Mostyn Lodge Keynsham Limited

Mostyn Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focussed inspection of Mostyn Lodge Residential Home on 13 December 2018. We last inspected Mostyn Lodge Residential Home on 01 September 2017 and we had rated the service as good. At this inspection we found the service had deteriorated and has been rated as requires improvement.

We carried out this inspection after we received concerns in relation to a lack of statutory notifications and information received from other health and social care organisations. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk. We inspected the service against three of the five questions we ask about services: is the service well led, effective and safe?

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Mostyn Lodge Residential Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care and support for up to 16 older people, living with dementia and/or physical disability. To the ground floor there are two lounges, one with a conservatory overlooking the garden that is accessible to people and contains raised flower beds. There is a communal dining room and walk-in bath/shower room.

There were 14 people living in the service at the time of our inspection

There was not a registered manager for the service. 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. A manager was in place and had applied to the Commission for their registration.

Radiators throughout the home were not covered, this meant that people were at risk of burns from potentially hot surfaces. Work to fit radiator covers commenced during our inspection, however when we contacted the provider after the inspection we were told that not all the work to cover the radiators had been completed.

The service did not consistently submit statutory notifications to the Commission. Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it.

The service did not consistently recruit staff safely. In one staff file we identified that a person who had disclosed a criminal conviction had been employed by the service without a photograph ID or risk assessment. This meant that people were not always protected from potential abuse

Audits did not consistently identify shortfalls and when issues were identified corrective actions were not always taken. For example, the lack of radiator covers and incomplete staff induction records, care records and recruitment files.

The service maintained safe levels of staff. The manager used a staffing dependency tool and this calculated staffing levels required according to peoples' individual needs, including the level of assistance required to use the toilet, mobilise and eat.

The environment was clean and free from malodours. Fixtures and fittings were well-maintained and in good condition.

The service worked with external agencies including opticians, GPs and district nurses. We also saw effective communication and respectful exchanges between staff working at the service.

We identified five breaches of the Health and Social Care Act (Regulations) 2014 and one breach of the Care Quality Commission (Registration Regulations) 2009. You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Recruitment processes were not always completed safely or in accordance with the service's own recruitment policy.

Safeguarding notifications were not submitted as required.

The service deployed enough suitably trained staff to meet the needs of people.

The home was clean and free from malodours. Measures were in place to prevent the spread of infection and cross contamination.

Is the service effective?

Requires Improvement

The service was not always effective

Care records did not reflect person specific assessments.

Capacity assessments and best interest decisions for people were not always completed in line with current relevant legislation.

Staff received supervision sessions and although people had not received regular appraisals and observations, the manager had identified that this was an area that required development and was taking actions to address this.

People spoke positively about the dining experience and were offered choices about what they would like to eat.

Peoples needs were met by the adaptation and design of the premises.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Audits did not consistently identify shortfalls and when shortfalls were identified corrective actions were not always taken.

The service was working in partnership with various local organisations, including a local school and church.

People and relatives spoke positively about the provider and the manager, saying that they were approachable and friendly.

The provider and manager had clear visions about the development of the service.

People and their relatives told us that they felt listened to.

Mostyn Lodge Residential 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.'

The inspection was prompted by information received about the service and our ongoing monitoring. This included low levels of reporting to the Commission and safeguarding concerns identified and reported to us by other health and social care organisations.

The inspection was carried out by two inspectors and one 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.

We spoke with 10 people and two relatives of people who use the service, we spoke with three members of staff, including the provider, manager and a healthcare assistant. We spoke with two healthcare professionals.

We reviewed various records, including five care plans, three staff files, 14 medication administration records and weight records, reports of incidents and accidents, the complaints file, various audits, policies and procedures. We observed people and interactions throughout the day and interviewed one staff member. We pathway tracked five peoples' records. We completed visual inspections throughout the home and of people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

Staff were not always recruited safely as checks had not been carried out to ensure they were suitable for employment. For example, one staff member had declared they had been convicted of an offence. There was no detail recorded about the offence and the provider and manager were unaware of this. The person had commenced employment but a Disclosure and Barring Service check had not yet been received. The DBS undertake checks that are designed to ensure that people who are working with vulnerable adults are suitable for this role. In addition, there was no full employment history available. There was no risk assessment in place to mitigate potential risks to people, although some supervision arrangements had been put in place.

Another staff file did not contain two references from the person's previous employers in accordance with Mostyn Lodge Residential Home's policy. The recruitment file contained one personal reference from the staff member's relative. There was a lack of satisfactory evidence that that the person was suitable for employment.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all radiators in the service were covered and at least two radiators that we checked during our inspection were very hot. There was also no risk assessment in place to identify and mitigate any associated risks. This meant that people were at risk from burns from hot surfaces. Because of feedback we gave to the provider, we saw immediate action was taken and work commenced to fit radiator covers during our inspection. We contacted the provider after the inspection who told us that although most of the radiators were now covered, many remained uncovered.

Where risks to people had been identified the provider did not always have person specific plans in place to mitigate these. People were kept safe by staff, but the steps needed to protect people were not reflected in care records. This was important to ensure all staff knew what action to take consistently, particularly newly recruited staff who would not be as familiar with people's needs. For example, one person was identified as at high risk of developing pressure ulcers and was cared for in bed. There was no individualised information to guide staff on how to support this person. The risk management plan consisted of computer-generated generic actions and did not contain the information that this person stayed in bed and the associated risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not submit all required statutory notifications to the Commission. Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. We use this information to monitor the service provision and to ensure people are safe. Specifically, the service failed to submit notifications about allegations of abuse made by people using the service, including accusations investigated internally and externally by the local authority safeguarding team. We saw

evidence that the service was working with the local safeguarding teams when the need arose, however the provider told us that they were not aware of their responsibilities to submit statutory notifications in relation to alleged or actual abuse.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Medicines were not always managed safely. The manager had identified shortfalls in the medicines management and had introduced procedures to improve the safety of medicines management. Medicines were obtained, stored, recorded and disposed of safely. Medicines were stored in a locked cabinet and those medicines requiring safer storage due to legislation were stored safely.

Recording of creams administration was not accurate or complete. Staff had not always signed medicine administration records (MARs) to confirm they had applied people's prescribed topical medicines. For example, one person's record of prescribed topical medicines documented that creams had been applied intermittently. However, people told us that they were receiving creams, comments from people included, "I have very dry skin (pointing to the left side of the face) I have been given cream to rub on, I can't do it so they do it for me….." and, "I get my tablets all of the time, I have to have eye drops, I used to do this myself, I can't cope anymore so they do it for me."

There was a lack of clear guidance in respect of 'as required' medicines. These are medicines which can be given in addition to the person's prescribed regular medicines. Protocols for these medicines contained insufficient information about when to give a specific medicine. For example, one person was prescribed a medicine to for when they became anxious and the guidance stated; "[Name] can get very agitated at times." The protocol described the signs the person may display but did not identify what other interventions to try before administering the medicine. Their medication care plan contained no information about when and why this medicine should be given. It contained only a generic statement generated by the electronic care records system that was not person specific. There was also no information in the person's care plan to guide staff about how to support them with this agitation. There was a lack of assurance that this person was receiving the medicine in a safe and effective way. Staff told us it had only been given once in the last month.

We recommend that the service reviews the system used to record the administration of medicines in line with current published guidance.

Staff were able to tell us how they would identify different types of abuse and the actions that they would take if abuse was witnessed, one staff member said that they would, "Follow the [safeguarding] procedure" and that indicators of abuse included, bruising, agitation and changes to communication. People told us that they felt safe, comments from people included, "The home is a home from home, calm and generally quiet, the staff all of them are wonderful, calm, kind and caring." The provider showed us evidence that they had referred an ex-employee to the Disclosure and Barring service because of an incident of alleged abuse.

There were adequate numbers of suitably qualified staff deployed across the service to meet the needs of people. The service used a staffing dependency tool to manage the level of staff required, the tool considered the level of assistance people required with certain tasks, including eating and dressing. Comments from people included, "You ring your bell and the staff come straight away, I am going to ring my bell, so you can see", the person rang their bell and a staff member attended the room immediately. Another person said, "Of course I feel safe here, why would I not feel safe? They [the staff] come around to see me, I see them passing the door and they shout are you okay? I am not worried or concerned about anything at all."

People were protected from the spread of infection. Comments from people included, "The home is clean and tidy" and, "They [staff] come and clean my room every day, this room is just how I like it." The home was visibly clean and free from malodours. We saw staff members using personal protective equipment, including gloves and aprons. We saw that mattress protectors were being used on mattresses and where required people were using waterproof mattresses that could be wiped clean. This meant that risks from the spread of infection were minimised.

Overall, environmental safety checks were being completed and this meant that risks to people were minimised. For example, there was a 'Building Regulations Compliance' certificate issued a result of recent building works and a valid 'Landlord Gas Safety Record'. The service was undertaking regular water safety and fire safety testing, including test of fire extinguishers located throughout the home.

The service reviewed and analysed accidents and incidents so that any trends could be identified. We saw that action was taken when trends had emerged, for example when one person experienced an increased number of falls the GP had been involved, 111 called and relatives contacted.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always effectively assessed and recorded within the electronic care records system. Although assessments were carried out using the electronic system the service had not used these to generate any meaningful or person-centred plans to meet these needs. For example, everybody had their communication needs assessed and the computer-generated care plan stated, for everyone whose care records we viewed, "Yes - [Name] can communicate including very minimal or irregular communication." This gave no person specific information about the assessed level of a person's communication abilities or needs or their preferred ways of communicating.

Assessments were updated on the system but not all were updated accurately. One person had an assessment for mental health needs. The assessment stated, "[Name] exhibits no memory problems." The plan went on to state, "[Name] sometimes forgets who is visiting or why. As a result, they may get confused or agitated. Carers need to be alert to this possibility and assist them with a number of actions…." This statement was in direct contradiction to the assessment made that the person had no memory problems

Throughout the care records system we saw repeated examples of staff having failed to input correct information following assessment and failure to develop an accurate plan to reflect people's individual needs. When assessments were updated staff had copied information from the previous assessment and had not updated the plan to reflect any change in needs.

These failures placed people at risk of receiving inappropriate or unsafe care and support These shortfalls had not been identified by the audit system in place.

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

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.

Electronic care records in respect of people's capacity to make decisions were not recorded clearly. For example, one person's stage one of the mental capacity assessment recorded, on 24 September that the person had an impairment of the mind, no diagnosis, no proof of impairment and did not state if this was permanent or changeable. The person had a diagnosis of dementia which was not reflected in the assessment.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person had a DoLS authorisation

in place and the service had applied for DOLs for a further five people.

One person's legal status stated, "[Name] has a DOLs in place which stops [Name] leaving the building unassisted. [Name's] DOLs has recently been renewed. However, this statement had initially been generated on 07 November 2017 and repeated on the next four assessments. The final date of 24 September 2018 made the same statement. The person's DOLs had not yet been renewed according to the service's DOLs tracker. This meant inaccurate information was recorded. For example, another person's legal status stated, "[Name] has a DOLs in place which stops [Name] leaving the building unassisted. [Name's] DOLs has recently been renewed. However, this statement had initially been generated on 07 November 2017 and repeated on the next four assessments. The final date of 24 September 2018 made the same statement. This person did not have a current DOLS according to the DOLs tracker and but the DoLS had expired in July 2018.

These failures meant that we could not be assured that people's legal rights had been protected in line with the Mental Capacity Act 2005.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, staff members received training to ensure that they had the correct skills to meet the needs of people. Training that people received included safeguarding, equality and diversity and moving and handling training. Staff members who were new to care services completed the Care Certificate, an industry set of standards relating to the induction and training of care staff.. People told us that they felt their needs were being met, comments included, "No worries about my [relatives] safety in here at all, she has had falls no one's fault, straight away, they check her over, make sure all is alright and ring me up, if a visit to the hospital is required, they arrange it." However, one staff member's records showed that they had not received any training since being employed with the service. Hand written notes recorded, "No induction" and, "No training at all." The 'Training review' document for this person recorded, "No training records found" next to each of the training courses due. We saw evidence that the staff member had been working at the service undertaking cleaning tasks. We brought this to the attention of the provider who told us that they would take actions to ensure that training was updated.

People were able to make decisions independently and were supported to make decisions when required. We observed one staff member assisting a person who was concerned about leaving the home to access an activity in the community, the staff member gently encouraged the person and reassured them. Comments from people included, "I have a choice about everything, how I spend my day, what I do, what I don't do, everything, they always ask me to agree to everything" and, "Nothing happens unless you agree to it, we get a choice and say about everything, food, everything." This meant that people retained control of their own lives and had the freedom to make their own choices.

People spoke positively about the food available. The tables included place mats and a decoration, condiments were available for people to use as required. We observed food being freshly cooked by staff and people were offered a choice of two meals, one person said, "The staff always ask me what I want to eat, I can pick and choose". Comments from relatives included, "The food looks good, they [people] get a choice about everything, they [members of staff] always offer me lunch when I come, I get a choice as well."

People's needs were met by the adaptation and design of the premises. There was a stair lift available for people who could not use the stairs. Equipment that was used, including hoists, had been serviced in line with legislation. There was a walk-in bath and a walk-in shower room, both included a seat for people.

Windows had window restrictors, and this meant that people were protected from the risk of falling from height.

Staff received regular supervision sessions, these were used to discuss various topics including safeguarding and infection control. Staff had not received regular appraisals and observations, we spoke to the manager about this who told us that they recognised this was an area for development. The manager showed us evidence about how they were in the process of developing staff observations and appraisals, including the introduction of new records. The manager was visible in the home and undertook caring duties as required, informal observations were completed during this time.

Requires Improvement

Is the service well-led?

Our findings

Audits systems were in place but were not effectively operated to ensure that shortfalls were identified. When shortfalls were recognised, corrective actions were not always taken to improve the service.

The 'Recruitment file audit - 2018' completed in May 2018 identified; 'If convictions evident is a risk assessment in place?' and, 'Evidence of DBS in place' however we reviewed one recruitment file where the staff member had disclosed a previous criminal conviction and no risk assessments or DBS checks were in place. No actions had been put in place to rectify these omissions. The same audit checked for 'Evidence of induction started/completed' however had not identified that one staff member had not received an induction, or any further training and another staff members file only contained one reference from a relative although the recruitment audit and policy required '2 written references.'

We reviewed various audits that had 'N/A' [not applicable] recorded next to areas to check. For example, the 'Health and safety checks – 2018' recorded 'N/A' relating to six monthly checks of air mattresses however, during our inspection we saw that there was at least one person who was using an air mattress. Dates were not recorded on this audit and so we could not review exactly when checks had been made or when the audit had been completed. This audit indicated that the air mattress was not checked to ensure it was working safely.

Environmental checks had not always identified risks to people to ensure these were managed. The 'Health and Safety Audit – 2018' required checks on radiators to ensure that they were fitted with guards, however 'N/A' was recorded next to this check. The audit indicated that these areas had not been checked.

Issues with care plans that we identified during the inspection had not been identified by the 'Service audit – is it effective?'. For example, the audit checked 'are care plans person-centred and focussed on the outcomes for service user?' and a handwritten note recorded 'seem to be quite good.' Throughout care records, we saw that generic statements had been generated and remained in peoples' individual care plans. Care records were not person-centred and this had not been accurately identified through the audit process.

Governance systems did not identify that the DoLS tracker for November 2018 was inaccurate. The tracker identified people as needing a DoLS who were not assessed as lacking capacity to consent to treatment or to live at the service.

These failures demonstrated that the provider did not have effective systems to monitor quality monitoring to ensure a consistently safe service.

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

There was a clear vision shared by the provider and the manager about how they wanted the service to

develop. The provider told us that a, "homely feel" was important and that people should be able to make their own choices, for example, "If a person wants to eat at 15:00 rather than 12:00 that's fine." Comments from people included, "The home is friendly and a happy place, a home from home, I would not want to be anywhere else" and, "The home is a home from home, calm and generally quiet, the staff all of them are wonderful, calm, kind and caring." During our inspection we saw there had been recent improvements, including a garden that was accessible with raised flower beds and refurbishment of the whole home, including peoples' bedrooms.

The provider and the manager spoke with us about how they were trying to improve their own knowledge so they were better equipped to develop the service. The provider told us that they had been undertaking research around current legislation and guidance and the manager had recently accessed learning opportunities and had plans to revisit these areas in the future.

People, relatives and staff spoke positively about the provider and the manager. Comments from people included, "The manager and the owner are very friendly, they, like everyone else here really care" and, "We have a new manager, they are very friendly, a nice person working hard to move things forward."

People and relatives told us that they felt listened to. Comments from people included, ""Yes we have meetings here, you can have your say" and one relative said, "Yes, I have completed quality surveys in the past, all good, I know they arrange relative's meetings, my [relative] attends those." When people chose not to participate in surveys and meetings this was also respected, one person said, "They have meetings in the lounge, but I always choose not to go"

The service worked in partnership with other agencies to achieve good outcomes for people. We saw evidence that healthcare professionals were involved with the care of people, including the GP, occupational therapist and physiotherapist. Comments from healthcare professionals included, "I phoned up they give a good handover" and, they are "Accepting of advice."

The service had developed links with the community. Children from a local school had visited the service and people had visited the school to watch the children perform in a production. During our inspection a local church visited, and this was a fortnightly occurrence. People were encouraged and supported to access opportunities outside of the home, we saw people being supported to access a group that encourages health and well-being through music.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection was displayed prominently at the service.

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 18 Registration Regulations 2009 Notifications of other incidents The service did not notify the commission about alleged and actual incidents of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records did not accurately reflect people's assessed needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not consistently ensure that consent to care was sought and documented in line with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not consistently identified or assessed so that they could be mitigated and when risks were identified records did not reflect how they should be managed. Radiators throughout the home were uncovered placing people at risk from hot surfaces.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not operated effectively to ensure that shortfalls were identified and when shortfalls were identified corrective actions were not always taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that people were protected from potential harm and abuse.