Mary Feilding Guild

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Inspection report

North Hill
Highgate
London
N6 4DP

Tel: 02083403915
Website: www.maryfeildingguild.co.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection of Mary Feilding Guild took place on the 21 August 2017.

The inspection was a focused inspection and was prompted in part by notification of an incident following which a service user died. The information shared with CQC about the incident indicated potential concerns about the management of risks in relation to the safety of the premises. This inspection examined those risks.

This report only covers our findings in relation to two outcomes, safe and well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mary Feilding Guild on our website at www.cqc.org.uk. At the last inspection the service was rated 'Good' overall.

Mary Feilding Guild is a not for profit charitable organisation registered to provide accommodation and personal care for up to 43 older people. The aim of the service is to provide support to older people who are independent both physically and mentally. At the time of the inspection there were 39 people using the service.

The provider had recently recruited a new manager who had applied to be registered with the Care Quality Commission. 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.

In response to the serious incident that had occurred in July 2017, the provider had commissioned an external contractor to carry out a risk assessment of people's rooms and communal areas. This assessment had highlighted a number of risks to people's safety. The provider was taking action to make sure these risks were mitigated.

Individual risks had been identified for people using the service in connection with their care provision. There was detailed information for staff about how to mitigate these risks, for example, to make sure people had their mobility aids with them at all times.

The systems used to identify and assess potential risk to people's safety were not always clear which meant there might be risks that were not picked up by staff.

Systems to assess, monitor and improve the safety and maintenance of the building were not always effective and there was no management oversight of this process.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to good governance. You can see what action we told the provider to take at the back

of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems for assessing the risks people faced in relation to their care were not always clear and did not assess the severity of the risk so appropriate control measures could be put in place.

As a result, of the above we have changed the rating for this key question from 'Good' to 'Requires Improvement'.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems for assessing, monitoring and auditing the safety of the premises were inconsistent.

As a result, of the above we have changed the rating for this key question from 'Good' to 'Requires improvement'.

Mary Feilding Guild

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 checked 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.

We undertook an unannounced focused inspection of Mary Feilding Guild on 21 August 2017. The inspection was prompted in part by notification of an incident following which a service user died. The information shared with CQC about the incident indicated potential concerns about the management of risks in relation to the safety of the premises. This inspection examined those risks. We inspected the service against two of the five questions we ask about services: 'is the service safe?' and 'is the service well-led?' This was because the inspection focused on the management of risk in relation to the safety of the premises.

Prior to the inspection we reviewed information we have about the provider, including previous inspection reports and notifications of any safeguarding or other incidents affecting the safety and well-being of people. By law, the provider must notify us about certain changes, events and incidents that affect their service or the people who use it.

We spoke with five staff which included the manager, the nominated individual, the maintenance person, one care staff and one domestic staff. We spoke with four people who used the service. We also spoke with the local authority safeguarding team and the police.

We checked six people's individual risk assessments and daily notes within their care plans and other documents relating to the safety of the environment. This included fire and buildings risk assessments, maintenance records, fire drill records and staff training records.

Requires Improvement

Is the service safe?

Our findings

In response to the serious incident which occurred in July 2017 the provider had commissioned a detailed buildings risk assessment and report from an external contractor. This was completed in August 2017.

The report identified five critical risks included unsuitable windows and window restrictors which could be overridden by people using the service. The report had identified that the heating, particularly in one part of the service, was difficult to control which had resulted in people feeling very warm.

People we spoke with confirmed that the home could get uncomfortably warm and that this problem with temperature control had been going on for many years. One person had purchased an air cooling system and told us, "I couldn't live without it." Another person commented, "I used to have it [window] wide open. It does get terribly hot." Although people told us they found the building hot, they had not raised this in feedback forums held by the provider.

Prior to the risk assessment being carried out, the provider had arranged for an engineer to check the boiler. The engineer's report stated they were unable to test all the boiler equipment as the control panel was faulty. This was rectified after our inspection visit when the panel was replaced.

Following the building risk assessment report, the window restrictors had been adjusted so they could not be overridden.

When people were admitted to the home an individual risk assessment had been carried out by staff in order to identify any potential risks they faced in connection with their care.

The risk assessment tool used was seen in all people's files we looked at. Where a risk had been identified there was guidance for staff to follow in order to mitigate the risk. For example, if people used mobility aids, there was guidance for staff to remind people to use these when moving around the home.

However we noted that some sections of this risk assessment tool were unclear as to how the scoring or weighting of each part of the assessment was calculated. The tool did not categorise the impact or the likelihood so the potential severity of the risk could be determined. For example, in the risk assessment tool relating to night checks and individual safety, there were 17 risk indicators in the form of questions. These included issues around mobility, medicines and sleep patterns. Each response was scored as either high or low. There was no weighting to each question and no indication around what total score indicated a high or low risk. We spoke with the nominated individual and manager about this. They told us they would review this tool.

There were also risk assessments undertaken in relation the self-administration of medicines. People's mental capacity was assessed to ensure they were able to manage their own medicines. The nominated individual and the manager confirmed that the vast majority of people using the service had full mental capacity to make their own decisions about their care and treatment.

Requires Improvement

Is the service well-led?

Our findings

The systems for recording maintenance issues were inconsistent and did not include any regular management oversight of records or audits to ensure action had been taken to address issues.

There were multiple books where maintenance issues were recorded. There was a maintenance book and other folders for specific aspects of maintenance. Staff were expected to put maintenance requests in a book when they saw issues or when people using the service had told them about problems. There were no formal management checks regarding the maintenance and safety of the premises.

During the inspection we went around the building with the manager and noted a number of maintenance issues that had not been identified or addressed. These included a poorly fitted and damaged light switch and damaged tilling.

A fire risk assessment had been undertaken in May 2017 by an external contractor. The final risk rating was identified as 'Low' however, there were four findings from the assessment that required action from the provider. This included a 'priority 1' recommendation regarding fire training and three 'priority 2' recommendations relating to the training and number of fire wardens at the service and replacing a fire extinguisher in the kitchen.

Staff had undertaken fire training and the nominated individual told us that fire warden training had been booked for September 2017. However, the fire extinguisher in the kitchen had not been changed. After the inspection the provider established that the existing fire extinguisher was not unsafe to use. However, their failure to follow the recommendations of the report had not been explained or documented at the point of inspection. The timescale for completing the three 'priority 2' recommendations was stated in the report as being within three to six months. There was no action plan in place to indicate how and when these recommendations would be addressed.

Records of recent fire drills showed that staff were not always following the required procedures.

Housekeeping staff checked water temperatures each week and recorded these tests. Records showed for 18 August 2017 that the water temperature at multiple outlets had exceeded the safe limit. The maintenance person told us they reviewed these records, and adjusted the thermostatic valves in order to lower the temperature. These records were then destroyed after action had been taken. This meant that it was not possible for management to audit or monitor water temperatures and identify possible problems with the water system.

This meant there was no effective auditing system in place to assess, monitor and improve the safety of the services provided.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider did not have an effective system to assess, monitor and improve the safety of the services provided to service users. Regulation 17 (1)(2)(b)