harm from scalding.

● We had imposed a condition on the provider's registration which required them to send us written confirmation that all radiators and associated pipework had appropriate covers in place that are securely attached to the wall. This was to prevent people encountering hot surfaces which may cause burns.
● The provider had sent us their action plan which stated all radiators and pipes would be covered and the covers securely fixed to the walls by 3 November 2023.
● During the inspection we found 2 radiators were not safely covered, 7 radiators had covers in place which were not securely fastened to the wall, and 2 radiators had covers in place with parts missing, so people could still encounter hot surfaces. We also found 5 rooms where hot water pipework was not safely covered and posed an ongoing risk of people being burned by encountering hot surfaces.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would not continue to place people at risk of harm from burns caused by encountering exposed hot surfaces.

● We had imposed a condition on the provider's registration which required them to send us written confirmation of their plans for repairing or replacing the lift. The lift was broken, and the provider told us it could not be easily repaired.
● During the inspection the provider told us they had not commissioned repairs to the lift and people would continue to be required to use the stairlift; which the provider had recently installed as a short-term measure.
● We observed the stair lift in operation and found it was cumbersome for some people to use. The relatively confined space on the staircase also prevented staff from easily getting upstairs to answer call buzzers when the stair lift was in use; thereby creating a risk of falls and/or injury.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would arrange for the repair or replacement of the lift, which was essential equipment to safely support people to move between the ground floor and their upper floor bedrooms.

● We had imposed a condition on the provider's registration which required them to send us written details

of their procedures for identifying, and addressing, environmental safety issues at Masson House, which impacted on the health and safety of the people who lived there. This included details of the timescales for completion of remedial works and who would be responsible for completing them.
● The provider had sent us their action plan which stated a new health and safety audit was in place and monthly meetings were being held to update it.
● During the inspection the provider told us they had not implemented a health and safety audit process.
● We found there were still environmental health and safety concerns present (as detailed above) which the provider stated they were unaware of. The provider continued to have ineffective health and safety audit processes in place, which meant people continued to be at risk of harm.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would take the necessary action, to keep people safe, by identifying and addressing health and safety issues at the care home.

● We had imposed a condition on the provider's registration which required them to instruct suitably qualified and independent professionals to complete a Legionella risk assessment and a fire risk assessment at Masson House. Additionally, the provider was required to send us confirmation those risk assessments had been completed, and a copy of their action plan to show how and when identified improvement actions would be completed.
● The provider had sent us their action plan which stated the Legionella risk assessment would be completed by 8 November 2023.
● During the inspection the provider told us the fire risk assessment had been completed but was not yet available.
● The provider told us a Legionella risk assessment had been carried out prior to our inspection. However, the provider could not evidence this.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would take the necessary action to identify and resolve risks to people associated with fire and potential Legionella infections.

● We had imposed a condition on the provider's registration which required them to have a suitable emergency evacuation chair available for use to evacuate people in an emergency.
● During the inspection we found the provider had complied with this specific aspect of the conditions which we had imposed on their registration.

● We had imposed a condition on the provider's registration which required them to send us confirmation that a suitable evacuation chair, or stair lift, was in place pending the repairs to the lift.
● During the inspection we found the provider had complied with this specific aspect of the conditions which we had imposed on their registration.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

We found the service was not working within the principles of the MCA and, if needed, appropriate legal authorisations were not in place to deprive a person of their liberty.

At our last inspection we found the provider failed to ensure care and treatment was only provided with the consent of the relevant person. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

● We had imposed a condition on the provider's registration which required them to review the care needs of each person who lived at the care home to determine their individual capacity to consent to receive care and treatment from Masson House; and to request any necessary DoLS authorisations from the relevant local authority without delay.
● During the inspection the registered manager told us they had reviewed each person to determine their capacity to consent to live at Masson House and receive care there, but they could not evidence this.
● At our previous inspection we observed some people may not have the capacity to consent to receive care at Masson House. Some people had told us they did not wish to remain there but were prevented from moving elsewhere. This meant there was a risk people may be subject to restrictions on their liberties which were not lawful.
● Some people potentially did not have the mental capacity to decide where to live, or have restrictions placed on their movements, or be subject to constant staff supervision for their safety. This meant people could potentially have been subject to unlawful restrictions on their liberty.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. This meant we were not assured the provider had carried out the necessary assessments of people's capacity to consent to live at Masson House.

Staffing and recruitment
At our last inspection we found the provider had failed to deploy enough staff to meet people's care needs. This placed people at increased risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● We had imposed a condition on the provider's registration which required they send us written evidence that reviews had taken place of the needs of all the people who were living at Masson House. The provider was also required to evidence how that review information had been used to calculate the numbers of suitably trained staff required to meet the care needs of people.
● The provider had sent us their action plan which stated people's care plans had been reviewed and updated. During the inspection we found the provider could not evidence this.
● Staff told us they could not access the provider's electronic care record system due to the internet connection not operating at the care home. This meant they had no access to people's care plans, and they could not update people's care records in respect of care provided on that day.
● People were exposed to the risk of harm from lack of care records and the inability of staff to refer to people's care plans. We were therefore not assured that staff had access to care plan information which would assist them to meet people's individual care needs.
● The provider had previously sent us copies of their Dependency Assessment tool, which they told us they

used to calculate how many care staff were required on each shift. We found this did not show how the assessment of people's care needs led to the calculation of how many care staff were required to meet those needs.
● During this, and our previous inspection, we observed several periods when people required staff support and no staff were available; as they were busy supporting other people.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. Therefore, we could not be assured the provider would take the necessary action to regularly review people's care plans and use that information to appropriately calculate how many care staff were required to be deployed to safely meet people's care needs.

Using medicines safely
At our last inspection we found the provider failed to ensure the proper and safe management of medicines. This placed people at increased risk of harm. This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We had imposed a condition on the provider's registration which required them to instruct a suitably qualified, and independent, nurse or pharmacist, to undertake oversight of medicines management at the care home and to send evidence to us that this had been done. Additionally, the provider was required to send us copies of their monthly medicine quality audits.
● During the inspection the provider told us no external nurse or pharmacist had been appointed to carry out monthly medicine audits at the care home. They told us they had not contacted the local pharmacy for support.
● The provider told us they had asked an external care consultant to focus on the medicine management in the care home. However, the provider had no evidence of that.
● During the inspection we checked the medicine records and found several errors. This included medicine administration record errors, potentially incorrect dosage of medicine given to a person, and a person not receiving their timed pain relief medicine at the correct intervals.
● None of the medicines' errors we found had been identified by the registered manager, and no incident record had been created for any of them.
● We found no evidence of regular medicine audits having been carried out by the provider, and the last internal audit check of Controlled Drugs was carried out on 5 July 2023.
● Some people were observed to be receiving their morning medicines at just before lunch time, which was not at the time the prescriber had intended. The medicines trolley was observed to be left unlocked and accessible to people for a period of at least 30 minutes, with no staff being nearby.
● There were shifts when no staff on duty were trained to be able to administer people's prescribed medicines. The provider had implemented 'on call' arrangements so a suitably trained staff member could be contacted if medicines were needed to be administered. However, this would inevitably impose a delay on people receiving their medicines if they required them.
● The provider did not have medicines profiles in place for each person. This meant new staff, and agency staff, would not have access to important information about people's prescribed medicines and this increased the potential risk of harm to people.
● The provider had failed to comply with this part of the conditions which we had imposed on their registration. People living at the care home were at continued risk of harm from poor medicine administration, management, oversight, and due to there being insufficient numbers of staff who were suitably trained to safely administer people's prescribed medicines.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated Inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had complied with the urgent conditions we had imposed on their registration with CQC. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection we found the provider failed to have effective systems in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was a breach of regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

- We had imposed a condition on the provider's registration which instructed the provider must not admit any new service users, or readmit current service users to Masson House (if they should have been admitted into hospital for example), without the prior written permission of the Care Quality Commission.
- The provider had not complied with this requirement and had readmitted 2 people who had spent time in hospital, without obtaining permission from us.
- The registered manager told us they had misunderstood the requirements of this condition. However, that was not credible, given the provider had previously been in discussions with us about the potential return of a person from hospital.
- This condition was in place so we could have oversight of admissions to ensure people moving into, or back into, Masson House were safe. Therefore, we could not be assured people were safe when moving into, or back into, Masson House because the provider had not complied with the requirements of that part of the conditions.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care and treatment was only provided with the consent of the relevant person.

The enforcement action we took:

We suspended the provider's registration until 2 February 2024.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess the risks to the health and safety of service users receiving care. They also failed to take action to mitigate any such risks as far as is reasonably practicable. This placed people at increased risk of harm. The provider failed to ensure the proper and safe management of medicines. This placed people at increased risk of harm.

The enforcement action we took:

We suspended the provider's registration until 2 February 2024.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes failed to safeguard people from the risk of abuse and improper treatment. This placed people at increased risk of harm.

The enforcement action we took:

We suspended the provider's registration until 2 February 2024.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The provider failed to have effective systems in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

We suspended the provider's registration until 2 February 2024.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy enough staff to meet people's care needs. This placed people at increased risk of harm.

The enforcement action we took:

We suspended the provider's registration until 2 February 2024.