B & M Hemel LLP

Montrose care Home

Inspection report

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Ratings

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

Overall summary

This inspection was carried out on 03 November 2015 and was unannounced.

Montrose Care Home is a residential home that provides accommodation and personal care for up to 50 older people, some of whom live with dementia. The accommodation was arranged over three floors and at the time of our inspection there were 48 people living at the home. There was a manager in post who was 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 and associated Regulations about how the service is run.

When we last inspected the service on 28 August 2014 we found them to be meeting the required standards. At this inspection we found that they were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. Mental capacity assessments had not been carried out by management for the people who lived in the home and DoLS applications had been made to the local authority just for the people who had a formal diagnosis of dementia.

Staff obtained people's consent before providing the day to day care they required however processes to establish if people had lacked capacity for certain decisions were not followed in line with the MCA 2005; as a result people were at risk of receiving care which was not in their best interest.

Staff was knowledgeable about their responsibility to safeguard people from possible abuse. They were confident in their ability to recognise abuse and report concerns following the safeguarding procedure which was displayed on notice boards around the home.

People felt safe living in the home; they told us that their needs were met when regular staff members were working; however they felt that at times the agency staff who worked in the home was not knowledgeable enough to meet their needs.

People had their medicines administered by staff who were trained. We found that the storage of medicines was not always safe and medicines which should have been stored in a locked cupboard in a locked medicines room were left out from the cupboard in the medicines room. Medicine audits were carried out monthly however they were not efficient and failed to identify medication errors.

People told us that the standard of food provided at the home was good. We saw that the meals served were hot and that people were regularly offered a choice of drinks. Staff monitored food and fluid intake for people who were at risk of losing weight however they failed to record this to ensure information was available for other staff members.

People living at the home and their relatives were positive about the home, the manager and the staff. They felt they had the opportunity to participate in activities provided by an activities coordinator until recently; however due to the absence of the activity coordinator activities were not planned and were not provided regularly.

People, relatives and staff were confident in raising any issues with management and they were confident that the management team will listen and will solve their problems. The management team carried out regular audits to check the quality of the service provided however there were no action plans developed following these audits to ensure a continuous improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Staff were knowledgeable about safeguarding vulnerable adults procedure and how to report any concerns they may have.

Risk to people`s health and well – being was not always recorded and managed in a timely manner.

People had their medication administered by trained staff, however medicines were not stored and recorded as they should have been.

Requires Improvement

Is the service effective?
The service was not always effective.

People had their needs met by staff employed by the service who were appropriately trained and had the necessary skills and knowledge to deliver care effectively; however they felt agency staff was not as knowledgeable.

Consent in relation to care was obtained by staff prior to delivery of care.

People`s mental capacity was not assessed prior to applications being submitted to the local authority to deprive them of their liberty.

People were supported to eat a healthy balanced diet.

Requires Improvement

Is the service caring?
The service was caring.

People developed good relationships with staff who treated them with kindness and compassion.

Staff had a good understanding of people's needs and wishes and where it was possible they were involved in decisions about their care.

People's dignity and privacy was promoted.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People's needs were identified, discussed and incorporated in their care plans; however these were not always implemented in a timely manner.

People told us that activities were provided regularly, however this had stopped due to the absence of the activity coordinator.

People were able to voice their views and opinions about the service provided.

Good

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

People had confidence in the staff and management team.

The management used systems to monitor the quality of the service provided, however these were not always efficiently used to improve the service.

There was always management support available for staff and people including weekends.

Accidents and incidents were recorded however these were not efficiently analysed by management to identify any trends or patterns.

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 carried out on 03 November 2015 by one inspector. 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.

During the inspection we spoke with seven people who lived at the home, four relatives, six staff members, the assistant manager, deputy manager and manager. We looked at care plans relating to six people and four staff files. We looked at other documents central to people's health

and well-being; these included staff training records, medication records, monitoring charts and quality audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in Montrose care home. One person said, "I feel really safe. The security of the front door and the door codes keep me safe from unwanted visitors." Another person told us, "I feel safe here because I have plenty of staff around me." Visitors also told us they felt people were safe. One relative said, "[Person] is very safe here, they used to have falls at home but they had none here. Somebody is around 24/7." Another relative told us, "This is the safest place for [person], staff do their best."

We found that risks to people's health and well-being were not always identified and in some instances there were no risk assessments developed to ensure that the risks were appropriately mitigated. For example we found that a person was using bedrails when they were in bed and staff confirmed that they were using these, however there was no assessment to detail why these rails were needed, the risk associated with the use of the ails and how were the risks mitigated. We saw that the bedrails could not be lowered for the person to get out from bed safely and staff were taking the top rail off the bed every time they hoisted the person out of the bed. This meant that staff used equipment which was faulty and could have caused harm to the person. We reported this to the manager who reassured us they will take appropriate measures to rectify the fault.

We found that there were no detailed care plan for a person who moved in the home almost three weeks prior to our inspection. There were no risk assessments or plans to detail the needs of this person and how staff should deliver care to meet their needs safely. We asked a member of the management team how they ensured staff knew the needs of the people. They told us, "Staff is educated to read the care plans and to care for people as in the care plan." They told us that the person was at risk to develop pressure ulcers, they had pressure relieving mattress in place and they were in bed all the time by choice. The risk associated with this decision was not assessed and there were no management plans in place to mitigate the risk of pressure ulcers. This meant that the person could have been at risk of staff not meeting their needs safely. We discussed this with the management team and they ensured that a staff member started completing the relevant assessments and care plan for the person on the day of the inspection.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure they assessed the risks to the health and safety of the people living in the home and that the risks were sufficiently mitigated to keep people safe.

Staff told us what their responsibilities were to safeguard people from abuse and avoidable harm. Staff knew the signs and indicators that could suggest abuse and how to raise any concerns that they may have. Information about possible abuse contact details for relevant safeguarding authorities were displayed around the home. This showed us that the provider had taken reasonable steps to identify the possibility of abuse and prevent it before it occurred.

People told us that they had their needs met by staff who worked at the service regularly however they were worried when agency staff was working, they felt they were not knowledgeable enough to meet their needs. One person said, "I need to divide staff in two the regular staff and agency staff. When it is agency staff working is the only time I am concerned I am not getting the attention I need." Another person said, "The agency staff don't know as much as the other staff."

The manager told us that they had been recruiting in the positions they had available and they had reduced the agency staff hour. One relative told us, "There were issues with staffing especially over the weekend but this seems to be sorted now. I noticed agency staff reduced as well." One staff member said, "Staffing is enough now and people come first." Another staff member said, "Most of the time staffing is fine, occasionally we are short."

There were sufficient staff to meet people`s needs on the day of the inspection. Call bells were answered in a short space of time, however we found that according to staff working rota`s there was not enough permanently employed staff to cover all the shifts. On occasions staffing was below the established numbers. The manager told us they cover the available hours with agency staff however on occasions when staff had given very short notice of their absence agencies were not able to cover shifts and staff had to work short.

The recruitment process in the home was not as robust as it should have been. We found that from four employment files we checked one had only one year's employment history listed; another had two references however none of

Is the service safe?

those were from the last employer and one had no record of being interviewed or evidence that the process of employment was operated in accordance with the equal opportunities procedure. We asked the assistant manager about the interview process and they said they did not conduct any interviews for that staff member and they did not know if it had been an interview process or not.

People had their medicines administered by staff using safe practices, for example, locking the trolley when not in use and signing for the administered medicines. People were supported to administer part of their medicines independently. For example one person was administering their own inhalers and eye drops.

We found that the storage and the recording of medicines classed as controlled drugs (CD`s) was not in line with the current legislation and best practice guidance. We found that CD`s were not recorded in a special numbered stock book to ensure that the administered medicines were all accounted for. The record book had several completed pages which were lose and could have been lost. We found that three bottles with significant quantities of CD`s were not locked in a wall mounted cupboard and were left in a box in the medicines room to be returned to the pharmacy. This meant that staff had access to these medicines whilst they were on their own in the medicines room which was not in line with best practice recommendations. It is recommended at all times for safety reasons the CD`s to be handled by two members of staff one of which to be a manager.

We found that for one person the home administered CD`s for pain relief without clear instructions from the prescriber. The medicine administration record (MAR) had been printed with instruction: `use one patch as directed` without specifying how often the CD was to be administered. The Deputy Manager told us that the CD was administered every three days. When we checked the records we found that on two occasions the person had been administered the CD on the fourth day. This error was not identified on the medicines audit carried out monthly. This meant that the person could have been in pain as they did not receive their pain relief in time.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they had not ensured the proper and safe use of medicines.

Requires Improvement

Is the service effective?

Our findings

People told us that staff knew how to meet their needs effectively. One person said, "I have been here a long time and staff know what help I need." Another person said, "They [staff] asks me if they [staff] can help me and they [staff] will offer me the help I need how I want it."

Staff members told us they received training and had regular supervisions from their manager and that they were able to discuss any aspect of their role with senior members of the team. One staff member said, "Managers always ask us if we want to do more training. We have the opportunity to develop because they offer us national vocational training." Newly employed staff told us they had thorough induction training and they had worked with a more experienced staff member before they were allowed to deliver care unsupervised.

Staff felt supported by managers and were confident to approach managers for advice. One staff member said, "managers are approachable and available and are on a rota every weekend." Another staff member said, "I like to work here because I have support from managers and they are approachable."

We observed that staff gained people's consent prior to support being provided and they were offering people choices. One staff member told us, "Even if people lack capacity we [staff] explain what we are doing and see if they are happy to accept the care." They continued to say, "It is all about the individual, we need to give plenty of choices."

At the time of the inspection we were told that deprivation of liberty applications had been made to the local authority, just in relation to people who had been formally diagnosed with dementia. People had not had their capacity assessed, before the applications to deprive them of their liberty were submitted.

We observed a person who had packed their clothes and said they wanted to go home, however they were not let out by staff. We asked one of the management team about the person and they told us they had not applied for a deprivation of liberty authorisation. They told us they had referred the person to be seen by the GP for a formal diagnosis and the person was seen regularly by the mental health team. They told us that they had not carried out any mental capacity assessment. We informed the manager of our concerns that the person may be unlawly deprived of their liberty. The manager reassured us they would carry out the required mental capacity assessments and follow the process to obtain the necessary authorisations.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was plenty to eat and drink and overall the food was good. One person said, "Food is always too much. It is generally good; on odd occasions things go wrong." Another person said, "The food is good, we get plenty of choices and they [staff] will always make something else if we don't like what`s on offer."

People had the opportunity to eat in several dining areas or their bedroom however there was just one food trolley available and this was pushed from area to area in a hurry to keep the food warm. We observed that staff were rushing around for people to get their meals in time and while still hot. One person told us, "Meal times are chaotic, since I have my meals in my room I feel content." One staff member said, "I feel during meal times we could do with more staff."

People were encouraged to eat and drink. There were drinks and bowls of fruit available throughout the day in all the areas of the home and staff had been encouraging people to eat and drink. However for the people who were at risk of losing weight and dehydration staff failed to complete the records to ensure information was available for staff on the next shifts.

The manager told us that they had identified the need to have a nutrition champion who would have the responsibility to work closely with staff and the chef to ensure people`s nutritional needs were met. The deputy manager had started the training recently.

People told us that outside professionals visited the home to support their health needs. One person said, "I can see my GP when I want, they [staff] will arrange it for me." Another person said, "I have the district nurses coming to see me twice a week." We saw that people were supported to attend appointments outside the home. For example on the day of the inspection a person had to attend a hospital appointment. They told us that the manager arranged for a staff member to take them to the appointment. People had regular visits from a hairdresser; chiropodist, dentist and optician to ensure their health needs were met.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring towards them. One person said, “I find staff very caring and approachable.” Another person said, “There are lovely staff here, very kind.” One relative said, “Staff are lovely and caring, they [staff] all seem to like their job which is good.”

People were valued and treated as individuals. We saw staff let people decide and choose as much as it was possible. People were asked where they wanted to spend their days, what they wanted to eat and drink and where they wanted to sit. We saw some people who choose to stay in their bedrooms and others were happy to socialise with other people. This helped people to take decisions and be in control of their day to day life and this made people feel happy. One person told us, “I am content here; I can go out when I want. I have no limitations.”

People felt they had their privacy and dignity protected by staff and they felt comfortable in the presence of staff. One person said, “Staff are respectful and knocks on my door. They are very good and lovely when they shower me.” Another person said, “Staff knocks on my door before they come in and they respect my privacy.” We saw staff knocking on bedroom doors and they addressed people by their preferred names.

Staff knew people`s individual needs and preferences in relation to their care, we saw that some people were involved in discussions about their care and where people were not able to share their views about their care, relatives had been involved. However we found that people were not always involved in reviewing their care needs on occasions the reviews were done by staff and relatives without an explanation of why the person was not present.

People were asked to think about their preferences of care nearer the end of their life and this was part of the care planning process. However we saw that a person had a do not attempt cardio pulmonary resuscitation (DNACPR) decision in their care plan, this showed no involvement of the person or a rightful representative. It also did not indicate if the decision was temporary or indefinite. This meant that the person was at risk of not receiving a treatment which could have saved their life if the DNACPR was meant to be just a temporary decision. We discussed this with the manager who reassured us they would liaise with the GP to ensure that the decision would be reviewed.

Staff were welcoming toward visitors and there were no restrictions on visiting times. Relatives told us they could visit when they wanted. We saw relatives visiting throughout the day of the inspection and some of them were participating in the care of their loved ones. For example we saw a relative who visited early in the morning and helped a person eat the treat they bought them. This meant that the management was encouraging people to maintain relationship with their friends and families and family members were included in the care of their loved one.

Good

Is the service responsive?

Our findings

People felt that they received the appropriate support they wanted and asked for. One person said, “I have told them [staff] I don’t want to be helped by very young female staff and this is respected.” Another person said, “They [staff] offer me the choice to get up but they respect my decision to stay in bed.”

Staff encouraged people to pursue their hobbies and interests. For example we found that a person was collecting postcards from different cities and countries and they enjoyed looking at these. The person told us staff and their family always brought a postcard for them or sent one if they visited other counties. They said, “Staff and family always send me a postcard from where they visit. I got permission from management to stick them on my wall. It is great to see all these places!”

People told us that the activities in the home were organised by an activity coordinator who had been absent for a long time and activities were not as organised as they were previously. One person said, “There are a lot of outside entertainers coming at present due to the absence of the activity person.” Another person showed us an area where it should have been a bar they said, “This bar should have opened a long time ago but nothing happens, they bought the nice glasses and we are still waiting.”

On the day of the inspection we saw staff had been allocated to do activities and they had an exercise session. One person told us, “The entertainment was good today; I did exercises and reminiscing in the afternoon.” One staff member said, “We go out shopping with people, we organise events and invite families. “ One family member said, “It is something going on all the time, we get invites for all sorts.”

The manager told us they were booking more outside entertainment to balance the lack of other activities and they were looking into employing another activities person to ensure that people had continuity and they could do the things they liked.

People told us that they were confident to raise any issues or concerns with the staff and management. One person said, “I am confident in talking to managers and staff, they always sort things out.” Another person said, “Management is very approachable, they are good in solving things.” Relatives were confident in approaching managers for any issues they had. One relative said, “I cannot fault staff and management, they always try to sort things out.” Another relative told us, “I am very confident in raising any issues with staff and management, they are now available over the weekends as well and they sort things out.”

The home had a complaints log and in each instance the complaints were investigated and responded to. We saw the home displayed the complaints procedure in visible areas for visitors and people`s reference. For example we saw a recent complaint which was investigated and responded to. The outcome was also discussed in staff meetings to ensure positive lessons were learnt. This meant that the provider encouraged an open and transparent culture and they valued people`s voice.

Requires Improvement

Is the service well-led?

Our findings

People who used the service, relatives and all staff members thought that the home was well-led. They told us that the home manager was approachable and very visible within the home. One relative said, “As a family we are absolutely delighted, the care is very good and the managers are good.”

People’s views and opinions were sought through a formal survey that was given to people living at Montrose Care Home and their relatives to complete. The responses to this surveys were collected, however there was no analysis or action plans accompanying the findings.

Staff told us that there were able to attend regular staff meetings, and were encouraged to raise any concerns or issues they had. Residents and relatives were also provided with meetings and a forum where they could discuss matters important to them. We looked at the minutes of a family forum meeting, and saw that family members had reported some issues to management. For example, wheelchairs had no footplates and they were not clean, some raised concerns about staff turnover, however there were no action plans developed to ensure these issues were addressed.

The manager, assistant manager and deputy manager had been monitoring the quality of the service and completed regular audits, however these were not as efficient as it could have been. For example we saw that a controlled medicines audit was carried out monthly however this had not identified the errors we found. The manager was not analysing data from accident and incident reports to establish any patters and prevent reoccurrence. Care plan audits carried out were not revisited to ensure the outstanding issues were completed.

We found two bedrooms with a strong odour and when we asked the manager they told us that some people suffer with urinary tract infection. They told us they were checking the environment regularly however they were not recording their findings. They reassured us that they were reporting issues with the environment to the provider and these were being solved in a timely manner.

We found that records were not completed in a timely way although managers confirmed they had the responsibility to check if these were completed; we found several gaps. For example a person at risk of losing weight had their food and fluid monitored daily. We found that days of recording were missing and at times there was just one recording for a day. This meant that information was not available for any review of the person `s fluid intake and the person could have been at risk of dehydration. This meant that the provider did not have an effective system in place to robustly monitor and review the quality of care provided to people.

The provider had implemented a new system to assess the quality of the service provided in the home. They had developed an audit tool that asked the same five key questions that the care quality commission asked during an inspection. This tool was designed to look at the same areas and topics as an inspection in an attempt to assist the managers to prepare and monitor their services for inspection and ensure compliance. We found that the latest visit by the provider found similar issues like lack of action plans and issues with medicines which meant that the measures and actions in place to prevent these reoccurring were not efficient.

Due to lack of accurate recordings, lack of systems to identify shortfalls of the service provision and the lack of responsiveness to improve the quality of the service provided we found the provider was in 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 legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure they assessed the risks to the health and safety of the people living in the home and that the risks were sufficiently mitigated to keep people safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure ensure the proper and safe use of medicines.**

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 **The provider failed to ensure they submitted applications to authorities to lawfully deprive people of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to ensure accurate and contemporaneous records were kept. There was a lack of effective monitoring of the quality of the service.**