Morton Cottage Residential Home Limited

Morton Cottage Residential Home

Inspection report

Morton Cottage
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Carlisle
Cumbria
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Tel: 01228515757

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28 July 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Morton Cottage Residential Home (the home) is registered to provide accommodation for people who require personal care. The home can accommodate up to 32 older people, some of whom may be living with dementia. Accommodation is provided over two floors in single rooms, but there are facilities for shared accommodation (2 rooms). All rooms have en-suite toilet and wash basin facilities. There are communal bathrooms and toilet facilities available throughout the home and a wet room has recently been installed at the service.

There is a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection took place over three days, 27 and 28 July and 11 August 2016. The inspection was unannounced.

We had previously carried out an unannounced comprehensive inspection of this service on 29 September 2015. Eleven breaches of the legal requirements were found. We judged that this service was "Inadequate" and Morton Cottage Residential Home was placed in special measures. We issued eleven requirement notices to the provider.

Requirement notices were issued as people who lived at the home did not receive respectful and dignified care or appropriate care and treatment that met their needs and reflected their preferences. People were at risk from unsafe practices relating to the control of infections and contamination, of having unlawful restrictions placed on their liberty and at risk as their nutritional and hydration needs were not met. People who lived at the home did not receive their care and support from people who had the skills, competence and experience to do so safely. The management of the service was not open and transparent, with no clear lines of accountability in place. There were no systems in place to effectively monitor and improve the quality and safety of the service and to ensure compliance with the requirements. The registered provider sent us an action plan to show how they would ensure compliance with these parts of the regulations.

Our unannounced inspection on 27 and 28 July and 11 August 2016 was a full comprehensive inspection. We found that improvements had not been made and breaches of the regulations continued. People who lived at the home did not receive care or treatment that had been personalised specifically for them. This placed people at risk of receiving care or treatment that did not meet their individual needs or expectations.

People who lived at the home did not receive care and treatment that ensured their dignity or treated them with respect. Procedures for obtaining consent to care and treatment did not always follow current legislation and guidance. This meant that people who used this service were placed at risk of receiving care or treatment that they had not agreed or consented to.

People who lived at the home were not protected from the risks of receiving unsafe care, treatment and avoidable harm. Medicines were not managed safely and people were placed at risk of not receiving their medicines as prescribed.

There were no systems in place to ensure people were protected from the risks associated with infection prevention and control. The premises were not clean and properly maintained. Equipment was not used properly or safely.

People who lived at the home were not always protected from the risks of abuse and improper treatment. The provider did not have effective systems and processes in place to monitor and assess the quality and safety of the service. This meant that the provider had no way of checking that they were keeping people safe or meeting the requirements of the regulations.

People were not provided with adequate support with their nutrition and hydration. This meant that people who used this service were placed at risk of malnutrition and dehydration.

The provider did not ensure that there were a sufficient number of suitably qualified, skilled and experienced persons deployed at the home. This meant that people who used the service did not always have their needs met appropriately.

You can see what action we told the provider to take at the back of the full version of the report.

We have also made a recommendation in relation to risk assessing whether staff were safe to work with vulnerable people.

People who lived at the home told us the home was "alright" and that the staff were "very kind."
We observed that staff were well meaning and we heard them speaking cheerfully and kindly to people. We also noticed appropriate interactions between staff and people who lived at Morton Cottage. Visitors to the home told us that their relatives seemed "happy" and that they had never seen anything at the home to cause them to worry. However this did not reflect our findings.

The service did not have an effective system in place to help monitor and improve the quality and safety of the service. We found that people did not always receive care, treatment and support that met their needs and preferences. Some people did not have care plans or risk assessments, whilst others were out of date and inaccurate. Medicines were poorly managed and people were placed at risk of not receiving their medicines as prescribed. We found that the home was not clean or properly maintained and staff did not always follow good hygiene practices. There were not always enough staff available to meet the needs of people who used this service and sometimes people had to wait for help.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

The risk assessments of people who lived at the home were incomplete. Where risks had been identified they had not been adequately recorded. Appropriate actions had not been taken to help make sure risks had been mitigated and people were safe.

Medication was poorly managed. This meant that people who lived at the home were not fully protected against the risks associated with the use and management of medicines.

People's health, safety and welfare was compromised because the registered provider did not have effective systems in place for preventing, detecting and controlling the spread of infections.

Is the service effective?

Inadequate

The service was not effective.

Staff employed at the home did not have the skills and knowledge required to support people safely. We observed some poor practices by staff, especially around infection control and when supporting people with their mobility and medicines.

There was a lack of understanding and inconsistent application of the requirements of the Mental Capacity Act 2005. This meant that people who lived at the home were placed at risk of unlawful restraint and of receiving care and treatment that they had not consented to.

The premises were not clean or properly maintained. Signage and equipment were not "dementia friendly" or took account of best practice guidance. This meant that the safety and independence of people who used this service were compromised.

Is the service caring?

Inadequate

The service was not caring.

Staff communication with people who had complex needs was

limited. This meant that people's needs were not always met or understood.

The privacy and dignity of people who used this service was not always respected or protected.

There was no information available at the home to help people access independent advocacy services if they wished to do so.

Is the service responsive?

Inadequate

The service was not responsive.

People who lived at the home did not have care and treatment plans that had been designed specifically for them. This meant that people were placed at risk of receiving care or treatment that did not meet their needs or expectations.

People who lived at the home did not know they had care plans and did not recall speaking to anyone about their needs and preferences.

People who lived at the home were not supported to be actively involved with activities within the home and in the wider community.

Is the service well-led?

Inadequate

The service was not well led.

Management and staff did not understand the principles of good quality assurance. There were no effective systems in place to help monitor the quality and safety of the service and to ensure compliance with the regulations.

The sample of policies and procedures we looked at had last been reviewed in December 2013 and made reference to out of date regulations.

The service did not effectively identify risks. There were no strategies in place to manage or minimise risks to help ensure the service ran safely and smoothly.

Morton Cottage Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 27 and 28 July and 11 August 2016 and was unannounced.

The inspection was carried out by one adult social care inspector, an adult social care inspection manager, a pharmacist inspector 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 care service.

Prior to the inspection we looked at the information we held about the service for example notifications, comments from relatives of people who used the service and from health and social care professionals. Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with ten people who lived at the home and three of their relatives, friends or visitors. We spoke with three members of staff, as well as the registered manager and the co-owner of the service. We contacted health and social care professionals via telephone and e-mail in order to get their views of the service.

We looked in detail at the care records of three of people who lived at the home. We looked in detail at the medicines; medication administration records (MARs) and other records for 19 people who lived at Morton Cottage.

We spent time in the communal areas of the home and observed staff providing care and support to some of the people who lived at this home.

We looked at the quality monitoring and auditing systems in place at the service and we sampled the policies and procedures in place at the home, looking at six of these in detail.

We looked at the way in which new staff had been recruited to the service. We checked the personnel records of two members of staff who had recently started working at Morton Cottage.

We looked at the ways in which the service managed and learned from complaints, incidents and accidents. The registered manager told us that the service had not received any complaints since our last inspection at Morton Cottage.

Inadequate

Is the service safe?

Our findings

One person who lived at the home told us; "I can wash and dress myself but I think someone should come and check that I'm alright in the morning. I think someone should have come and asked if I needed help too."

A visitor to the home felt that their relative was "Safe here (Morton Cottage)." They told us that their relative had made their own decisions about living and staying at the home.

Another visitor told us, "I have never seen anything to worry me and my friend always seems happy."

One person told us; "We are very happy with the home. My relative has been here two years and there always seems enough staff. I am happy that my relative is safe here."

We looked at the way in which the registered provider kept people safe from the risks of harm, injury or abuse.

The sample of care records we looked at contained risk assessments in relation to supporting people with their mobility, supporting people at risk from falls and supporting people who may at times become distressed or anxious. There was insufficient information recorded and little evidence of guidance for staff to follow to help ensure they worked safely and that the people they were supporting were kept safe.

When people had suffered a fall, we found that risk assessments had not been reviewed and updated when necessary in order to help reduce the risks of that person falling again. We found that some people had bed rails in place but there was no evidence to confirm that people had fallen out of bed and that bed rails were the most appropriate type of equipment to use.

Risk assessments for supporting people who may become distressed, instructed staff to "divert" this type of behaviour "before it occurs". However, there was no guidance about the type of effective diversions that should be used nor was there any information to help staff identify the circumstances that might lead to someone becoming distressed or anxious.

We looked at the accident and incident records kept at the home. We found that over a two month period there had been five incidents where people who lived at the home had suffered injuries when being supported with their mobility needs by staff at the home.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who lived at the home were not protected against the risks of harm or injury because the registered provider had not done everything reasonably practicable to mitigate the risks.

There was a policy and procedure in place with regards to safeguarding vulnerable adults. This document

referred to out of date regulations and made no reference to the local authority safeguarding processes. Not all staff at the home had undertaken training with regards to safeguarding matters. Additionally, when we checked the accident records at the home, we found five incidents that should have been referred to the local authority as potential safeguarding matters. The provider had not reported them. CQC made the safeguarding referrals to the local authority immediately following our inspection.

This was a breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not always protected from the risks of harm, abuse and improper treatment.

The safeguarding policy at the home also stated that people who used the service would be protected from abuse by staff because the service operated "rigorous pre-employment checks." However, when we looked at the sample of staff recruitment records we found that rigorous checks, risk assessments and supervision had not taken place. For example the results of checks on one person had revealed some negative issues and there was no evidence to support that their training qualifications had been verified. There was little information recorded as to how the registered manager would monitor and manage the performance of this person.

We recommended that the service considers current advice and guidance in relation to the safe recruitment and performance management of staff.

One of the staff we spoke with thought that the staffing levels were sufficient. They told us; "There are enough staff on duty. Usually there are three of us during the day and a senior." At the time of our inspection there were three members of staff on duty, plus a senior carer. The registered manager and the owner were also at the home. We looked at the staff rota and this confirmed what we were told.

However, in practice, there was not enough staff on duty or appropriately deployed in order to meet the needs of the people who lived at the home. There were three occasions where inspectors had to go and find staff and ask them to attend to people who were calling out for help. People did not have easy access to call bells in order for them to summon staff when needed. We observed a professional visitor to the home looking for a member of staff and looking for a call bell to alert staff that they were in the home.

We spoke to the registered manager about how staffing levels were determined. The registered manager told us that they did not have any processes in place to help them determine the correct numbers of staff needed to meet the needs and dependencies of people who used this service.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have their care and support needs met in a timely manner because there were insufficient numbers of staff deployed at the home.

We looked at medication records, medicines and other records of care (both planned and received) for 19 people who were living in the home. We found discrepancies and concerns in all of the examples we looked at. We observed part of a medication round being carried out and spoke with the registered manager and two care workers on duty about medicines management within the home. We found that medicines were not stored safely and were accessible to staff who were not authorised to handle them. There was no system in place to ensure medicines were kept at the correct temperature.

Care workers were unable to identify medication before administering it. The pharmacy supplied most medicines in blister packs, but there were no identifying marks recorded to determine which tablet was

which. One person's medication had been supplied from home in unlabelled containers. Care workers had administered these medicines even though they were unable to be certain what the tablets were or what dose had been prescribed.

We saw that the care worker did not always stay with people to make sure they had taken their medicines safely and often signed the medication records before the medicines had actually been taken. We noticed one person still had a tablet on their plate at least 10 minutes after the care worker had given it to them. The care worker did not lock the medication trolley during the round and frequently left medication on top of it. This meant that anyone could access the medicines whilst the care worker was not looking.

We found that people did not always get their medicines given correctly or as prescribed. We found one person being given tablets at breakfast that should have been taken at night. Others had not been given their medicines because stock had run out. This included strong painkillers, eye drops and creams. People were at risk of suffering unnecessary pain and discomfort when adequate supplies of their medicines were not reordered in good time. Some medicines were not given at the right dose. We saw ear drops prescribed to be used twice a day only being used once daily and one person regularly missed their evening medication as they were asleep before the medication round started. We saw other examples where medicines, including painkillers and inhalers had been signed for but not actually given.

This was a breach of Regulation 12 (2) (f) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The health and wellbeing of people living in the home was placed at unnecessary risk because they did not always get their medicines as prescribed.

We observed that the home was not kept in a clean, fresh and hygienic condition. This included high risk areas such as bathrooms, wet room and the laundry. We spoke with the registered manager about these matters at the time of our inspection and showed her examples of our concerns with regards to the cleanliness of the service and the management of infection control and prevention.

We noticed that the home had a supply of specialist cushions, usually used by people at risk of developing pressure ulcers. These were used "communally" and should be kept for individual people. We saw that these were not washed in between use, increasing the risk of cross infections.

We observed that staff did not consistently demonstrate effective infection control and prevention practices. For example, protective clothing was not always worn when necessary and staff did not always wash their hands in between tasks. We also observed some poor food hygiene practices such as meals being carried through to lounge areas without being covered and a communal biscuit box where people could sort through to find the biscuit they wanted.

The provider had infection control policies and procedures in place, but these were out of date and did not reflect current regulations and best practice guidance.

This was a breach of Regulation 12 (2) (h) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected against the risks associated with detecting, preventing and controlling the spread of infections.

Inadequate

Is the service effective?

Our findings

People who lived at Morton Cottage told us that the food was "alright" and "adequate."

One person said; "I like the food." Another told us; "I had breakfast today and it was quite adequate."

Health and social care professionals told us they had been into the home to offer advice and support to staff to help them understand some of the specific needs of people who lived at the home. However, we were also told this advice was "not always acted upon" and followed.

We spoke to three members of staff during our visit to Morton Cottage, about their training and development. Staff told us that they had done "lots of training" but gave vague answers when asked about specific training completed.

We looked at the staff training plan and records. These showed that there were gaps in staff skills and knowledge. In particular with regards to the Mental Capacity Act 2005, safeguarding vulnerable adults, moving and handling, health and safety, dignity in care, infection control, medication, and end of life care.

We directly observed poor moving and handling practices and infection control practices by staff. For example, brakes were not always applied to wheelchairs when transferring people to or from them. Foot rests were not always fitted or used when transferring people around the home in their wheel chairs. Staff did not consistently practice good hand hygiene and failed to use protective clothing such as gloves and aprons appropriately.

We also observed poor practices with regards to the administration of medicines. We checked records and found that not all care workers authorised to administer medicines had been trained to do so. The registered manager told us that she had not carried out any assessments to ensure that staff were competent to handle medicines safely.

We observed staff working with people who lived at the home during our inspection visits. We observed two incidents where people became very distressed and confused. We observed that the actions of the staff, though well-meaning only made matters worse. Staff were unable to implement effective strategies to cope with these behaviours, and had limited understanding of why the incidents happened.

We observed that some staff became flustered when lots of demands were being made on them. For example, repeated calls from people who lived at the home. On one occasion one member of staff became quite short when speaking to a person and said; "You'll just have to wait a bit, I'm the only one here."

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who lived at the home were placed at unnecessary risk of harm because staff had not received appropriate training.

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 so that they can 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). We checked whether the service was working within the principles of the MCA.

The registered manager told us that they had made applications to the local authority for authorisations to deprive people of their liberty. The outcome of these applications had not been determined at the time of our inspection.

Half of the staff at the home had received some training to raise their awareness of the MCA and DoLS. The registered provider had policies and procedures in place but these were out of date and needed to be reviewed to ensure they reflected current legislation and good practice guidance.

We checked the care records of three of the people that lived at the home. We found that one person was receiving their medicines covertly (i.e. without their knowledge and consent) and that restrictions had been placed on people who lived at the home without lawful consent. There was no evidence to confirm that mental capacity assessments had been properly undertaken, that alternative methods had been used to help people make decisions about their care and treatment or as to whether care was being provided in the person's best interests. Staff at the home did not have the knowledge and understanding about lawful consent and the decision making processes.

This was a breach of Regulation 11 Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not supported to make decisions and give consent to their care and treatment.

We spoke with people who lived at the home whilst they were waiting for their breakfast. We observed one person trying to drink milk from the milk jug on the table, but it was empty. Another person was holding a glass out wanting a drink. Two other people told us that they hadn't had a drink since supper time the previous night. One person was very upset that they hadn't had a drink and the other said their mouth was so dry their tongue was sticking to it.

Later in the morning, after breakfast, we observed that jugs of juice were brought into the lounge areas. However, not everyone could reach them by themselves. In one of the lounges a member of staff got a cold drink for the four people who were sat in that part of the home but this was not the case in the other lounge areas, despite it being a warm day.

We observed that although cups and saucers were available, most people were given their drinks in plastic mugs. We did not see any adapted cups in use to help people maintain their dignity and independence. We also noticed that the plastic mugs were heavily stained inside even though they had just been washed. We found that some adaptive cutlery was in use including plate guards. We did not see any contrasting coloured, tables, plates or cups in use to help promote the independence of people living with dementia.

At lunchtime some people chose to eat their meal in the lounge. We noticed that trays and plate covers were not used. We saw, in these areas, that people sat at occasional tables that were not right in front of them. This meant that they struggled to get food into their mouth without spilling it on their clothing.

There were two people who lived at the home who required food supplements to be included in their diet. There was no information detailed in their care plans to guide staff about the use of these products or how these people should be effectively supported with their nutritional needs. Nutritional assessments, care plans and dietary intake records were poorly maintained. It was impossible to tell the level of support people needed or how much they had eaten or drank.

This was a breach of Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were place at risk of malnutrition and dehydration because their nutritional needs had not been properly assessed and managed.

During our inspection of Morton Cottage, we looked around the home. We found that the home had not been well maintained and equipment was not always used correctly or safely by staff. The home was not clean and hygienic, particularly the communal wet room, bathroom and laundry area.

The service had purchased specialist equipment such as pressure relieving cushions and mattresses, as well as a supply of wheelchairs and hospital type beds.

Wheelchairs were not used safely. Footplates were missing and we saw staff transferring service users from seats to wheelchairs without first applying the brakes. Call bells were not available or not easily accessible to people who used this service and they had to rely on staff coming to check on them (which was not done with any regular frequency) or by calling out for assistance.

Morton Cottage provided care for older people suffering from dementia, Alzheimer's, memory loss and similar disorders. However, during our inspection we found no evidence of "dementia friendly" lighting, colour schemes, assistive technology or signage, including bathrooms, toilets and people's private bedrooms. There were no aids to assist people with orientation and enable them to maintain some level of independence.

Cumbria Fire and Rescue Service had visited the home in March 2016 and asked the registered provider to make some improvements. This had included the need to maintain escape routes to ensure they were usable and available at all times, and were clear of trip hazards. During our inspection we saw that the metal fire exit steps, leading from the back of the first floor, were overgrown with ivy and vegetation. We acknowledge by the end of that the day the gardener had cleared this but up until that time the fire exit was not clear of trip hazards and placed the safety of people who lived and worked at this service at risk. In addition to this fire exit signs were not clearly posted throughout the home, particularly in the dining room. We spoke to Cumbria Fire and Rescue service about our concerns following our inspection.

This was a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the home was not properly maintained and equipment was not used safely.

Inadequate

Is the service caring?

Our findings

Two of the people who lived at the home told us that the support they got was "Alright." Another person said; "It's alright really the girls are very kind."

A visitor to the home told us the home kept them up to date. They said; "They (staff) have got my phone number and contact me and I can visit when I like." Another visitor said; "We're very happy with it (the home). The girls (staff) are very good and we come in when we want."

We noticed that people who lived at the home were frequently left unsupervised and without any means of contacting staff if needed. People had to shout or call for help and support from staff because they did not have access to call bells.

We observed that the appearance of people who lived at the home was unkempt. Hair was not brushed, men were unshaven and the clothes of many people were mismatched or dirty. Most of the people wore socks only with no shoes or slippers and some of those in slippers were without socks or stockings. After lunch many people had clothes soiled with food that were not changed or cleaned.

We observed staff applying medicine patches to people whilst they were sat at the dining room table eating their breakfast and we observed another person receiving treatment in one of the communal lounge areas. These treatments should have been done in the privacy of people's own rooms to help protect privacy and dignity.
We observed two people who needed help with aspects of their personal care. For example; one person was walking with a walking frame and said "Oh I've coughed and peed myself". The member of staff responded; "It's alright you have pads on" and hugged her, but did not take the person to change. Staff failed to notice that another person needed help with a similar matter and we had to ask staff to attend to this person's needs.

We also saw that a person had spilled a drink and although staff cleaned the floor and placed a "wet floor" sign up, they did not attend to the wet clothing of the person. We had to ask staff to assist this person to change their wet clothing.

We found that information about people who lived at the home was not always kept securely. For example lists of everyone's name, their room numbers and status were on display in every corridor. The lists included the names of people who had recently died.

We looked at a sample of records relating to the care needs of people who lived at the home. We found that there was no information recorded about people's personal preferences and lifestyle choices. The lack of guidance for staff meant that they could not be sure that people were appropriately supported to maintain their autonomy and independence.

This was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 because people who used this service were not consistently treated with respect or dignity.

We observed some carers having short conversations with some of the people who lived at Morton Cottage. We heard staff speaking cheerfully to people and observed some appropriate interactions between staff and people who lived at the home. We also saw a member of staff politely distract a visitor away from their relative who was having a meeting with their social worker so they could speak in private.

During one of our inspection days at Morton Cottage, we witnessed the registered manager dealing with a medical emergency that involved one of the people who lived at the home. Although the person was anxious and very distressed, we noted that the registered manager handled the situation very well by trying to calm the person and protecting their privacy and dignity throughout.

Inadequate

Is the service responsive?

Our findings

People who lived at the home told us there was "not much to do" at the home. One person said; "I fold the napkins, there's not much else." Another person told us; "There's not much to do really, I'm not one for jigsaws and things like that, they like you to do them but I'm not bothered."

We spoke to people about their care needs, expectations and care plans. The people we spoke with could not remember discussing them and most did not know they had a care plan.

One person told us; "I don't know anything about a care plan. No one has asked me about the help I need or would like." We checked with the registered manager about this person's care plan on the first day of our inspection on 27 July 2016. The registered manager confirmed they did not have a care plan in place. This person remained without a care plan until when we checked again on 11 August.

We found that many of the people who lived at the home had been prescribed creams and medicines that only needed to be taken or used when required. For example, painkillers and laxatives. We found that there were no care plans in place for the use of these medicines and this meant that there was not enough information available to enable staff to give the medicines safely. This was of particular concern as some of the people who lived at the home were unable to recognise or communicate their needs. There was no evidence that pain assessment tools were regularly used to help determine whether or not people were in need of their painkillers. The lack of information about people's individual needs, communication methods and preferences meant that they were at risk of not being given their medicines when they needed them.

We found that people who lived at the home were not able to exercise choice about aspects of their personal care needs. For example we read in the minutes of a recent staff meeting that staff had been told to "stick to their allocated baths….to ensure residents are receiving a bath/shower at least weekly."

Following our inspection in September 2015, the registered manager had told us that they intended to appoint an activities co-ordinator, to help ensure people who used this service had access to leisure and social activities. We found that this had not happened.

When we carried out the inspection in July and August 2016 we observed that there was very little social stimulation provided for people who lived at the home.

We did not see any information about activities displayed around the home. We asked staff about activities and events at the home.

One member of staff said; "Oh there is an activities plan and an activities book", but another told us; "There is an activities book, but I don't think there is a plan." We were also told by a member of staff; "There is a man who comes on a Thursday for entertainment." Another member of staff said; "We do things when we can."

We looked at the activities book, which consisted of loose leaved paper, one for each person who lived at the home, with dates and a list of what they had done. The activities recorded included, newspaper reading, reminiscence, chair exercises and visits to the hairdresser.

We asked staff about how people's spiritual needs would be met. We were told there were no religious services held at the home, although a church group brought communion once a week for one of the people who lived at Morton Cottage.

In the sample of care records we looked at we found examples of people who lived with dementia and had limited communication skills. We found that "life story books" had not been completed. This kind of information would have helped staff plan and develop a programme of meaningful activities for these people. We also noted that care plans referred to the use of "memory aids", "prompt and picture cards" and "memory albums" to help staff support people with their dementia. We asked the registered manager about these tools. The registered manager told us that they were not in use and these documents had not been produced.

This was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive appropriate assessments or care planning that met their individual needs and preferences, including their social and spiritual needs.

We checked the information we held about this service and we checked the information that had been sent to us by the provider. We had not received any complaints about this service. During our inspection of Morton Cottage, we did not receive any concerns or complaints from people who lived at the home or their visitors. We checked with the registered manager who confirmed that no complaints had been raised directly with the service since the time of our last inspection in September 2015. The provider had a complaints process in place that provided information to help people raise complaints if necessary.

Inadequate

Is the service well-led?

Our findings

None of the people we spoke to made comments about the management of the service. However, we did not receive any adverse comments or complaints from people who lived at the home or their relatives and friends.

The staff we spoke to were not willing to comment on the management of the service.

Health and social care professionals commented that the management team in the home were very pleasant but at the same time reluctant to take advice.

At our last inspection of the service in September 2015 we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager and registered provider sent us an action plan describing the things they would put in place to make sure Morton Cottage operated safely and effectively.

During the inspection in July and August 2016, we found that the registered provider had not improved standards and did not have effective systems in place to monitor and improve the quality of the service.

We looked at the way in which the registered provider ensured medicines were managed safely. Although the registered manager had completed audits (checks) of the medicines and records, these had failed to highlight any of the concerns and discrepancies that we found. Where issues had been identified, we were unable to see how these issues had been addressed. When we visited the home again on 11 August 2016 we found that the concerns regarding out of date medication, creams in other people's bedrooms and out of stock medicines had been addressed by the registered manager. However, concerns regarding the management of medicines, remained.

We looked at the way in which the registered provider ensured the health and safety of people who lived, worked and visited Morton Cottage were protected. Care plans and risk assessments were either not up to date or did not exist. There was no evidence to support that these types of records had been audited to help ensure they reflected the current needs and requirements of people who used this service. This meant that people who lived at the home were placed at risk of receiving unsafe and inappropriate care and support.

We saw that some work had been done to monitor falls and accidents but the records were not accurate. The registered provider had not used the information gathered to help mitigate any further risk of harm or injury to people who used this service.

The infection control and prevention systems at the home were not effective. The home was not clean and we observed that staff did not adopt good hygiene practices. The registered provider had developed a system to carry out daily observation checks of the home. We looked at the records of these checks and found that they had not been carried out with any frequency.

We looked at a sample of the policies and procedures in place at the home. For example, the medication policy, complaint process, consent to care and treatment, safeguarding vulnerable adults and infection prevention and control. We found that these had not been reviewed and updated to reflect current legislation and best practice guidelines.

We looked at the ways in which people had been consulted on the quality of the service and how people were able to voice their opinions. We noticed that there were satisfaction surveys available in the reception area at the home. The registered provider showed us a sample of some that had been completed. These were generally complimentary of the service provided. We asked to see copies of the relatives and "resident" meetings that had been held at the home, but the registered provider could not find the minutes for these meetings. We saw that staff meetings had been held and the minutes of these were available. There were no formal processes in place at the home to help ensure the views of people who lived at the home, visiting health and social care professionals or other visitors (such as relatives and friends) were gathered, analysed and acted upon to help improve the service.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems and processes in place to monitor and assess the quality and safety of the service. This meant that the provider had no way of checking that they were keeping people safe or meeting the requirements of the regulations.