Care Quality Commission

Mostyn Lodge Keynsham Limited

Mostyn Lodge Residential Home

Inspection report

2 Kelston Road
Keynsham
Bristol
BS31 2JH

Tel: 01179864297

Date of inspection visit:
26 October 2023
06 November 2023

Date of publication:
11 January 2024

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Mostyn Lodge Residential Home is a residential care home providing personal care without nursing for up to 16 people. The service provides support to older people who often have dementia. At the time of our inspection there were 16 people using the service.

The home is an adapted building where each person has an individual bedroom and there are shared facilities. There is access for all to lounges, the kitchen and the garden.

People's experience of using this service and what we found
People were comfortable in the presence of staff and were able to tell us they felt safe. However, systems to keep them safe from potential abuse were either not being followed or were ineffective. Information was not shared with external bodies such as the Care Quality Commission (CQC) or the local authority.
Some risks and ways to mitigate them were assessed in line with best practice, such as pressure care and use of hoists. However, there were areas where care plans lacked guidance for staff around other risks. For example, supporting people who could become distressed or upset and eating and drinking.

People had individual medicine administration records which included their preference of how to support them. However, concerns were found with other areas of medicine management placing other people at risk of potential harm. Some of these were rectified by the management during the inspection.

People and their relatives felt staffing had recently got better at the home and records demonstrated this. Although, there were feelings that care staff were stretched by having to work in the kitchen as well. Recruitment systems were in place although improvements were required in some of the checks being completed.

Systems were not always in place or effective to manage the service. The management had a wealth of audits they completed. However, concerns identified on the inspection had not always been found within these. The provider's policies and procedures were not always being followed.

People, relatives and staff were incredibly positive about the manager and the support they provided. Although, differing approaches at management level led to inconsistencies.

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

Rating at last inspection
The last rating for this service was good (published 27 August 2021).

Why we inspected
The inspection was prompted in part due to concerns received about medicine management, infection

control, staffing and safety of people living in the home. As a result, we undertook a focused inspection to review the questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to medicine management, risk assessment, keeping people safe from potential safeguarding and systems to manage the service.

Please see the action we have told the provider to take at the end of this report.

We have also made two recommendations in relation to recruitment and the duty of candour.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect or assess the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Mostyn Lodge Residential Home

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 provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors and 1 member of the medicines team.

Service and service type
Mostyn Lodge Residential Home 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. Mostyn Lodge Residential Home is a care home without 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 not a registered manager in post. The manager who started work in

September 2022 had begun the registration process earlier this year. Unfortunately, circumstances beyond their control had prevented the registration process being completed.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people and 3 family members on site. A further 3 relatives provided feedback following the first day. We spoke with 9 staff on site. This included the manager, the provider's consultant and the nominated individual who was the owner. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Following the site visits, we also spoke with 4 more staff on the telephone.

We carried out a range of observations to capture people's experiences in the home. We looked at various records on site and remotely. This included 6 people's care records, medicine records, staff files, health and safety records, policies and procedures and a range of governance documents.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
● Relatives had mixed opinions on how safe their family member was. Some comments included, "We feel our relative is safe which has been a huge relief to us" and "I have no concerns on safety." Whilst others provided examples of where they were worried about the safety of their family members.
● Systems and processes in place were not effective or being followed to keep people safe from potential abuse. Incidents were being recorded and not identified as potential safeguarding. Examples found included person on person incidents and injuries following unwitnessed falls resulting in hospital treatment.
● The management were not alerting external bodies such as the local authority and CQC when these incidents had occurred in line with their own policies and procedures and legislation. This was despite the manager seeking guidance from the local authority safeguarding team about expectations. This meant external scrutiny of potential safeguarding was less possible to keep people safe.

Systems were not effective to keep people using the service safe from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were comfortable in the presence of staff and management and were reassured when they became distressed.

Assessing risk, safety monitoring and management
● Risks to people outlined in care plans had not always been assessed fully, contained contradictions and lacked guidance for staff to follow. For example, 1 person was identified as having an increased risk in falls. Multiple areas in their care plan referenced different pieces of equipment to support with mobility. A member of staff told us only a walking stick was required and could not tell us why the care plan was inconsistent.
● Another person was witnessed struggling to eat at lunchtime. Staff were seen pushing the person's bowl in encouragement towards them despite the person's protests. The provider's representative told us this person had lost their appetite, so it was known they were eating less. They shared how they monitored people's weights. However, the person's care plan provided no guidance for staff on what to do in order to support the person effectively.
● People who could become distressed or upset did not always have clear guidance for staff to support them and ensure consistency. One person had a known history of distress that was not reflected in any of the risk assessments to protect themselves or others. Their behaviour care plan lacked information about input from a specialist team and the GP. This meant new or agency staff may not know the best ways to

support them.
● Improvements in line with a November 2022 fire risk assessment were not completed at the time of the inspection until queried by the inspector. This was despite them being listed as medium and high risk which should have been resolved within 2 months. For example, improvements to emergency lighting was required. This meant people were being placed at risk in the event of a fire. Following the inspection, they provided an invoice to work considered medium and high risk from the fire risk assessment to confirm the required work had now been completed.

Systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were slowly working through all care plans to review them in line with current best practice. They were also going to ensure there was enough guidance for staff to ensure consistent support for people.
● Environmental risks had been considered and checks such as fire drills and fire alarm tests completed to keep people safe in the event of a fire.
● People had some risks considered in line with best practice and guidance for staff in place. For example, 1 person required hoisting and clear guidance was in place. Other people had risks of pressure ulcers and there was guidance for staff on how to mitigate these risks.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection
● People were placed at risk of infections spreading because staff were not always using personal protective equipment (PPE) safely. Staff were seen going to a central place to get disposable aprons because no bathrooms contained them. We saw staff walking through the house wearing used aprons.
● On other occasions staff were seen leaving rooms wearing gloves after delivering personal care to get something and then returning with the same gloves on. One staff member was seen delivering personal care with just disposable gloves on. No apron was worn to protect their clothing in line with best practice.
● Areas of the home had a strong smell of urine at various points of the day of inspection. A used incontinence pad was found in a jug in a bedroom, which staff had not identified. When it was raised by the inspection team, staff removed the jug.

People were placed at risk of infections spreading due to ineffective systems around managing infection control. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● People were able to have visitors and they could come whenever they liked. Throughout the inspection multiple visitors were seen. People confirmed they were happy to get visitors.

Using medicines safely
● Medicines were not always managed safely. One person was seen to have another person's topical medicine applied to their hands by a member of staff. Another person recently returned from hospital, had eye drops with no records to demonstrate they had been administered since returning. This meant the staff were not following instructions from the prescriber.
● Temperatures were monitored for where medicines were kept. However, the records made did not provide assurance that the temperature had remained within the range specified by the manufacturer of the medicines stored. This meant there could have been a risk of medicines not being stored in line with manufacturers guidance.
● Some people had medicines administered using patches. The site of application of these was not always recorded. This meant it was not possible to see that the site of application was changed in accordance with the manufacturer's directions.
● Where people were prescribed medicines 'when required' the protocols present were generic and did not detail how the individual decision was to be made. Staff spoken with were able to only explain how some of these medicines were used. The care plans contained no further guidance. The daily notes did not record the reason for administering these medicines or the outcome of the administration. This meant there was a risk that 'when required' medicines would be administered inconsistently.

Medicines were not always managed safely placing people at risk of potential harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were suitable arrangements for storing, and disposal of medicines, including those needing extra security. Staff received training in safe handling of medicines and had competency checks to make sure they gave medicines in a safe way.
● The new manager had created new personalised medicine records for each person. These contained information about the person's administration preferences to guide staff.

Staffing and recruitment
● Records had not always evidenced that safe recruitment procedures were being followed in line with the provider's policy and legislation. Checks were being completed with previous employers, character references and criminal records. However, some discrepancies in employment records had not been identified by the management. For example, dates within references did not match application forms or employment history provided by the staff. This meant there was a risk an unsuitable member of staff could be employed.

We recommend that the provider update their recruitment practices in line with current best practice, guidance and legislation.

● People and relatives felt the home did not have enough staff working with them. Staff were completing caring and cooking duties in the home. Comments received included, "They are understaffed. Always rushing around", "It can take time to get an answer to phone calls and there has been an increase in

temporary staff. But they have always been available when needed" and "There definitely needs to be more staff…The staff are pulled in so many directions. We often have to wait some time to be let in the front door."
● There were long periods of time when people went without interactions. We were told people who chose to remain in their bedrooms lacked staff checking on them.
● All were positive the manager had recently increased staffing levels and rotas confirmed this change. The increase reflected the provider's dependency tool in relation to staffing levels.

Learning lessons when things go wrong
● People were living in a service where the management wanted to learn lessons when things went wrong. Systems were in place to record accidents and incidents then apply learning from them. However, the systems were not always effective, and records did not always reflect this. For example, when people were supported following an incident, records were not demonstrating this had happened. Neither had they prevented an escalation occurring within a few months.
● On another occasion, monitoring a person's repositioning to prevent a potential pressure ulcer developing had not been followed up. The provider's representative told us the person was fully mobile. This meant there was a risk that appropriate support and learning may be missed for people.

Requires Improvement

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 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems were not effective or being followed to assess, monitor and mitigate risks to people and ensure they received safe care. Incomplete records or records lacking detail were identified during the inspection. For example, accident and incidents and care plans.
- Systems were not ensuring information was shared to other organisations in line with the provider's own policies or legislation. Examples found included people requiring hospital treatment following an unwitnessed fall and potential safeguarding incidents. This meant there was reduced opportunity for routine external scrutiny by CQC and the local authority.
- Staff and the management were not always following the provider's policies and procedures. For example, around safeguarding, medicine management and infection control policies.
- Audits were completed for a range of areas in the home. This included a provider visit audit. However, when actions had been identified no monitoring was apparent about who was responsible, the date it should be completed by and whether it had been completed. Examples were found in the provider's overall audit, the infection control audit and the health and safety audit. This meant there was no way to monitor actions and whether they had been met.
- On some occasions the audits had failed to identify concerns as found during the inspection. For example, the health and safety audit from October 2023 had not recognised actions had not been completed from the fire risk assessment. Additionally, the provider's visit audit from July 2023 had not recognised concerns found with the fire risk assessment issue at the inspection. This meant audits were not always highlighting concerns to be resolved.

Systems had not been established or were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives were positive about the manager. Comments included, "We have found the manager to be very helpful. [They] know our relative well and is happy to discuss our concerns or progress" and "[The manager] is pretty good and has increased staffing levels."
- The manager had plans in place to improve the service and explained they had not always had the time or flexibility to undertake these. Examples were seen around eating and drinking and staff levels. Staff were positive about the changes the manager was making. One told us, "[Manager] has added a good structure and we all have someone to look up to and go to when we need anything." However, there were

discrepancies in approaches between members of management which had led to inconsistencies.

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
● The management were aware of the duty of candour and openly reported when things went wrong to relatives and said sorry. However, they were not currently following the duty of candour process in full as apologies were not formally followed up in writing.

We recommend that the provider seeks guidance on the duty of candour and updates their practices accordingly.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The management were proud of creating a homely feel at the home. Comments reflected their aims, "Mostyn Lodge is a small and friendly home. Being so small everyone knows everyone and the [staff] do generally know the residents well" and, "The home is lovely."
● However, there were occasions where this culture had not embedded into practice which was observed during the inspection. For example, a staff member was observed not to be respecting a person at lunch and records were not demonstrating support for people was in place following an accident or incident. We raised this with the management who assured us they would take action to rectify this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The new manager had introduced a range of regular meetings to get people, relative and staff feedback to drive the running of the service. People had already been involved in changing meal choices prepared for them each day with a new four-week menu.
● Relatives were positive they could speak with the manager who would listen to their concerns. Examples provided were health professionals getting involved to support their family member's declining health. This was witnessed during the inspection.
● Staff felt engaged by the manager as to how things were running. Comments included, "There is a lot of support since [manager] has arrived. I know I can air any problems, issues or concerns and they will be listened to" and "The management seem fine, and they always ask me how I am."
● The management ensured people and staff's cultural and religious needs were respected. Comments from staff with protected characteristics gave positive examples of how they were supported. Care plans demonstrated people's wishes had been considered including at the end of their life.

Working in partnership with others
● The management had built links with other organisations and health and social care professionals. There was a weekly meeting with the GP to discuss any changes with people to ensure they were monitored.
● The management attended meetings to learn from other providers and organisations.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not always in place to manage risks and find ways to mitigate them. Medicine management and infection control were not always keeping people safe.

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 Systems were not in place or effective to protect people from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established or were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.