B & M Hemel LLP

Montrose Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

We carried out a responsive comprehensive unannounced inspection at Montrose Care Home on 16 May 2018. This inspection was in response of the concerns the Care Quality Commission (CQC) received from members of the public. At our last inspection on 14 September 2016 we found the service was meeting the required standards. At this inspection we found that there were serious failings from management and staff to ensure people received care and support in a safe and effective way.

Montrose Care 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.

Montrose Care Home is registered to provide accommodation and personal care to 50 older people some of whom may live with dementia. At the time of the inspection there were 48 people living in the home. The home spread across four levels, one of which is below the ground floor and accommodates the kitchen, chapel and two dining areas for people. The ground floor and two upper floors accommodate 50 bedrooms, lounges and storage facilities.

There was a manager in post who had registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

People told us that they felt safe living in the home, however they all reported that they felt there were not enough staff to meet their needs in a timely way. People told us they waited long periods of time for their call bells to be answered and they assumed this happened because the service was short staffed. We found that call bells at times rang in excess of 20-40 minutes. Staff were not present to provide support for people sitting in the communal areas for long periods of time on the morning of the inspection.

Risks to people`s well-being and health were not always identified, assessed or mitigated in a way to reduce them. There was a high number of un-witnessed accidents and incidents recorded in the home and we found that people involved in these accidents had no risk assessments or care plans in place to provide staff with sufficient guidance about how to mitigate the risk of reoccurrence.

The provider told us that from March 2017 they started to roll out the switch from paper records to electronic care planning in every home they had in a fazed way, Montrose Care Home being scheduled to start in November 2017. The registered manager told us that paper records were archived in November 2017 when the electronic care plans were set up and only the electronic care plans were available. Care plans we checked only had a care plan summary completed to detail personal information about the person and any immediate risk that had been identified at the time of completion. These had not been updated regularly to reflect any risk identified after the summary page was in place. The care plans we checked had no falls,

seizure, mobility, choking risk assessments completed although some people had these risks listed on the summary page of their care plans.

We found that after people had falls and sustained injuries there was no review of their care needs and no preventative measures were considered to reduce the risk of falls. Staff and members of the management team told us that people were frail and lived with dementia and they could not stop people falling.

People who came to harm because of ineffective measures in place to mitigate risks had not been referred to local safeguarding authorities. This meant that further actions had not always been implemented to keep people safe. Staff were knowledgeable about signs and symptoms of abuse and their responsibilities to report these. However we noted instances when staff had reported concerns to their managers but these had not been reported to external safeguarding authorities as required under local safeguarding protocols. Notifications were not always submitted to CQC as required.

People who needed the aid of a hoist to be transferred had no individualised slings to ensure they were protected from the risk of infections and to ensure that staff used the correct size slings when transferred them. Medicine management systems were in place to aid staff to administer medicines safely as intended by the prescriber; however we found in three instances where the amount in stock did not correspond with the records kept. There were no protocols for staff to follow where people were prescribed medicines on as and when required basis.

People who presented with behaviours which could challenge others had no care plans developed around this need to give staff an understanding of how to effectively manage these behaviours and keep people safe. We found that staff used distraction techniques when they found themselves in a challenging situation; however they had no support to understand how to prevent and de-escalate situations before they occurred.

Staff told us they received training and support to carry out their roles effectively. We saw that there was an effective training monitoring system used by the registered manager to identify staff who needed refresher training. Recruitment processes were robust and ensured that the staff employed were suitable to work in this type of care setting.

People told us they liked the food provided for them and they had enough choices. We found that a high number of people were identified by staff as losing weight. Staff told us they encouraged people to eat and that the food provided for people was fortified. However there were no nutritional care plans developed to ensure every staff member knew how to meet people`s nutritional needs.

People living in Montrose Care Home came from different ethnic and cultural backgrounds. We found that where care plans were in place for these people these had not identified this as an area where people may need support to maintain their cultural and ethnic identity.

People were asked for their consent to the day to day care and support they received from staff. We observed that in most cases staff assisting people communicated with them or asked for their involvement. The principles of the Mental Capacity Act 2005 (MCA) were not followed when people`s capacity to make certain decisions were carried out.

People and relatives told us there were not enough opportunities provided for people to engage in activities and occupy their time. Three people told us they stopped joining in activities as these were not suitable for them and were not enjoyable.

Staff told us they were given information by senior care staff and managers in handover about people`s changing needs. They used hand held devices to access people`s care records and also to record what support they gave people. However we found that information was not always consistently communicated to staff and care plans were not available on staff`s hand held devices for them to fully understand people`s needs.

The provider had a range of governance systems in place to monitor the quality and the safety of the care provided to people. We found that these systems were not effectively used by the registered manager to ensure they had an overview of the service. They had not monitored and analysed accidents and incidents in the home to identify themes or trends and implement the measures to prevent reoccurrence. The management team was not proactive in managing the risk presented to people`s well-being, the lack of care plans, lack of risk assessments and ineffective deployment of staff. They had also failed to recognise the need to use equipment to alert staff if people were getting up unaided and needed help.

We found that the audits carried out by the management team were not consistent and at times only provided generalised limited information about the issues found. There was little evidence found in meeting minutes that lessons were learned or that actions were implemented to improve the quality of the care people received.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always kept safe from harm.

Staff were not always aware of risks to people`s well-being and health and how to effectively mitigate these.

There were not sufficient staff deployed to meet people`s needs in a timely way.

Incidents identified and reported to managers were not always escalated and reported to external safeguarding authorities.

People`s specific health conditions were not always assessed and guidance was not in place for staff to know how to maximise their health.

People who required the use of a hoist to be transferred to a chair or wheelchair had no individual slings to protect them from the risk of infections and to ensure that staff used the correct sling.

High number of people had un-witnessed falls or had unexplained injuries and no actions were taken to prevent falls or injuries.

People received their medicines from trained staff; however people didn't always receive their medicines as intended by the prescriber.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of MCA were not followed when staff assessed people`s capacity to make certain decisions.

People who lived with specific health conditions had no plans in place for staff to know how to maximise their health.

People told us they were happy with the quality of the food they

were provided with.

People had access to regular GP visits and staff involved other health professionals in their care if there was a need for it.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that they had not been involved in their care planning and had no review meetings to discuss their care needs.

People did receive care and support from staff in a kind way, however there was often a delay to meet peoples` needs.

People from different ethnic and cultural background had no support to maintain their cultural identity.

People`s dignity and privacy was maintained.

There were no restrictions for people to have visitors in the home.

Confidentiality was maintained by staff who kept people`s records on password protected devices or locked in offices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive personalised care. Care plans were not in place to reflect people`s likes and dislikes.

Care and support was delivered to people in a task orientated way following a well-established routine.

People`s care plans were not detailed around people`s needs to provide staff with sufficient guidance to meet their needs effectively.

People told us there were not enough opportunities provided to help them pursue social interests and take part in meaningful activities.

People`s end of life wishes or care plans were not in place for staff to know their wishes and preferences about the care they should receive nearing the end of their life.

People told us they could raise their issues with the managers

and they knew who the registered manager was.

Is the service well-led?

Inadequate

The service was not well led.

The systems and processes used by the registered manager to quality assure the service provided for people were not comprehensive and did not identify the concerns we found in this inspection.

The registered manager was not able to provide us with evidence of an effective monitoring system they used to ensure the service was safe.

People`s care records were not completed, up to date and did not provide sufficient detail for staff in how to deliver care and support to people in a safe way.

Potential safeguarding concerns were not reported to local safeguarding authorities or CQC.

Montrose Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, 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 in part by concerns raised by the general public in regards to the care and support a person received whilst living in Montrose Care Home. The information shared with CQC raised concerns about the management of risk of people's care. This inspection examined those risks.

The inspection was carried out on 16 May 2018 by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The inspection was unannounced.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

During the inspection we spoke with five people who used the service, five relatives, five care staff members, the assistant manager, the deputy manager and the registered manager. We also spoke with a visiting health care professional. Before the inspection we received feedback from the local authority contract monitoring team.

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 communicate with us. We also looked at other care records relating to the management of the home including medicine administration records and audits.

Inadequate

Is the service safe?

Our findings

People told us they generally felt safe at Montrose Care Home; however they said they felt there was not enough staff. One person told us, "The staff make me feel safe, happy and comfortable, the only thing I would say as a concern is, I think staff are short because when you ring the buzzer there is an awful long wait sometimes." Another person told us, "I don't feel safe sometimes because of the other residents who are [living with dementia]. There are not always enough staff to stop them when they shout and argue. I pulled my cord [call bell] in my room the other day and waited nearly an hour before someone came." A third person said, "Yes I do feel safe. The security is very good here for coming in and out. Staff are very pleasant, although quite often they are short staffed. I rang for my lunch to have it in my room no one came for over an hour."

Relatives told us that they felt people were safe when staff was around, however they also told us they thought there was a shortage of staff in the home. One relative told us, "[Person] has fallen from their recliner when left in the small lounge by themselves. How that happened I really don't know, but I put it all down to staff shortages." Another relative said, "At times they [staff] are running about all day when they are short staffed."

We checked a printout of the call bell response times between 24 April 2018 to 16 May 2018 and we found that numerous times it took staff between 14 and 40 minutes to answer call bells. The majority of the delayed response to call bells happened between 6am and 1pm; however we found that during the evening some calls took more than 20 minutes to get an answer from staff. This meant that people were at risk of their needs not being met in time due to ineffective staff deployment.

Staff gave us mixed views when we asked if there was enough staff to meet people`s needs. One staff member told us, "We have enough staff to provide proper care, they [people] have their dinner, go to the toilet and we put them to bed, always we could use more staff but I think it is safe." Another staff member said, "We only do the basic care for people because it's no time for anything else. It`s not enough staff. We are always rushing."

On the day of the inspection we observed long periods of time where people were left sitting in the communal areas or dining areas without staff supervision or support. We observed at 09.45 am 12 people in ground floor conservatory where one senior was administering medicines and no other staff were present. The ground floor lounge at 9.30am had 10 people in again with no staff present, along with 2 people fast asleep at the dining table. Between 09.45 am and 10.15 am no staff member was present in the dining room. We asked the registered manager if they allocated staff to monitor the communal areas and ensure people were safe. They told us, "I allocate a member of staff in the lounges in the afternoon, but unfortunately I cannot do it in the morning. I just don't have enough staff." This meant that people were at risk of falls because there were no staff members available to support them.

We looked at all incidents logged by staff between 12 February 2018 and 14 May 2018. In this period 33 times people were found on the floor following an un-witnessed fall. Out of the 33 incidents 20 were in communal

areas including corridors, conservatory and lounge. Two people had sustained fractures following their fall and 21 people had sustained skin tears, bruises, head injuries or pain. We found that eight people had more than one fall in this period of time. There were no fall risk assessments carried out for people and no preventative measures were taken to mitigate the risk of falls. There were no sensor mats used for people to alert staff when they were in need of help and the registered manager could not provide any evidence that they had considered any actions to help reduce the reoccurrence of falls. The only action from staff in response to falls was that they contacted people`s GP or called emergency services to respond to any injury people had. This meant that people were exposed to a continuous risk of getting harmed because the risk of falls was not assessed or mitigated.

One person had a fall in April 2018 and they sustained a fracture. Following a stay in hospital they returned to the home and they had another fall two days after returning. We looked at what actions had been taken by staff to mitigate the risk of falls and found that there was no fall risk assessment or mobility care plan in place prior to or after the person sustained the falls. There was no equipment used such as a sensor mat to alert staff if the person needed assistance. Staff told us they were checking on the person every half hour during the night. We asked staff to show us this person`s records. They told us the care plan was not in place yet and the summary page did not identify this person being at risk of falls.

We asked staff and members of the management team about the high number of falls people sustained and they told us that people were frail and had dementia and they could not stop people falling. One staff member told us, "It is difficult to avoid the falls; these people are old and will fall." Another staff member told us, "They [people] have dementia and they don't understand and have falls." They were not able to demonstrate an understanding of the risks to people or explain how they mitigated those risks.

We found that 12 care plans out of the 14 we checked had not had risk assessments in place to provide staff with the needed guidance in how to keep people safe. For example a person`s care plan summary page identified that one person was at risk of seizures. There was no risk assessment or care plan to detail what actions staff had to take to address this need or to mitigate the risk of injury in case the person had a seizure. Another person had two seizures in March 2018 and was admitted to hospital. Again, there was no risk assessment or care plan to help ensure staff could monitor any signs of seizure activity. A third person`s care plan summary identified them being at risk of choking. We asked staff about this and they told us they didn't know that the person was at risk of choking but they were on a soft diet. There was no choking risk assessment or care plan in place to detail what measures were taken to mitigate this risk. This meant that staff were not provided with sufficient information to enable them to deliver care and support to people in a safe way.

We found that people`s medicines were not always managed safely. On the day of the inspection we observed staff administering people`s morning medicines until 11am. When we checked the medicine administration records (MAR) we saw that there were instructions for some people to have certain medicines before food and also to keep a recommended four hour gap between the second dose of their medicines. We found that the lunch time medicine round started just after 1pm which meant that the recommended gap between medicines was not respected. We also found that the stock of medicines we counted did not always correspond with the records kept. For example we counted a person`s Warfarin tablets. Warfarin is prescribed for people at an increased risk of developing harmful blood clots. We found that according to the MAR there should have been 46 tablets left in the box, however there were 47. This meant that the person had not received one dose of warfarin that had been signed for as being administered.

For another person we found that 15 tablets left in the box when there should have been 16. This meant that

the person may have received an extra dose of their medicine. Two people we reviewed required their antibiotic to be administered before food, however because of the time it took for senior staff to administer people`s medicines they received these after food. This meant that safe medicine administration procedures were not followed and people were at risk of not getting their medicines as intended by the prescriber.

People who required hoisting did not have individual slings to help ensure they were protected from the risk of infections. Staff told us, and it was confirmed by the deputy manager that nine people had been assessed as needing hoisting for all transfers. We asked a staff member about a person and what type and size sling they needed. Staff told us the person required a small full body sling; however they told us they could never find any small full body slings in the home so they used a medium sling. They told us there were no individualised slings for people and these were not kept in people's rooms. The deputy manager helped us look for the small sling and found one in a ground floor sling cupboard, however the person's room was on the middle floor. This meant that for people who required the permanent use of slings for transfers had not had these readily available for staff to use and keep them safe.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient staff deployed to meet people`s needs safely, risks to people`s well-being were not sufficiently mitigated to protect them from harm and people`s medicines were not managed safely.

There was safeguarding information displayed around the home and staff had received training in relation to identifying and reporting abuse. Staff knew how to report their concerns internally and externally to local safeguarding authorities and they were knowledgeable about whistleblowing procedures.

We found that where staff reported and recorded incidents members of the management team failed to raise these with local safeguarding authorities or to CQC. They failed to investigate and put protection plans in place to help protect people from further harm. For example, records showed that two people had an argument on 12 May 2018 at 07:30pm which resulted in one of them getting two skin tears to their hand and arm. We also found a record of an incident on 10 April 2018 where another person had been found with inappropriately touching another person without their consent. Neither of these incidents had been raised as a safeguarding concern to the local authority. The staff had involved the mental health specialist team in supporting these individuals but had not implemented any protection plans for staff to follow and prevent these incidents from reoccurring.

Between the 12 February 2018 and 14 May 2018 five different people were found with unexplained injuries like cuts and skin tears. There was no action taken in response to these unexplained injuries. Staff asked emergency services or district nurses input to treat the wounds, however the management team failed to report these incidents to safeguarding authorities and they did not carry out any investigations to try and establish how these injuries occurred.

We found that where people had behaviours which challenged others there were no plans developed to help ensure they were protected from hurting themselves or others. One person told us, "One [person] was grabbing my wrists and [people who live with dementia] can become very strong. A staff member did come eventually; they [staff] are very good at distracting them away in a kind way." For another person staff had recorded that they found them trying to tip another person out of their wheelchair as they thought they were in their own bedroom. There were no positive behaviour plans in place to help ensure people were occupied and had support to safeguard them and others from harm.

Following the inspection the registered manager reported five safeguarding concerns to the local safeguarding authorities and the inspectors raised a further four.

We found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because safeguarding processes and systems were not developed or used effectively to protect people from abuse.

Staff were knowledgeable and had training in fire safety. They told us they regularly had fire drills to help ensure they were competent and knew how to evacuate people from the home if there was a need for it. However staff knowledge regarding the use of the lift in case of a fire was contradictory with the provider`s fire risk assessment. The provider`s risk assessment detailed that there were two fire evacuation lifts installed in the building which could be used in the event of a fire, however staff told us they would not use the lift.

People had personal emergency evacuation plans (PEEPs) in place, however these recorded basic details, for example, `person is fully mobile but confused`. PEEPs were not sufficiently detailed to provide information in regards to how many staff were needed to evacuate each individual and what equipment was needed to evacuate people safely. The provider`s fire risk assessment was carried out on 15 March 2018. We found that the assessment detailed that there were five staff in the building during the night to evacuate people in case of an emergency; however we found that there were only four staff. In addition actions required to be completed by the end of April 2018 had not been completed. For example the assessor had identified that a number of fire doors needed adjusting to ensure they were effective in preventing fire from spreading and at the time of the inspection this action was still outstanding. Following the inspection the provider sent us the updated risk assessment and confirmed that the immediate actions were completed. The provider had a sprinkler system installed in the home which significantly reduced the risk of fire spreading from one area to the other in the home.

Safe and effective recruitment practices were followed to help make sure that all staff were of good character, physically and mentally fit for the roles they performed and relevant checks were in place such as verifying references. Staff told us before they started working at the service they went through a thorough recruitment process where their employment history was explored, references were requested from their previous employers and a criminal records check was done to help ensure they were suitable for the roles they had to perform.

Requires Improvement

Is the service effective?

Our findings

People told us the food was good and they had enough. Comments from people included, "The food is okay, very nice and if you don't like what they offered they will always cook you something else it's never a problem." Another person said, "The food is very good and plenty of it, too much sometimes. I have never asked for anything after my last meal but I am sure they would find something to give me. They come and fill my jug up in my room. There are always plenty of juices to drink downstairs and at meal times, they [staff] make sure you drink plenty."

People were helped to one of the dining rooms for lunch. The ground floor dining room was nice and bright with tables for four and there was a social atmosphere with staff chatting with people and supporting them appropriately to have their meals. In the basement there were two dining areas and staff told us they had to use the rooms in the basement because there was not enough space to accommodate everyone on the ground floor. The basement dining room had no natural light and when people ate their lunch there was no social atmosphere or chatter. Some people out of choice stayed in their rooms. One person told us, "I used to eat downstairs with a few other chaps, but not anymore, I eat in my room now, because some of the other residents wander around arguing, you can't hear yourself speak because of the noise." We asked staff if they considered using the ground floor dining area and arrange two settings for people to ensure everyone`s meal time experience was pleasant. They told us they had not thought about it.

Some people living in Montrose Care Home required specialist diets to meet their nutritional needs. Staff told us they provided this for people, however there were no care plans to detail how staff were meeting people`s nutritional needs. For example, a person who had been in hospital for a period of three weeks had lost 12kg which equalled to 20% of their body weight. Staff told us that they had involved the person`s GP in their care, however there was no care plan in place to provide staff with clear guidance and support in meeting this person`s nutritional needs.

We asked the deputy manager to provide us evidence of how they monitored people who were at risk of weight loss and malnutrition. They provided us with a list of people`s weights from November 2017 to May 2018. We identified 22 people losing between 3 and 10kg weight over this period of time. The registered manager and the deputy manager told us that they had taken action to address this, however we were not provided with the evidence to demonstrate that staff effectively addressed the risk of people losing weight. Because people constantly lost weight month after month from November 2017 to May 2018 any actions taken had not been effective.

Staff monitored every person`s weight and the electronic care planning system used a malnutrition universal screening tool (MUST) to calculate the malnutrition risk level for people. The electronic care planning system flagged an alert on the summary page for each person who lost weight indicating the percentage of body weight loss. Alerts included 11%, 8%, 9% body weight loss, however there were no care plans developed to ensure a consistent and joint approach from every staff member when meeting people`s nutritional needs.

Staff told us some people required soft or pureed diet; however it was unclear for them who had recommended this and why. For example a person`s care plan detailed that they were at risk of choking and lived with diabetes. Their nutritional care plan detailed that they were on a diabetic soft diet, however there was no detail about who had assessed the person as being at risk of choking and who had recommended a soft diet. Another person's relative told us, "I think it's a lovely home and [person] is safe and well looked after, my only quip was [that person] was put on a pureed diet and I don't know by who, this went on for a year, and I could see [person] looking at other people's food in the dining room and they tried to take some of it. That day it was shepherd's pie I think, I asked the carer if [person] could try some and they ate it all up. I asked if they could try the pudding and they did the same with this. I was just a little upset that [person] had been put on this diet when they could have been eating the same as everybody else." This meant that there was a risk that staff took decisions which they were not skilled or trained to take and put people at risk of harm.

Staff monitored every person`s fluid intake, however they told us this was because the electronic care planning system required them to do so and not every person had to be monitored for fluid intake. However when we checked people`s fluid intake we found that every person had the same recommended target for fluid intake over a 24 hour period and there were no instructions for staff to know when they had to raise concerns with their seniors if people were not meeting the required amount. For example, the electronic care planning system flagged up an alert when people had not reached the recommended target, however the management team in the home had not monitored these alerts. This meant that although staff recorded fluid intake for people, these were not effectively monitored to ensure actions could be taken in time and prevent dehydration.

We found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people`s nutrition and hydration needs were not always met.

People told us they felt staff were knowledgeable and trained. Relatives told us they never had concerns about staff. They told us staff were skilled in recognising if people`s needs changed and if they had to ask GP or District Nurses input in peoples` care.

Training for staff included dementia awareness, medicines, health and safety, infection control, moving and handling and others. There were some additional subjects for care staff to develop a better understanding of how to support people with end of life care, care planning and challenging behaviour. Staff also received training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us they were able to make decisions regarding their care and staff asked for their consent before they delivered any aspects of their care and support. We observed staff being respectful and asking people for their consent throughout the inspection. However, we found that mental capacity assessments were not decision specific and the principles of the MCA were not always followed when best interest decisions had to be made. For example, we saw a mental capacity assessment for a person. The assessment recorded that a decision had to be made to `identify the decision that the person is unable to make`. The staff who carried

out the assessment reached a decision that the person lacked capacity, however it was unclear in regards to what decision. Best interest decisions were signed by staff and had not been taken following a best interest process with the involvement of other professionals and the person`s legal representatives.

This meant that although staff were giving people choices in regards to their everyday life there was a risk that important decisions were not taken following a best interest process with involvement of other professionals to ensure that the care and support people received was truly in their best interest. This was an area in need of improvement.

The design and layout of the building enabled people who were physically able to move around the home independently. Corridors were wide, hazard free, bright and airy. The colour of the walls was not in line with current good practice guidelines regarding complimentary colours for people living with dementia. Information in the home was displayed mainly in written word and there was little signage or pictorial information provided to help people find their way around the units. Some people's bedroom doors had numbers on them but no name or photographs to help them identify their own room. There were no memory boxes or memorabilia in the corridors or in the lounge areas to help stimulate people`s memory. People's bedrooms were personalised with familiar pictures and items to help ensure they found comfort in their room.

People told us that they received good support with their health care needs. One person told us, "I have not been well and they [staff] were on the ball to call the doctor for me. I am on antibiotics now I have a chest infection. They are very good like that." Another person said, "I have had hospital appointments and a staff member has always accompanied me and never left me. She [staff member] stays the whole time then brings me back here. Everything is on hand, doctors and hairdresser. I get my feet done every few weeks." People`s records did not always evidence why they had been visited by the GP. Staff told us they asked the GP to complete the electronic record of their visit; however this had not always happened which meant that there was a chance that staff could call the GP out for the same issue more than once or miss reporting an issue to the GP if a visit already took place.

We spoke with a visiting health care professional on the day of the inspection. They told us that staff called the surgery to request GP visits appropriately however they felt that the threshold for staff calling a GP was very low. They told us that they knew that the home was a residential home, however they felt senior staff could have been more experienced and skilled in recognising when they needed GP input. They told us they felt they were spending a lot of time in the home and at times they were wondering why staff called them. This was an area in need of improvement to ensure health care professionals time was used effectively.

Requires Improvement

Is the service caring?

Our findings

Although we observed throughout the day of the inspection that people were treated with kindness and compassion by staff, some of staff`s actions in regards to how they met people`s needs had not been caring. For example, we used a short observation framework (SOFI) to observe the care and support people who were not able to communicate with us received. We observed two people sitting in the dining room in the morning fast asleep in their chair and as their heads tilted forward they were dribbling on their clothes. A staff member brought another person in the dining room and left them sitting in a chair and left without having any interaction with the two people. The staff member didn't check if the two people were comfortable and safe sitting and sleeping at the table.

When we checked the records for one person we observed sleeping we found that according to their records the person received personal care at 6.13 and was sat in the dining room with their breakfast at 7.31 am along with coffee. They were then left in the dining room with no interaction other than at 08.09 am when given another coffee. Between 09.45 and 10.15 no staff member was present in the room. This meant that staff left them sitting and sleeping at the dining room table for more than three hours.

Whilst staff were not present in the dining area another person came in and drank one person`s orange juice whilst they were asleep. We saw that staff later recorded that the person who was asleep drank the juice; however we saw that they didn't. This meant that records relating to people's fluid intake were not always accurate.

We also observed staff providing activities in the home. The activity person set up a table in the conservatory and they moved four people around the table for arts and crafts activity. They had not asked people sitting in another lounge or people sitting and sleeping in the dining area if they would like to join in the activities. We observed a few people sitting in a small lounge upstairs with the television on and the programme was for teenagers. We pointed this out to a staff member who quickly changed the channel. This meant that although staff were kind and caring when talking to people some of their actions needed improving to ensure these were not discriminatory against less able people.

People told us staff were kind and respectful towards them. One person told us, "I have to say they are very caring and lovely girls, I think they know me as an individual, they learn things about me, they chat when helping me to get washed, that's a good time to chat because they are busy the rest of the day." Another person told us, "I have been here about five years, so there must be something about the place I like. They do genuinely care about our well-being, and I think they would have a lot more time for us if there were more staff. I am quite independent and not so needy. They have to support other people that are not as well but then I suppose people like me don't get the chance to chat because they [staff] are so busy running round after the others."

Relatives told us they appreciated staff`s kindness. One relative told us, "Staff are very kind. They are very respectful." Another relative said, "It's very good here for [relative], it has a family atmosphere, staff are lovely, very approachable."

People told us staff protected their privacy, dignity and promoted their independence. One person told us, "I prefer a man's barber; the staff very kindly take me to town. If it's busy they will say 'give us a call from your mobile when you are ready'. That makes me feel I still have my independence, by choosing where and who cuts my hair." Another person told us, "They [staff] keep my dignity intact they will cover me up when washing me."

People told us they could influence their care and staff listened to their views when they delivered care and support. However, for people who were less able to voice their needs and preferences there was little evidence that staff involved them or their family to find out more information about them. Some care plans had a social history completed for people and this identified if people had a different cultural and ethnic background. However this information was not filtered through into the care that people received. For example other than staff identifying people`s cultural and social backgrounds the social activities or the nutritional assessment did not take into account how different cultural backgrounds could influence people`s needs. This was an area in need of improvement.

People and visitors told us that there were no restrictions on visiting times and staff were always welcoming towards visitors. One relative told us, "I can arrive anytime and they [staff] will always welcome me with a nice cup of tea. They even know I don't have sugar, it's a friendly homely feel I cannot praise the staff enough." Confidentiality was well maintained by staff and information held about people's health, support needs and medical histories were held securely.

Requires Improvement

Is the service responsive?

Our findings

People told us they did not always enjoy the activities on offer. They told us they enjoyed outings and sitting in the garden but activities were not designed to take account of their likes and preferences. For example, one person told us, "I used to go downstairs but it gets boring, everybody sat round in chairs nodding off, and people asking me the same questions over and over. They [staff] try their best, but it might get better when the warm weather comes." Another person told us, "I get bored sat in the lounge listening to music all day sometimes the same CD. I like it when we go out on trips, we have to take it in turns, and it's nice to go to the garden centres. We go out in the garden when it's nice and have our tea, the gardens are very nice. I'm not complaining the girls have a lot to do, I also like the church services we have."

We observed 12 people seated in the conservatory and 10 people in the lounge in a semi-circle. In the conservatory one person was reading a newspaper, others were sat with music playing. Staff providing activities asked four people to join in arts and crafts session in the morning and held a knitting club later in the day. People in the lounge and dining area were nodding off in their chair. The same music was playing throughout the day of the inspection.

Relatives told us they felt more could have been done to help ensure people were not bored. One relative told us, "Not much goes on. They [people] all sit round in those chairs looking bored to death, not everyone wants to or can knit. I have been to the meetings where people have complained that they are bored. [Relative] can't join in most of the activities but they could put something on their table for them to look at instead of looking at everybody else."

People told us that they did not know about their care plans and they assumed their relative would be involved in those. One person said, "I don't know what a care-plan is. My family might." Another person said, "I'm not quite sure what a care-plan is I haven't had any reviews on my care." People who could talk to us told us they were happy with the care they received. One person said, "They [staff] will ask me what I would like to wear, my clothes are always nice and clean, I feel spoilt by them, I have had a lovely shower today." A relative said, "I have been coming here [length of time] and my [relative] is always spotless. Their clothes are matched perfectly down to a matching necklace, that keeps my [relative`s] pride and dignity intact and I am very grateful to the girls [staff] for doing that."

We found that out of 14 care plans we checked only two had been partially completed. Care plans were not completed to evidence people`s personal history, individual preferences, hobbies and interests and cultural needs. We saw that people living in Montrose Care Home came from different cultural and ethnic backgrounds. However staff could not tell us how people`s cultural needs may have influenced the care they received. People`s care plans were not developed around this need. For example, a care plan for a person who lived with dementia detailed that they were born and grew up in a different country. Staff had not considered exploring if by providing music or meals specific to this person`s culture they could get the person more interested and settled. We saw this person being restless and constantly walking around asking questions and occasionally sleeping in a chair. They were not engaged with any activity in the home.

People's care plans did not include the necessary information for staff to understand their needs and health conditions and to be able to respond and meet people`s needs in a timely way. We found that each person had a summary page completed which gave staff some information about the person. This included the person`s name, picture, date of birth, any allergies they had, how many staff they required to support with their needs and also if they had any identified risks to their well-being and health. We found that some people were diagnosed with type 2 Diabetes and identified at risk of low and high blood sugars. However there were no plans in place to tell staff what the signs and symptoms were if the person had low or high blood sugar levels.

Some staff we spoke with were able to tell us about people`s social history and background, however not their current care needs in terms of mobility, pressure areas and behaviour support. Staff told us they used their electronic hand held devices to access information about people and what support they required. When we asked if they could access care plans anywhere else staff told us they only had access to the electronic version of the care plans. One staff member said, "No we use the MCM (Mobile Care Monitoring). I see what people need and then update what I do in there." Another staff member told us, "Before we had the paper care plans, but we have moved to this phone system which is a lot easier and quicker to record what we do."

End of life care was provided for people by the service. However, care plans were not completed and not available for us to see what plans were in place to help ensure people were comfortable and pain free when they were nearing the end of their life.

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people`s needs and preferences were not always assessed and care plans were not developed to meet all their needs in a personalised way.

People told us they were given the opportunity to provide feedback, suggestions or to complain at monthly meetings. One person told us, "They [staff] do give us an opportunity to provide feedback to them on certain issues. I mentioned that the CD's were never in order and they had some students come in to sort them. I also told them about the tea trolley always getting to my room late in the afternoon, they organised it so the trolley would take it in turns to cover the three floors and not just start at the same floor all the time, I have asked for a herb garden, they said that will take shape this summer for me." The provider had a complaint policy in place and we saw that the registered manager appropriately logged and responded to complaints.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service on 14 September 2016 we found that the service was meeting the required standard. Prior to this inspection we had received concerns from family members of people who used the service regarding the quality and safety of the care and support people received.

We found that quality monitoring was inconsistent, had not identified risks to people and had not led to action being taken to address areas of concern and mitigate risk to people`s health and wellbeing. Falls audits collated the number of falls over a period of a month for each person and listed actions in response to each fall. However although the information was available on the number of falls these were not always accurate and the actions were just immediate responses such as emergency services called, GP visit or monitor closely. The analysis of the audit did not give consideration of further preventative actions that could be taken to prevent reoccurrence. The registered manager when we asked was unable to give us an overview of all the falls occurring in Montrose Care Home or demonstrate how they analysed these to look for trends and patterns.

For example we found that staff had recorded 47 incidents and accidents between 12 February 2018 and 14 May 2018. These incidents were un-witnessed falls, unexplained injuries and incidents between people who had behaviours that challenged others. People had suffered fractures, skin tears, and head injuries. The registered manager could not provide any evidence that they had effectively analysed the incident and accident reports for trends and patterns and that they had put actions in place to reduce the reoccurrence of falls.

In addition we found that at times staff had not recorded falls people had and these were then missed from the overall incident and accident report. For example a person had been pushed by another person on 22 March 2018 and they had a fall. This had not been flagged as an accident or incident and did not appear on the incident process report we were given by the registered manager. Another person had been found on the floor on 13 May 2018 and they had sustained a skin tear. Again this had not been recorded and flagged as an incident and was not on the incident report. This meant that there was a possibility that more incidents and accidents had happened in the home than records showed.

The registered manager had failed to recognise that some of the incidents reported and recorded by staff were safeguarding concerns and had to be reported to the safeguarding authorities. They had failed to report to local safeguarding authorities and there were no protection plans in place to help ensure people were protected from the risk of harm.

There were numerous audits carried out mainly by the deputy manager. These included health and safety audits, infection control, medicine audits and care plan audits. The deputy manager also prepared an internal quality report where they listed the areas in need of improvement. The audits carried out by the deputy manager did not identify all the concerns we identified in this inspection. Where actions were identified as needed actions were not clear about who, when and how will complete these. For example, an internal quality report done by the deputy manager identified that `care planning` was needed. There were

no actions on what care plans they had identified in need of updating or creating, who will be doing this and who was going to ensure this action was completed.

We asked the registered manager how we could access people`s care plans. They told us that the provider had a Person Centred Software in place and that all the care plans were in an electronic format. They told us they archived all the paper records in November 2017. We therefore checked people`s electronic care records and found that for 12 people out of the 14 we checked there was only a summary page completed, MUST, and risk assessments for going on the minibus and peeling potatoes. No other sections of the care plans in regards to falls, mobility, cultural and social needs were completed. The registered manager and the deputy manager told us they were struggling to find the time to complete people`s records on the computer. The lack of risk assessments and care plans in place could have contributed to people sustaining numerous falls and people losing weight. This was because there were no measures considered after each fall or weight loss to minimise the risk of reoccurrence. We asked the assistant manager to make available the care plans which were archived for staff to have some information to refer to until the electronic care records were fully completed. They confirmed that they had done this before we finished the inspection.

The registered manager told us they had analysed call bell response times and they thought there was a fault in the system showing that calls took a long time to be answered. However, there were frequent calls on the call log in excess or 7, 15, 25 and 40 minutes. The registered manager could not provide any evidence that the system was faulty and people told us they had waited a long time for calls to be answered. This meant that people`s needs were not met in a timely way and put them at risk of harm because there were no actions taken to address these long response times.

The provider used a dependency tool to establish the level of care people needed and they calculated their staffing hour's requirements based on this. However we found that when the rota`s were planned senior care staff were included in the numbers to deliver hands on care and provide support for people with personal care needs. We found and senior care staff confirmed that they administered people`s medicines in the morning and they spent limited amount of time providing care to people. The registered manager told us that during the night they needed four staff members to meet people`s needs. However, we checked the night allocation rota and found that in addition to one hour break for each staff member on duty they were each allocated one hour to spend in the laundry and additional tasks like peeling potatoes, checking fire doors and checking MAR charts. The provider's dependency tool did not consider the layout of the building and the environment. Therefore we found and people told us that there were not enough staff deployed effectively to ensure they could meet people`s needs in a timely way.

The provider had a system to assess the quality of the service provided in the home. They carried out a periodic audit looking at the same five key questions the care quality commission is asking about during an inspection. However, the audit was divided over a period of a year. This meant that the safety of the care and support provided to people was only checked by representatives of the provider's senior management team once a year. The provider told us they were in the process of developing their governance system and ensuring that issues could be picked up in a more timely way.

We found that due to the ineffective quality assurance systems used and the lack of effective monitoring people suffered harm, they sustained fractures and skin tears. Risk assessments were not developed and care plans were not in place for staff to deliver personalised care and support to people. Staff were not deployed effectively which caused delays in responding to people`s calls and also people had limited opportunities provided to engage in meaningful activities in the home.

Therefore we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 as their governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. However, we found that not all reportable incidents were reported to CQC in a timely way. This meant that the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Following this inspection we received an immediate action plan from the provider which addressed some of the concerns we had raised with the registered manager in feedback following the inspection. The provider put immediate actions in place to help ensure the care people received was safe and developed a more detailed action plan to address all areas of concerns.

We received feedback from the local funding authorities who carried out reviews of the people living in Montrose Care Home. They told us that the provider had placed extra resources in the home to support the registered manager. Staffing had been increased and also sensor mats had been ordered as an immediate response to help mitigate the risk of falls for people.

People we spoke with told us they knew who the manager was and they had confidence in approaching them with any issues. People told us they were happy how the service was run. One person said, "Yes, the manager is [name of registered manager], she is very nice very friendly, they all are." Another person said, "Yes I know [name of registered manager] she's very approachable, I suppose she oversees things, but the staff are the people I would say are the real gems."

Relatives spoke highly of the staff and management. One relative said, "I also think the [registered] manager is very good and honest. There was an incident that involved my [relative] that I would never have known about, but she rang me and told me and it was all dealt with professionally."

Staff told us they were happy with the support from managers. They told us they had regular supervisions and team meetings where they could voice their opinions and make suggestions.

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 Not all reportable incidents were reported to CQC in a timely way by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People`s needs and preferences were not always assessed and care plans were not developed to meet people`s needs in a personalised way.

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 Safeguarding processes and systems were not developed or used effectively to protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People`s nutrition and hydration needs were not always met and people continued to lose weight and be at risk of malnutrition.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The governance systems were not effectively used by the registered manager to ensure the quality and the safety of the care people received was monitored and improved.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that there were insufficient staff deployed to meet people`s needs safely, risks to people`s well-being were not sufficiently mitigated to protect them from harm and people`s medicines were not managed safely.

The enforcement action we took:

We issued a Notice of Decision to restrict admissions