Mountfield House Care Home

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Inspection report

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West Midlands
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14 November 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on the 12 and 14 November 2018. Mountfield House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Mountfield House is registered to provide accommodation for up to 14 people. At the time of inspection there were 12 people living at the home. Mountfield House is arranged over two floors, some of the people who lived there were living with dementia.

There was a registered manager in post who was also the registered provider. 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.'

At our last inspection on 18 October 2016 we rated the provider as 'good'. At this inspection we found that improvements were required and the service is now rated as 'requires improvement'.

Staff had not recognised an incident between two service users as meeting the criteria for reporting and therefore the correct process had not been followed. Lessons were not always learnt when things went wrong.

People's preferences were not met in relation to what time they got up. People were not encouraged to follow their individual interests and people told us that they would like more to engage in. Staff had not always been responsive in relation to people's foot care needs.

The provider's audits in place did not identify the shortfalls we did during our inspection. There was no oversight of delegated roles and responsibilities. People's care plans were not reflective of their current needs and had not been reviewed following incidents.

There were enough staff to meet people's needs. People told us they felt safe. The home was clean and tidy and staff wore personal protective equipment (PPE) as required.

People were supported by staff who had the skills to meet their needs. Staff demonstrated a good understanding of the Mental Capacity Act 2005 and sought consent people supporting people. People's nutritional needs were met. People had access to professionals when required.

People were supported by kind and caring staff who knew them well. People's privacy and dignity was maintained. People were encouraged to remain as independent as possible.

People and relatives knew how to raise concerns with the registered manager and felt comfortable doing so.

We saw that complaints were dealt with appropriately.

People, relatives and staff spoke positively about the registered manager. People's feedback was sought and acted on. Staff told us they felt supported.

We found the provider was not meeting the regulations around person centred care and the overall governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

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 home was not consistently safe

People were not always safeguarded from abuse because staff had not recognised an incident between two service users met the criteria for reporting.

People told us they felt safe. There were enough staff to meet people's needs.

People were protected from the risk of infection. The home was kept clean and tidy.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the skills to meet their needs.

People's consent was sought before providing care.

People had accessed to health care professionals when required. People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well.

People's privacy and dignity was maintained when being supported by staff.

People were encouraged to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences were not met in relation to what time they

got up. Staff were not always responsive to people's needs.

People were not encouraged to follow their individual interests.

People and relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The audits in place had not identified the shortfalls that we identified during our inspection.

People's care records were not reflective of their current needs.

People, relatives and staff spoke positively about the registered manager.

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.

This inspection took place on 12 and 14 November 2018 and was unannounced. The inspection team consisted of two inspectors and an expert- by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted following concerns received from partner agencies and members of the public that included but is not an exhaustive list:

- Neglect
- Lack of person centred care
- Insufficient staffing numbers
- Lack of training/supervision for staff

These concerns were followed up during our inspection. When planning our inspection, we looked at the information we already held about the service. Providers are required to notify the Care Quality Commission (CQC) about specific events and incidents that occur such as serious injuries and incidents that put people at risk of harm. We refer to these as notifications. We looked at the notifications we had received from the provider. We also were aware of complaints we had received and spoke with the local authority and the commissioners of people's care to obtain their feedback and discuss concerns we had received prior to inspection regarding the care at the home.

During our inspection we observed care and used the Short Observational Framework for Inspection (SOFI).

SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three people who use the service, five relatives, one healthcare professionals, eight members of staff and the registered manager. We looked at a range of records. This included eight people's care plans, people's medicine records, staff records and quality assurance systems that were in place.

Requires Improvement

Is the service safe?

Our findings

Staff demonstrated an understanding of their responsibility to protect people from harm and poor care. One member of staff said, "If I felt that people were being treated wrongly or badly I'd report it straightaway. I know I can also go straight to the local authority and CQC". However, staff did not consider an incident between two service users met the criteria for reporting. We found that there had not been an incident form completed, a referral to the local authority had not been sent and we had not been notified as the registered manager and deputy manager had not been informed of this incident. Following our inspection, the registered manager has since submitted these. Since our inspection, there has been a further incident we have been made aware of which we are currently making enquiries about.

We found that other accidents and incidents had been recorded and reported appropriately. There was a process in place to analyse trends every six months to reduce the risk of reoccurrence. However, an analysis had not been done since 2017. This meant that opportunities to learn lessons when things went wrong were missed.

Individual risks to people had been assessed. People's risk assessments had not been reviewed following incidents and did not provide up to date guidance for staff. However, all of the staff we spoke with were knowledgeable about the risks to people and how to reduce these risks. Our observation confirmed that staff knew how to support people appropriately.

People told us they felt safe and there was enough staff to meet people's needs. One person told us, "If I need anything I have the buzzer in my room and they come in the night." We saw that when people needed support, staff were available to help. Staff we spoke with told us they felt there was enough staff and they did not feel rushed. One staff member said, "Most of the people living here are fairly independent so the staffing is alright for the people we have".

People were supported to take their medication as prescribed. We saw that staff informed people of what their medication was for and gave them time to take it. Staff confirmed that they received training in the administration of medicines and were observed to ensure they were competent.

The provider had recruitment systems in place to ensure staff were suitable to work with people living at the service prior to them starting their employment. There was a check list to ensure that all staff members had been required to provide references from previous employers and complete a check with the Disclosure and Barring Service (DBS). The DBS checks helps providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people.

The home was clean and tidy. The registered manager had already identified that the home would benefit from some refurbishment which we saw had been organised and was in the process of being completed. We saw staff wore personal protective equipment (PPE) when required and staff told us they had access to it when they needed it. One member of staff told us, "We have access to it [PPE], its kept in the store room and we have a key for it, we've got always got a lot of stock".

Good

Is the service effective?

Our findings

People were supported by staff that had the skills to meet their needs. Relatives spoken with said they thought the staff were well trained. One relative told us, "They seem well trained and they know [person]." Staff spoke positively about the training and the support they received. One staff member said, "We have had training recently on first aid. Someone came in to do that and showed us how to resuscitate people, apply slings and the recovery position. At the moment we're doing infection control." The registered manager had a system in place to monitor staff training and organised for refresher training when they were due.

People's diet and nutritional needs were met. We saw where people required support to eat their meal, they were supported appropriately. One person required a special diet and we saw this was met. People were given a choice of what they would like to eat and there was a variety of choices on the menu. We saw that where people had finished their meal, they were offered more and if people had not eaten much, they were offered an alternative. People spoke positively about the food and the choices offered.

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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Staff demonstrated a good understanding of this legislation and understood the importance of seeking consent before providing support to people. We saw that DoLS applications had been made appropriately to the local authority.

People had access to healthcare professionals when required. We saw in people's care records that calls had been made to the GP to inform of any changes to people's needs. One person had raised a concern during our inspection and we saw their doctor visited later that day. We saw that there was frequent contact with the local GP practice and regular requests for support from other health care professionals, for example occupational therapy. We read that one person had a sore mouth and a request had been sent via the GP for a visit from the nursing service to provide oral care for this person. A relative told us, "They tell me if the doctor visits and I know the chiropodist comes." A healthcare professional we spoke with told us they felt they had a good relationship with the home and were kept updated as required. They said, "There is a good handover of information from staff when we visit. They follow things up and will ring us for results."

The premises were suitable to meet people's needs. There was a quiet lounge and a main lounge, as well as the conservatory which people said they enjoyed sitting in. Some people had names on their doors, whilst

others only had a number and some did not have any identifiable information. We discussed this with the registered manager and she advised that everyone knows which room is theirs but that she would look at some dementia friendly signage or some personalisation for their bedroom doors. People bedrooms were personalised to them and people said they were happy with their room.

Good

Is the service caring?

Our findings

People and relatives spoke positively of the care staff. One person said, "The staff are lovely, really nice to us". Another said, "I wouldn't live anywhere else, they're very kind here". A relative told us, "They [staff] are brilliant]." We saw that staff were kind and caring in their approach and gave people time to make their own choices and decisions. Staff we spoke with said they felt they knew people well and had good relationships with people. One staff member said, "I like being around them [people], they make my day."

Staff knew how to promote equality and diversity and knew people well including their likes, dislikes, preferences and history. We saw people were spoken to in their preferred way and staff spoke to people about their family and their background which we saw people responded well to.

We saw that people's privacy and dignity was maintained when staff were supporting people. Staff addressed people by their preferred name and knocked on doors and called out before entering and spoke discreetly when speaking to people about personal care. People's independence was promoted and staff encouraged people to take control when they were moving from their chairs.

There was a calm and homely atmosphere within the home. People and relatives used the communal areas of the home but also spent time in their own rooms if they wished. A relative we spoke with said, "It's nice and homely. lovely and clean." People were encouraged to maintain relationships with their family and friends. One relative told us how they had visited and stayed to have lunch with their family member and staff supported them to do this.

Requires Improvement

Is the service responsive?

Our findings

People's preferences in relation to what time they got up were not met. We found that 10 out of the 12 people living at Mountfield House were up on our arrival at 7am. Seven of which were sitting in chairs, fully clothed and asleep. The local authority did an unannounced visit on 09 November 2018 and arrived just before 7am. They found that five people out of the 11 that were living there were up and dressed, two of which were sleeping in their chairs. One person told us, they like to be "Up with the birds", whilst another told us they liked to get up between 7 and 7:30am. However, other people were unable to tell us their preferences. Three of people's records we checked said their preferred time to get up was between 7 and 7:30am. We discussed this with the night staff who explained they were told people had to be up before their shift ended at 8am else they are made to stay over. They told us, they started getting people up at 5:45am and that only one out had wanted to get up. We also discussed this with the registered manager. They told us and we saw evidence from staff meetings and supervision that staff had been informed to leave people in bed until they were ready to get up, as long as they were safe and dry. We also spoke with another night staff member who told us, "They [people] are given a choice whether they want to get up. The manager doesn't mind us leaving people in bed as long as they are dry and safe." The registered manager told us on our second day of inspection that they had spoken with the night staff who informed the message had come from the ex-deputy manager of the home. The registered manager already had a night staff meeting booked for the 21 November 2018 where they would discuss this concern.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We found that the service was not always responsive to people's needs. For example, one person was sitting in the main lounge and their shoe had come off, we saw that the person's toe nails were long and required care. We looked at this person's care records which stated that staff are to monitor foot care and refer to a chiropodist when required. We checked the person's professional visits and there was no visit from a chiropodist. We saw after a short while; a staff member came passed and put the person's shoe back on but did not raise any concerns about their foot care. We discussed this with the registered manager who advised that the chiropodist had been out yesterday but they had not been on the list. The chiropodist had been contacted by the end of our inspection.

We saw that people had limited opportunities to engage in activities which were enjoyable for them and which promoted their social interaction. There was no activity coordinator employed by the home. The responsibility for supporting people to pass their time in a way they enjoyed was part of the carer role. People we spoke with told us they would like more to be offered to them. One person said, "It's a long day and it would be nice to do something other than watch the television". We saw that the care staff, on the day of our inspection provided group activities which did not interest all the people living in the home. One person told us, "I would like something to keep our minds active".

People were supported to follow their faith and maintain religious beliefs. The church service came in at Christmas for people who wanted to be involved. There was not currently anyone living at the service that

followed a different religion or culture. However, the registered manager explained they had previously supported people that did by ensuring that the service and staff were aware of their needs in relation to their religion and culture and how to meet them. For example, ensuring they were supported to prey and are offered their choice of food.

People's care plans contained information about their likes, dislikes, preferences, social history and family relationships. There were reviews of people's care which showed people and their family had been involved. Staff knew people well and we saw they had good relationships with people.

No one was receiving end of life care at the time of our inspection. The care plans we reviewed reflected people's wishes for their EOL care including spiritual support and family involvement.

People and relatives told us they knew how to raise concerns and felt comfortable doing so with the registered manager or staff members. Information to support people to raise concerns or complaints was displayed in a communal area. A person we spoke with said, "If I'm not happy, I'll just go and tell them. I wouldn't worry about it". One relative explained, "I did have to make a complaint a few months ago about another resident but [registered manager] dealt with it." The registered manager had a complaints record in place, this showed that complaints were dealt with appropriately and trends could be identified to reduce reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had audits in place for areas including; medication, falls and the environment. There were also spot checks on staff practice and medication competency checks completed. These audits were used to identify errors and actions had been highlighted where required. However, these audits had not been effective as they had not highlighted the shortfalls that we identified during our inspection. For example, whilst we saw that most people's needs were met, the provider's systems had not identified and ensured that care plans were accurate and reflective of people's current needs. One care plan we looked at stated, 'continue to follow existing controls'. However, there was nothing recorded to explain what these controls were. People's risk assessments and management plans were reviewed but not in relation to incidents. For example, two people had been identified as being high risk of falls. It was recorded that one person had fallen on eight occasions over a six-month period. Four of these were preceding the month of our inspection. Following these falls, there had been no update of their falls risk assessment. This person had also changed walking aids from a stick to a frame but their moving and handling care plan did not reflect this change. Another person that was at high risk of having falls was staying at Mountfield House for a period of respite due to having two falls at home. This person did not have a falls risk assessment in place. Another care plan we looked gave contradictory information about them going out of the home and needing the support of staff to minimise risk. Their care plan stated they required support to go out of the home. However, the person and staff told us they go out on there are and are safe to do so. Therefore, the person's care plan did not reflect their current needs or provide up to date information for staff to follow.

The governance systems in place had not ensured that people's preferences were met in relation to what time they got up. The registered manager was unaware of this concern until we identified it as there was no oversight of this or night spot checks completed.

We found that monitoring and auditing systems that were in place were not effective in ensuring that where roles and responsibilities had been delegated to staff that they had been completed.
The registered manager told us that the completion of care plans had been delegated to member of staff that no longer worked for the service. However, there was no system in place to ensure this task had been completed as evidence in relation to care plans showed. We also found that where medication competencies were delegated, there was no system in place to ensure these had been completed and recorded. For example, we asked the registered manager if medication competencies were recorded. They told us they completed the medication competency checks for the deputy manager and the deputy manager completed ones for the rest of the staff. They informed the ones they completed were recorded but they did not know whether the deputy manager's ones were.

The processes in place to monitor the recording of people's medications had not been effective. We found that the recording of medicines was not accurate. One person was prescribed a tablet in the morning. Staff had recorded that two tablets had been administered each day for a 22-day period. On investigation we found that staff had been recording a different tablet on the wrong line of the person's medicine administration record (MAR). We checked the remaining stock which confirmed that the correct number of tablets had been administered. This meant that staff had not noticed that a recording error had been made

and continued to record inaccurately until we identified the problem. Another person was prescribed a pain killer on a regular basis however we saw that at time this was refused. There are codes in place to identify why a person does not receive prescribed medicines. Staff had wrongly coded their entries which meant it was unclear if the person had been offered the medicine as prescribed or on an ad hoc basis.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's feedback was sought via quality questionnaires and regular resident meetings. We saw relatives did not attend these but that residents had input into what they wanted in the home. For example, a Halloween buffet and trips out. We saw these suggestions had been taken on board and put in place for people.

People and relatives spoke positively of the registered manager. One person said, "She is great, lovely and will do anything for you". We saw that people responded well and recognised the registered manager, smiling and saying hello to them.

Staff told us and records showed that they had regular supervision and staff meetings. Staff we spoke with said they felt supported. One member of staff said, "If I had any issues, I know I could speak to either the deputy manager; she's like a mother to us or the owner; she's here every day".

The home had strong links with the community and other professionals. Staff told us and records confirmed, they worked closely with district nurses and GPs. The local church also visited at Christmas and on a regular basis if people followed a faith.

All organisations registered with the Care Quality Commission (CQC) are required to display their rating awarded to the service. The registered manager had ensured this was on display within the home and on their website. The provider had correctly notified us of any significant incidents and events that had taken place. This showed that the provider was aware of their legal responsibilities. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider had been open in their approach with us during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's preferences were not being met in relation to what time they got up.

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 17 HSCA RA Regulations 2014 Good governance Governance systems that were in place had not identified the shortfalls that we did during our inspection. People's care plans were not reflective of their current needs. Medication recording errors had not been identified. There was no oversight of other staff member's roles and the provider was unaware that people's preferences were not being met in relation to what time they got up.

The enforcement action we took:

Notice of proposal sent to impose positive conditions