Mountfield Care Home Limited

The Mount Residential Home

Inspection report

226 Brettell Lane
Amblecote
Stourbridge
West Midlands
DY8 4BQ

Tel: 01384265955

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Mount 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.

The Mount accommodates 18 people in one adapted building.

A registered manager was working at the home but was absent as they had been suspended at the time of the inspection. 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.

Although relatives told us they felt their family members were safe, we could not be assured that practices within the home ensured all concerns were recorded and escalated appropriately. Practices within the home did not ensure the appropriate stakeholders were notified of accidents and incidents as these occurred. Learning from accidents and incidents was also not always shared that might reduce the risk of reoccurrence. Risks assessments whilst completed did not always contain all of the information necessary to care and support people in accordance with their needs. Recruitments process had not always been completely followed and there was a risk that staff recruited might not have been suitable for working at the home. People received support to take their medicines which were stored appropriately.

Changes in staffing and within the management team meant that staff did not always receive the correct level of supervision and training. People were involved in making decisions about their care and their consent was appropriately obtained by staff when caring for them. People who could not make decisions for themselves were supported to have a decision made about their care and support which was in their best interest. Staff understood the MCA but did not know which people had restrictions on their liberty in place. People accessed help from a number of different healthcare professionals and were supported to maintain a healthy lifestyle. People were offered choices in their meals and could make day to day decisions affecting their care.

People liked the staff supporting them. People needs were not always understood by staff. Care records were being updated to reflect people histories. People's families were involved in planning their care where this was appropriate. People's preferences for end of life care planning had not consistently been discussed and recorded although relatives felt comfortable speaking with staff and making their views known.

People's choice of hobbies and interests were not always known and supported by staff that were occupied with day to day care tasks. People understood they could complain if they needed to and the process for doing so.

The registered manager had been at the home for a number of years and had been supported by staff who had also been there for some period of time. The registered manager had recently been absent from the home and a number of long standing care had left in recent weeks and this had caused anxiety and instability within the home. The registered provider had not always challenged practices within the home and had relied on the registered manager to guide them about the home and how it was ensuring people received appropriate care and that all practices within the home were based on best practice. The registered provider did not have systems in place to review the quality of people's care. We found the registered provider did not have oversight of staffing, recruitment, notifications submitted to the CQC, training and supervision as well as quality assurance. They were unable to demonstrate how they assured themselves people receive high quality care that was monitored routinely because systems did not exist. The registered manager had not always worked in partnership with other stakeholders to ensure practices within the home appropriate especially with respect to reporting incidents that should have been reported.

You can see what actions we told the provider to take at the back of the full version of this 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 service was not consistently safe.

Concerns about people's safety were not always escalated appropriately. Risk assessments were not always clear in their guidance for staff. It was also not always clear how staffing levels were assessed. Systems for ensuring staff were recruited safely were not consistently followed. People had received their medicines which were recorded and stored safely. It was not clear how lessons were learnt and learning shared from things that had not gone so well at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had not always had access to training and supervision. People were encouraged to maintain a healthy lifestyle and accessed additional support from healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were busy and not always able to support people appropriately. People knew and liked the staff supporting them. People were involved in making day to day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their families were not always involved in planning their care. People understood how to complain if needed.

Is the service well-led?

Inadequate

The service was not well led.

Systems to ensure people received high quality care were not effective. Systems of governance were not robust. The provider

had not demonstrated how people were engaged in feeding back what they thought about the home. The registered provider's quality assurance systems had not shown how they were learning and improving the care for people living at the home or working with other partners.

The Mount 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.

This inspection took place on 8 March 2018 and was unannounced.

There were two Inspectors in the inspection team.

The inspection was prompted due to concerns raised about people's safety living at the home. During the inspection we included the concerns as part of our inspection. Before we undertook the inspection, we reviewed notifications the registered provider had completed in order to review how improvements had been made.

During the inspection we spent time speaking to two relatives, four care staff, the deputy manager, the registered provider, the chef and two visiting social workers.

We reviewed four people's care records to case track people's care. We also reviewed the communication book, minutes of staff and residents meetings, the complaints folder as well as safety certificates to demonstrate equipment had been checked. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We previously inspected the home in June 2017 and rated this section as Good. At this inspection we could not be assured that people received care to keep them safe. Practices at the home were not always robust and had not ensured people were safe.

Where people had accidents or incidents these had been recorded by staff but we could not understand what action taken as a result because this information was not available. We reviewed four people's care plans to review their care. One person had had a series of falls. We saw from their file they had attended hospital but we could not see any evidence of action that had been taken to update the person's care. There was a risk that people were not being kept safe from harm. Staff we spoke with confirmed information from accidents and incidents had not always been shared with them. The provider was not able to show how they reviewed people's incidents and accidents to share learning and improve care for people. There was a risk that learning was not being shared with staff to improve people's care.

Although relatives we spoke with told us there were always staff available to speak with them when needed, we saw during our inspection that there were times when staff capacity was stretched and people were not always able to access help from staff. During the morning of the inspection we saw the deputy manager supported by two care staff. The deputy manager was busy with the visiting GP and the two care staff were left to support 17 people. Some of the people required the support of two care staff. For example, during the afternoon we saw one person become agitated and upset in the lounge and began to demonstrate aggressive behaviour. Staff were busy helping other people in other parts of the home and one person began to display aggression toward another. There was a risk that people may have become hurt if the other people became more agitated and aggressive. It was not clear how staffing numbers were determined. The registered provider could not explain how staffing numbers were determined and how people's care needs affected staffing levels. Four people's care plans we reviewed indicated that people had 'Medium needs' however it was not clear what this meant in terms of staff required. We also saw in the afternoon, there were care two staff on duty. One of whom had only been at the home for a few weeks and another agency staff member for whom this was their first shift at the home. When we raised this with the registered provider agreed to add another member of staff on duty to assure themselves of people's safety.

The registered provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed. This was a breach of Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014.

The registered provider explained to us that that recruitment related information was not always recorded correctly. The system for ensuring staff recruitment processes were complete had not been updated to demonstrate an application was complete. They shared with us that a recent review of recruitment processes by an independent consultant had highlighted areas for improvement. We reviewed three files for staff that had been appointed recently. We saw from the staff files recruitment practices were not always completed in a systematic manner. We saw the files were not always competed in the same way to demonstrate what was complete and what was outstanding. We saw in one file we could not determine whether a staff member had received a Disclosure and Barring Service check (this check helps employers

make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups). When we spoke to the registered provider they advised us all staff had received a Disclosure and Barring Service check however not all confirmations had been recorded in files. In another file another staff member had not had all of their references returned. There was a risk that key checks required about the safety of staff working at the home were being missed because the system for ensuring all checks were complete was not consistently applied.

Staff also shared with us that some people that awoke during the night might get out of bed. Staff we spoke with told they could hear people walking across the floor and that the doorway to the stairs was alarmed. When we raised this with the registered provider they felt sufficient precautions were in place with the alarmed door. However, they agreed to immediately have in place sensor mats where appropriate as an additional safety measure.

Although the home was tidy and odour free there were some parts of the home where we saw some measures to spread the control of infection could have been better. We saw a box of nail clippers that were used for all people living at the home and were not specific for the care of individual people. As some people had behaviours which meant they declined personal care, there was a risk infection could be spread. Whilst the communal areas looked clean we saw the bathroom was untidy with piles of clothes blocking access to the sink and shower. We saw a seat for an adapted bathroom seat had heavy staining from use and there was a risk of infection from people using the seat. We saw within the home some equipment had not been replaced such as the seat to the specialist bathroom adaptation in order to reduce the risk of infection. When we drew to the registered provider's attention, they immediately agreed to get the equipment repaired.

Relatives of people living at the home told us their family member was safe. Care staff at the home understood how to help protect people living at the home from abuse. They told us they would report any concerns to the deputy manager as the registered manager was absent. We spoke with the deputy manager and they understood how to protect people from the risk of abuse. The registered provider assured us that they would report any concerns they had themselves if necessary to both the CQC and local authority in the absence of the registered manager.

We saw staff were able to help support people to move safely. We saw staff used specialist equipment to transfer people which was done safely. Staff we spoke with understood whether people needed the support of one staff member or two. For example, if they needed specialist moving equipment such a hoist, that would require two staff. We reviewed people's risk assessments contained within their care plans and saw guidance was not always detailed. For example, we saw risk assessments did not always suggest a follow up date or how many people were needed to support a person. Two staff we spoke with had been there for a number of years and knew people well. However, a number of key staff and management had left the home. There was a risk that if the information was not recorded new staff would not always know how people needed support to ensure their safety.

We reviewed how the medical administration records (MAR) for people living at the home and observed a medication round. We saw people were supported to receive their medicines safely and that there was a process in place for ensuring people received their medicines as they should. We saw that the deputy manager supported people and ensured people received the support they needed. We saw that medicines were stored appropriately and that there was a system for disposing of unused medicines.

Requires Improvement

Is the service effective?

Our findings

We previously inspected the home in June 2017 and rated this section as Good. At this inspection we could not be assured that people received support that was based on best practice.

At the time of the inspection, a number of key staff had recently left that included the deputy manager and some care staff. A number of new staff were being introduced to the home. Two staff we spoke with told us they had received training in their previous role as care staff but not since working at the home. They told us their training had not been reviewed whilst they had been at the home because the registered manager was absent. Whilst we saw staff support people in a safe manner, there was a risk that people were being supported by staff who were not aware of care based on best practice. We asked to view the training records but in the registered manager's absence it was not clear where these were. Staff we spoke with also told us supervision meetings had also not taken place and we could not find any records to confirm staff supervision had taken place. We asked the registered provider about training and supervision and they advised us that in the Registered Manager's absence these had not taken place.

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.

We spoke to three staff about the importance of obtaining a person's consent. Three staff we spoke with could explain to us what it meant to obtain a person's consent. We saw staff at the home explain what they were doing before they undertook care tasks such as move a person from a wheel chair to a chair. Staff we spoke with understood the MCA legislation and how people required support.

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).

We saw in one file evidence of a Best Interest decision where a person's family had been consulted to ensure they received the most appropriate care. Three staff we spoke understood what a Best Interest decision was and how these were relevant to people who could not always make decisions for themselves. However, staff could not tell us whether anybody at the home had a DoL in place and what this applied to. There was a risk that people could be restricted inappropriately. We checked with the local authority who advised us that six applications had been submitted and one had been granted. We saw that whilst there was a process in place for making DoL applications, communication of the outcome of decisions had not been effective.

People's nutritional and personal preferences were known by the chef preparing meals at the home. The chef told us about people's meal preferences and how they ensured people received healthy meals they chose. They explained they catered for a number of different meal types including vegetarian and softened

diets. We sat with people over lunch and saw people received support where appropriate to have their meal. One person chose not have to the desert available and was immediately offered something else. Two staff we spoke with knew which people required food that had been softened so that they received these meals.

Staff we spoke with told us they worked well together in order to try and work together so that people could get the care they needed. Although staff reported to us they were getting used to changes in staffing that had recently occurred. Staff we spoke with told us they handed over to incoming staff before they left each shift. We saw also a communication book that staff used to covey messages about the completion of care tasks to one another.

We saw people had access to healthcare professionals to support their health needs. The GP had visited the home and seen people that required their support. Relatives we spoke with told us their family member's had access and support from other healthcare professionals such as the chiropodist and optician. We saw in the communication book that the staff referred to, that the deputy manager had noted down any changes needed to people's care following the GPs visit. We saw the deputy manager then work their way through the actions left by the GP affecting people's care.

Relatives we spoke with told us they encouraged to bring in ornaments and photos from home to support their family member to feel at home. We were invited into one person's bedroom and saw that they were surrounded by possessions that were important to them. The relative we spoke with told us they felt able to bring in items from home they chose to.

Requires Improvement

Is the service caring?

Our findings

We previously inspected the home in June 2017 and rated this section as Good. At this inspection we could not be assured that people received support from staff to meet their needs.

People were not always supported by staff in a timely manner. During this inspection we saw a person become upset and show signs of anxiety. They repeatedly asked questions to clarify what was going on. One staff member was able to offer verbal reassurance, however the staff member was busy and unable to continue to provide the reassurance the person wanted. The person repeatedly asked what was going on. On another occasions we saw staff were often busy with providing people with care focussed around their personal care. On a number of occasions we saw a staff member ask a person to sit back down when they got up. We saw staff suggest this because they were focussed on completing the task they were doing such as completing care plans or serving drinks. Two staff we spoke with told us support to people was limited to task based care and opportunities to offer emotional support were not possible because they were so busy.

People's privacy was not always respected. We saw people's care plans were stored in an unlocked cupboard within the hallway of the home. We saw throughout the day staff use the files and return them to the cupboard. We drew this to the registered provider's attention and asked that the files could be stored more securely.

Relatives we spoke with told us they liked and valued the staff. One person told us about staff, "They are very caring." We saw a number of examples where staff demonstrated they cared for people. We saw as a staff member left for the day, they spoke to each person and told them they were leaving for the day. People greeted the staff member warmly and affectionately. On another occasion, we saw a staff member sit with a person over lunch and chat with them and encourage them to eat.
People's families were supported to help make decisions and contribute towards people's care. Two relatives we spoke to told us communication with staff was good and that they were kept informed about their family member's care. Both relatives we spoke with felt they were able to contribute towards their family member's care planning. One relative told us, they had other immediate members that visited regularly and who felt were able to input into their family member's care.

Family members we spoke with told us they felt able to visit at any time they wanted. Two relatives we spoke with told they felt able to visit whenever they chose and were able to select where within the home they chose to spend their time.

Requires Improvement

Is the service responsive?

Our findings

We previously inspected the home in June 2017 and rated this section as Good. At this inspection we could not be assured that people received support from staff to meet their needs in relation to their wellbeing.

People living at the home did not have consistent access to activities and past times to support their wellbeing. Two relatives we spoke with told us they had seen activities take place although their family member was not always able to engage with them. For example, one relative told us, "They do try." We asked relatives about activities aimed at including people with dementia, and they could not recall any.

During the inspection we saw that people sat in the communal lounge area. We revisited the lounge on a number of occasions during the day. We saw the TV was not working on the day of the inspection and was being fixed. We heard the same CD played continuously but did not see people being offered a change of music. At one point we saw a person become anxious and began to shout at another person when they started to sing along to the music.

Staff we spoke with did not know about people's choice of hobbies and interests. The registered provider was not able to show how they supported people in activities and maintaining interesting things to do. There were not any planned activities displayed for people and their families to refer to. Two staff we spoke with told they would like to spend more time with people to engage them in an individual past time but this was not always possible because there was not enough time.

Relatives we spoke with told us they were kept up to date about people's care and were involved in discussions about their family member's care. We saw from people's care plan that they people had their care plan's reviewed and updated. We saw one person had a difficulty sleeping and the registered manager had worked with the family to identify a way of supporting the person so that they could sleep better. Another relative told us although they did not attend meetings, they were in the home regularly and were kept up to date by staff supporting their family member.

People's end of life wishes had not been recorded. We reviewed four care plans and saw that evidence of people's life histories were being introduced but people's end of life preferences were not yet recorded. When we spoke with staff they told us no one at the home was currently on end of life care. Two relatives we spoke with told us they visited the home frequently and had good relationships with care staff and felt able to communicate their wishes so that they were known to staff.

Two relatives we spoke with felt comfortable speaking with staff and the registered provider about their family member's care. One relative we spoke with told us the register provider had recently been in touch and discussed their family member's care. We reviewed the complaints folder and whilst there hadn't been any recently complaints, there was a system in place for acknowledging and responding to the complaint.

Inadequate

Is the service well-led?

Our findings

We previously inspected the home in June 2017 and rated this section as Requires Improvement. At this inspection we could not be assured that people received care to continuously review and monitor their care so that they received high quality care.

The registered manager was absent at the time of the inspection as they had been suspended. A deputy manager had been promoted and had been placed in a management position the same week of the inspection. A number of key staff, including the previous deputy manager and care staff had recently resigned their positions in recent weeks.

During the inspection it became clear the registered provider did not have quality assurance processes in place. When we asked the registered provider about checks they completed, they told us they visited the home on a weekly basis and relied on the registered manager to guide them about what was needed at the home. The registered provider could also not explain any records they kept to monitor the registered manager's performance because again they did not exist. There was a risk that people received care that was not reviewed and monitored to ensure if was of a high quality.

During the inspection we explored how people's experience of care was overseen to ensure it was reviewed and updated so people received the most appropriate care in relation to their needs. During the inspection we did not find any evidence of a system for reviewing people's care. When we asked the deputy manager questions about people's individual care, they advised us that they were beginning to get to know people and had only been at the home since January 2018 and had only very recently been promoted to deputy manager. The registered provider was unable to answer questions about people's care because they did not know and did not have a system in place for overseeing how care was being reviewed.

The registered provider could not explain how staffing was assessed and deployed so that people received the support when needed. We reviewed four care plans and saw people's needs were assessed through risk assessments, but guidance for staff about staffing needed to support people appropriately was not available. The registered provider could not explain when staffing had last been reviewed and amended because they did not have a system in place for understanding the staffing levels needed in relations to people's care. There was a risk that people would not receive the individual care they needed because insufficient staff were available to meet their needs.

The registered provider explained to us that that recruitment processes had not always been followed correctly. The system for ensuring staff recruitment processes were complete had not been updated to demonstrate an application was complete. For example, two staff files were reviewed did not contain information that could assure the registered provider all recruitment processes had been followed, including one file without a DBS. Although the registered provider confirmed all DBS checks had been completed, there was a risk people could be cared for by unsuitable staff.

Staff told us that training and supervision was also not up to date in the registered manager's absence. The

registered provider accepted that the recent changes in the management team had meant that staff supervision did not always take place and that staff training had not been reviewed.

The registered provider did not make regular checks of the service and had not ensured high quality care had been delivered. This was a breach of Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have an effective system in place for ensuring all notifications that required submission were sent to the CQC. We reviewed four care plans together with accident and incident forms completed by staff. We saw some incidents should have been reported to the CQC. We also asked the local authority to confirm whether any people had a DoL in place as we could not see from our records that we had been notified of this. There was a risk that people had not received high quality care because we could not identify how checks were being made to oversee accidents and incidents. We also could not identify how care was being adjusted and how this was recorded in care plans following for example falls.

The registered provider did not ensure notifications about injuries and applications submitted to deprive a person of their liberty were submitted to the CQC is a timely manner. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Staff reported feeling unsettled and that morale was low following recent staffing changes at the home. We spoke to three staff about how they were able to contribute their feelings about people's care and about care delivered at the home. One staff member stated they did not feel able to share their feedback about the home. Two staff stated that whilst they could speak with the new deputy manager they did not know what was going on and made them feel unsettled and less valued. We asked staff about learning from individual's care was shared so that staff could learn to improve their practice. Two staff we spoke with told us this had not been discussed at team meetings. We reviewed the folder for staff minutes and saw that not all staff minutes were available and had not been filed. There was a risk that staff were not learning from mistakes in order to prevent their repeat.

We saw during the inspection there were missed opportunities to develop partnership working with local stakeholders such as the local authority contract monitoring teams. We did not see any evidence of partnership working. We asked the registered provider about how they developed their knowledge about care and best practice within the care industry. We asked whether they worked with the local authority or attended training events. The registered provider could not share with us details of training they had attended or how they improved their knowledge about caring for people because they told us they had relied on the registered manager for guidance. The registered provider accepted they had not always challenged practices within the home.

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not make regular checks of the service and had not ensured high quality care had been delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed.