Morton Cottage Residential Home Limited

Morton Cottage Residential Home

Inspection report

210-212 Wigton Road
Carlisle
Cumbria
CA2 6JZ
Tel: 01228 515757

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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?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We visited the home on 29 September 2015. The inspection was an unannounced scheduled inspection visit.

At the last inspection on 18 November 2013, we asked the provider to take action to make improvements to the ways in which records were maintained and to the ways in which the provider assessed, monitored and improved the quality of the service. The provider submitted an action plan which stated that the legal requirements would be met by the end of March 2014. We found during our latest inspection, that this had not been completed.

Morton Cottage Residential Home is a large house within private grounds, situated in a residential area of Carlisle.

Summary of findings

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 ensuite toilet and wash basin facilities and communal bathrooms and toilet facilities are available throughout the home.

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.

We spoke with people who used this service and to some of their visitors. They told us that the staff were "nice", "kind" and that "no one was nasty" to them. The relatives we spoke with told us they could "come and go" as they pleased and that they had never seen anything at the home to "worry" them. One person commented; "I can't fault it here, they look after us and visitors can come when they want, they are not strict like that."

Allegations of potential abuse and safeguarding had not been managed consistently. This meant that people who used the service had been placed at risk of harm and abuse.

This is a breach Regulation 13 of the Health and Social Care Act (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.

People's medicines were not stored and disposed of safely. This meant that people had access to medicines that were not theirs and had not been prescribed for them, placing them at risk of harm.

This is a breach Regulation 12 of the Health and Social Care Act (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.

Where risks to the health and safety of people using this service had been identified, the provider had failed to keep these under review and up to date in order to mitigate any such risks. This meant that people were not properly protected from the risk of harm or injury.

This is a breach Regulation 12 of the Health and Social Care Act (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.

We found that the provider had not ensured that the premises were safe and secure. Windows on the first floor did not have restrictors in place and this was a risk to the safety of people living at Morton Cottage. Additionally, we observed poor infection control and prevention practices by staff during our visit to the home. This meant that people who used this service were placed at risk of acquiring infections.

This is a breach Regulation 12 of the Health and Social Care Act (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.

The staff that we spoke with told us about the training and support they were provided with. We observed examples of staff practices during our visit to this home. We found that there were shortfalls in their skills and knowledge.

This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because lack of staff skills and knowledge placed people at risk of harm or of receiving inappropriate care. You can see what action we told the provider to take at the back of the full version of the report.

Although staff had received some training about the Mental Capacity Act 2005 we found that there was a lack of understanding. We noted that the principles of the Mental Capacity Act 2005 Code of Practice had not been followed when assessing people's ability to make a particular decision or when placing restrictions on their liberty.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that people who used this service did not

Summary of findings

always receive care and treatment that had lawfully been provided in their best interests. You can see what action we told the provider to take at the back of the full version of the report.

People were provided with meals and drinks, which they told us they enjoyed. On the day of our visit we noted that mealtimes were not a sociable or dignified event. We also found that people's nutritional needs were not adequately assessed and monitored, where necessary.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that people who used this service were placed at risk of poor or inappropriate nutrition. You can see what action we told the provider to take at the back of the full version of the report.

Staff were inconsistent in the way they supported people with their personal care needs. Some needs were dealt with discreetly whilst other staff lacked understanding of how to support people and communicate with them effectively. We did not receive any complaints about the service but we did notice that many of the people that lived at Morton Cottage appeared unkempt and needed their hair brushed or items of clothing changed.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that people who used this service were not always offered the support they needed to maintain their dignity. You can see what action we told the provider to take at the back of the full version of the report.

People told us, and we noticed that there were very limited social and leisure activities available at the home. We were told of some events that had taken place and people told us that they had enjoyed these "very much".

Care and support records were out of date and staff told us that they didn't always read them. We saw some examples where people did not get the care and support they needed, when they needed it.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not experience care and treatment that had been personalised specifically for them. You can see what action we told the provider to take at the back of the full version of the report.

There was no effective system in place to help monitor and manage the quality of the home and of the service provided. Personal records were out of date and environmental audits had not taken place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that the provider did not have systems in place to ensure the safety and quality of the service. You can see what action we told the provider to take at the back of the full version of the report.

We have made a recommendation that the service attends to the access arrangements for the home, including the provision of a contact telephone number. This will help ensure that visitors to the home are able to gain access to Morton Cottage.

Safe recruitment processes were in place to help ensure suitable staff were employed to work with people who used this service. There was a low staff turnover and this meant that staff and people who used this service got to know each other very well.

The home had not received any concerns or complaints about the service provided. No one raised any concerns with us at the time of our visit to the service. We checked the information we held about Morton Cottage Care Home. This also showed that we had not received any complaints about the service.

There were some positive aspects to the environment at the home. Individual bedrooms were spacious and all had en-suite facilities. Some floorings and furnishings had been replaced in communal areas, helping to make them pleasant.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The service was not safe.

People who used this service were placed at risk because medicines were not managed safely. Medicines were not stored securely and people did not always receive their medicine as their doctor intended.

Risk assessments relating to people's care and support needs had not been kept up to date nor reviewed as people's needs changed. This meant that people were placed at risk of unsafe or inappropriate support with their care needs.

The home was not well maintained or properly clean. Staff paid little attention with regards to good infection control practices. This placed people who used this service at risk of harm, injury or of contracting an infection.

Is the service effective?

Inadequate

The service was not consistently effective.

People who used this service told us that they were satisfied with the care and support they received. No one raised any concerns with us during our inspection of the home.

Staff at the home were provided with training to help them carry out their roles safely and effectively. However, this was not consistently demonstrated in their practice and approach towards supporting people who used this service.

There was poor management and monitoring of people's eating and drinking needs. This placed them at risk of poor or inappropriate nutrition.

People who used this service did not always receive effective care and support that recognised and respected their legal and human rights.

Is the service caring?

Requires improvement

The service was not consistently caring.

People who used the service told us that they thought the staff were "very nice" and "kind". We did see some evidence that this was the case.

Staff were not always mindful of people's privacy and dignity. People were "labelled" by staff and personal care needs were not always undertaken discreetly.

We also noted that many of the people who used this service were unkempt. People were left without means of summoning staff for help when they needed it.

The wellbeing and independence of people who used this service was not adequately maintained.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

People who used the service were not supported with their diverse cultural and spiritual needs. People told us that there was “nothing to do” (activities) at the home.

Care planning and care plan reviews were not carried out as people needs changed and this meant that people who used this service were placed at risk of receiving care that did not meet their individual needs.

Is the service well-led?

Inadequate 

The service was not well led.

Although staff received training and supervision, there were no processes in place to ensure staff practice was safe and appropriate.

Records relating to the health and welfare of people who used this service were out of date.

Quality audits of the environmental standards at the home had not taken place and there were no formal processes for obtaining people’s feedback about the service and leadership.

People who used this service were placed at risk of receiving a poor quality service.

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.

This inspection took place on 29 September 2015 and was unannounced.

The inspection was carried out by two adult social care inspectors and included 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.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, previous inspection reports and action plans that had been submitted by the provider. A notification is information about important events which the service is required to send us by law.

Prior to our inspection we asked the provider to complete and submit 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 used this information to help us plan our inspection.

During the inspection we spoke to thirteen of the people who used the service and two relatives. We spoke to four members of staff as well as the registered manager and the provider. We looked, in detail at three care records (pathway tracking) belonging to people who used this service. We also looked at a sample of medication administration records and we observed staff supporting people with their day to day needs, in communal areas. We looked at the recruitment records and staff training records of three members of staff.

We also looked around the home to check that the environment was clean, safe and appropriately maintained.

Inadequate

Is the service safe?

Our findings

During our inspection of this service we spoke to 13 of the people who lived at Morton Cottage and two of their visitors. We spoke to four of the members of staff on duty and the registered persons during our visit too.

People who used this service, who we spoke to, told us "It is nice here" and "They (staff) look after me well."

A relative said "The care is good; I've never seen anything to worry me."

The provider had safeguarding policies and procedures in place. We saw from staff training records and from speaking to staff that most of them had undertaken training with regards to abuse and keeping vulnerable adults safe. One of the members of staff we spoke to was not aware of the safeguarding processes but did say they would have no hesitation in reporting bad practice.

From the information we held about the service, we noted that the provider did not address allegations of abuse in a consistent manner. Social workers had told us and we were aware of instances that had been dealt with very well by the provider. However, there were other allegations that had not been addressed or notified appropriately. People who used this service were not always adequately protected from abuse and improper treatment.

This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because people who used this service were not always adequately protected from abuse and improper treatment

We looked at a sample of care records belonging to three of the people who lived at Morton Cottage, in particular their risk assessments and risk management plans. We found that risk assessments had not been routinely reviewed and updated. For example one person's falls risk assessment had not been reviewed and updated for over a year, despite them having experienced falls during that time. Another person had been identified at high risk of falling but this had not been included in their falls risk assessment. We observed that one of the people who used this service continually wandered up and down the home and outside, in an agitated state. The support plans and risk assessments did not provide staff with appropriate information and guidance to help ensure this person was supported safely. We spoke to staff about this but they were unable to give an appropriate response to assure us that this person was safe.

This is a breach Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because the health and safety of people who used this service were placed at risk.

People who used this service did not have personal emergency evacuation plans in place for use in the case of an emergency at the home. One member of staff told us that they did not know of any emergency plans for the home.

We found areas of the premises that required attention in order to ensure they were safe and secure. Window restrictors were missing from many of the windows on the first floor. We spoke to the provider about this at the time of our inspection as this matter needed to be addressed quickly to ensure the safety of people who used this service.

We looked at the way in which medicines were managed at the home. We found that the arrangements in place for the secure storage and safe administration/recording of controlled drugs were in order. However, other medicines in use at the home were not kept safely. We found a large quantity of medicines stored in a corridor waiting to be returned to the pharmacy. This area was accessible to people who used the service and visitors to the home. During the morning medication round we observed the medicines trolley to be left unlocked and unattended, again in an area accessible to people using the service and visitors to the home. We spoke to the provider about this matter at the time of our inspection as this needed to be addressed quickly in order to keep people safe.

This is a breach Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because medication was not safely managed.

We observed areas of the home that were not clean and hygienic. This was particularly noticeable in the communal bathroom, toilets and lift area. The underside of bath seats had debris and rust on them and this placed people using these at risk from cross infection. We observed poor practices by staff in relation to the prevention and control of infection. Personal protective clothing such as aprons and gloves were not always worn when necessary and we

Inadequate

Is the service safe?

observed that staff did not wash their hands in between supporting service users. There were no hand gel dispensers for staff and visitors to use to help reduce the risks of cross infection.

The laundry at the home was not designed to minimise the risk of cross contamination between soiled laundry and clean laundry. The provider has told us that the laundry is going to be resited in order to address these risks.

This is a breach Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because appropriate arrangements were not in place to protect people from cross infection.

The security pad on the gate at the entrance to the home did not work properly. Access to the home was difficult because this equipment was faulty. Two members of our inspection team experienced this problem and observed that the GP and visiting relatives also experienced access problems. The staff we spoke to during our inspection were aware of this fault but there was no indication as to when it would be rectified. There was no phone number at the gate in order to ring the home and no means of other entrance.

We recommend that the service attends to the access arrangements for the home, including the provision of a contact telephone number. This will help ensure that visitors to the home are able to gain access to Morton Cottage.

We looked at a sample of staff recruitment records. We found that the provider had safe processes in place to help ensure suitable staff were employed at the home to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

One of the people that used this service told us that; "I wash my own face but the girls wash the rest of me, I can't get in the bath, and they say (the provider) they are going to put in a new shower soon, but I don't know".

Another person said; "It's nice here, they look after you" and another said "They are nice enough, no one is nasty to you"

Five of the people who used this service told us that the food provided was "good" or "ok".

We observed staff supporting people who used this service. Staff spoke to people kindly and respectfully. The staff we spoke to told us that they had received training to help them carry out their duties and that they had regular supervision and meetings with the manager of the home. Staff records also indicated that training and supervision took place.

Some of the staff practices that we observed identified shortfalls in staff knowledge. Staff were not familiar with safeguarding processes and one member of staff told us that their induction training had been one day "shadowing" an experienced member of staff at the home. Another staff member said when asked about training; "Oh I had two weeks shadowing an experienced carer." They added "I was shown about standing aids and hoists and which coloured bands for the hoists to use for weight."

We observed some poor moving and handling practices used by staff during our visit to the home. We also observed that staff paid little attention to infection control and prevention. Protective clothing was not used with any consistency. These practices placed people who used this service at risk of harm or injury. We told the provider about these concerns during our visit to the home as they needed to be addressed quickly.

These are breaches of Regulation 12 and Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014because people who use the service were at risk from unsafe practices.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The provider told us that there was no one at the home subjected to authorisation under the Deprivation of Liberty Safeguards (DoLS). On the day of our visit we checked this information again with the provider who confirmed that there was no one at the home subjected to DoLS.

Staff told us and their training records confirmed that Mental Capacity Act 2005 awareness training had been undertaken. However, staff practice, care records and the care plans that we looked at, showed that the principles of the Mental Capacity Act 2005 Code of Practice had not been followed when assessing an individual's ability to make a particular decision or when placing restrictions on their liberty.

For example; we found that one person received their medicines, on occasions, covertly. We found that the GP had been consulted on this matter but there was no evidence to confirm that these decisions had been made in the best interests, or with the consent of this person. Their records also stated that they liked to go out into the garden and walk around. We observed this person to be pacing up and down the home on the day of our visit and also noted that they were out in the garden and attempting to climb the fire escape. We spoke to staff about this during our visit. Staff confirmed that this person did go out but added; "This person is sometimes challenging so it is best not to go outdoors, so we keep them indoors when they are like that."

Two other people had bed rails in place to help keep them safe when in bed. Risk assessments or best interest's assessments had not been carried out to help ensure this was the most appropriate and least restrictive method of keeping people safe.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014because the service was unable to demonstrate that they were acting in the best interest of an individual and that consent was not actively sought.

We observed the service of the lunchtime meal. We saw the advertised menu for the day was not the same as the actual meal served. We spoke to the cook they told us that they were aware of everyone needing a special diet such as soft foods, diabetic meal or finger foods. The cook told us that there was no one at the home requiring a fortified diet to help maintain their body weight.

We saw people who used this service being supported into the dining rooms by staff. People had plastic aprons placed

Inadequate

Is the service effective?

on them without anyone asking if they wished to wear one. There were no napkins on the table nor did we see any specialised plates or cutlery in use, which would have helped people to eat more independently and in a more dignified manner.

Some tables had condiments but they were empty and one service user said; “It’s empty again this” indicating the salt pot. There were no teaspoons and one of our inspectors, plus the people sat at the same table, added sugar to their tea using a tablespoon. There was no milk available and this was later brought round by staff using a four pint milk container.

There were two choices of hot main meals at lunchtime and people were able to choose which they preferred. However, the meals were carried in by care staff two at a time with no trays and no covers over the food. Substantial puddings were served and again there were choices available and offered. We noted that the food was enjoyed by the people that used this service.

The room was silent through lunch. There was no conversation and no music. People who used the service had no way of summoning staff from the dining room if they were needed because there were no buzzers. We observed that staff were often away from the room for more than 10 minutes at a time.

We looked at a sample of people’s nutritional records, assessments and care plans. These had been poorly completed and had not been reviewed and updated as needs changed. Food and fluid intake charts were not sufficiently detailed and it was impossible to accurately assess how much someone had had to eat or drink. There was no record of what types of alternative foods had been offered when a person did not want the set menu nor were there any records to confirm people had been offered and eaten a meal missed due to being asleep.

We found that one person had been identified as having a “poor appetite” but their care plan and nutritional risk assessment had not been reviewed for six months. Another person was recorded as needing a “diabetic diet”. Their body weight records showed they had lost a significant amount of weight but this was not being effectively monitored and managed. A third person had been identified at risk of urinary tract infections and their records instructed staff to ensure “plenty of fluids”. There were no records of fluid intake even though other aspects of their records showed that the GP had been contacted monthly because of urinary tract infections.

Nutritional care records were out of date and did not reflect an up to date account of people’s nutritional needs. The records did not provide instructions or guidance for staff to follow to help ensure the people living at Morton Cottage were supported effectively with their nutritional needs.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were at risk of receiving an inadequate diet for their needs.

Requires improvement

Is the service caring?

Our findings

People who used this service, who we spoke to, were all happy with the staff. We did not receive any complaints or concerns from anyone at the home during our visit.

One person said; “It’s nice here, they (the staff) look after you” and another told us; “They are nice enough, no one is nasty to you.”

We were also told by a person who used this service; “The staff are very good to me, I couldn’t ask for better. My family visit me when they like and the girls are very kind to me.” Other people who lived at Morton Cottage thought the staff were “nice” and one person commented; “I can’t fault it here, they look after us and visitors can come when they want, they are not strict like that.”

One of the visitors to the home told us that they thought “The care is good, I’ve never seen anything to worry me.” Another relative said; “If my relative is happy then I’m happy. I can come when I want, I think I’m part of the staff now, they are always cheery and say hello.”

We observed some inconsistencies with regards to staff respecting the privacy and dignity of people who used this service. Some staff lacked understanding of how to support people and communicate with them compassionately and effectively.

For example, we observed some staff discreetly asking people if they needed the toilet whilst others shouted from the door “do you want the loo?” One member of staff referred to one group of very mobile service users as “the walkers”.

We saw one staff member reassuring a person with poor memory. We also observed this member of staff speaking kindly and wiping the hands of another person who used this service with a wet cloth. We did not observe anyone else having hands or faces wiped of food debris throughout the day apart from this one occasion. We saw another member of staff sat and spoke with a distressed person until they settled again. The same person was called after loudly by other staff or tried to be sat down when they obviously wanted to go outside.

Although no one who used this service raised any concerns with us, we noticed that most of the people that lived at Morton Cottage appeared unkempt. Their hair had not been brushed, some of the clothing they wore had food debris spilled down the front or were uncoordinated, and some items needed mending. Most of the people we saw seemed to be without stockings or socks, though most had slippers or shoes on.

The staff we spoke to during our visit to Morton Cottage told us about their work. They spoke to us about “tasks” that needed to be completed. For example they told us that they “made sure” people were up, washed, dressed and fed. One member of staff felt that people who used the service were “well cared for” but the member of staff added they would “like to spend more time with the residents.”

Whilst we observed staff to be “well meaning” towards people who used this service, they lacked understanding and insight with regards to maintaining people’s autonomy and independence.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014because people who used this service did not receive care and treatment that met their needs and reflected their personal preferences.

Inadequate

Is the service responsive?

Our findings

We spoke with people who used this service. They told us that there were limited social and leisure activities available for them at Morton Cottage. We did not observe any meaningful activities taking place on the day of our visit to the home.

We were told by relatives that they were able to visit when they wanted. We saw that some people who used this service had their favourite newspapers and magazines delivered and some had their own telephone to help keep in contact with friends.

One of the people who used this service told us; "It's alright, just alright, there is nothing to do, we just sit here." Another person said; "I will go downstairs later, there is stuff going on, but I don't bother with it." We were told by other people who used this service that there was "not much to do" and "there is nothing much to do we just sit here."

We asked staff about Church services and were told that there were no services and no visits from the clergy to the home.

A member of staff told us that the home did not have an activities co-ordinator and that "we just do it ourselves." Another said; "Activities are limited, I would like to be able to spend more time with our residents." Staff and people who lived at Morton Cottage told us about the garden party held in the summer and of a music therapy group that had recently visited the home. Everyone seemed to have enjoyed these activities.

As well as speaking to people who used the service and the staff that supported them, we looked at a sample of care records. We found that care records and plans were out of date and did not reflect the current needs or provide an accurate picture of people who used this service. One member of staff confirmed to us that they didn't read people's care plans and relied on the staff handover at the start of each shift to get information about people's care and support needs.

During our visit to the service we observed that a person who used this service was quite unwell. This person was seen by a health care professional in the morning but during the day their condition worsened and we had to ask staff to contact the doctor again, which they did.

We spoke to another person who was in their room waiting for staff to attend to them. This person told us that staff had been in to see them and said they were going to come back, but they had not. This person was cold and sat in wet clothing. Their call bell was on the other side of the room and they could not reach it. We noted that in several of the bedrooms, the call bells were positioned on the opposite side of the room to the bed. This meant that people would not easily be able to summon staff if needed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who use this service did not experience care and treatment that was personalised specifically for them.

We checked the information we held about this service. We had received no complaints about Morton Cottage Care Home. We checked the complaints records kept at the home during our visit. We found that the home had not received any concerns or complaints from people who used this service or their relatives.

Inadequate

Is the service well-led?

Our findings

The staff that we spoke to during our inspection of this service told us that they received regular support and supervision from the provider. Staff records confirmed this to be the case. The provider told us that they regularly monitored staff practices. However, during our visit to Morton Cottage, although we observed some examples of good practice, we also noted poor practice by staff. This was particularly noticeable when staff were supporting people with their mobility needs. Additionally staff lacked understanding with regard to privacy, dignity and depriving people of their liberties.

We looked around all areas of the home during the inspection of this service. There were some positive aspects to the environment. For example, people's individual bedrooms were spacious and had en-suite facilities. People were able to bring some of their personal belongings into the home with them. Some floorings and furniture had been replaced in the communal areas but there were areas of the home where furniture, décor and soft furnishings needed repair or replacement. An audit of the environment would have identified these shortfalls.

Care records, risk assessments and emergency plans for people who used this service were out of date and did not reflect the current support needs of people living at Morton Cottage. This placed the health safety and welfare of people using this service at risk.

At our last inspection of this service in 2013, the provider did not operate an effective system to assess and monitor the quality of service people received. We told the provider at that time, that this needed to be improved. The provider sent us a plan of the actions they would take to bring about these improvements. The provider had told us more recently, that there was a system in place for monitoring the quality of the home and the service provided. However, when we asked the provider about this during the inspection we were told that no auditing had been carried out.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has a registered manager in post. Staff turnover is low and this helps to make sure people receive support from staff they know well and trust.

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 9 HSCA (RA) Regulations 2014 Person-centred care People who used this service did not receive care and treatment that met their needs and reflected their personal preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People who used this service did not receive support and treatment that respected their dignity. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who used this service and others were not protected against the risks associated with unsafe care because of inadequate risk assessments. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

People who used this service and others were not protected against the risks associated with unsafe care because of inadequate staff competence and skills.

Regulation 12 (1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used this service and others were not protected against the risks associated with unsafe management of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used this service and others were not protected against the risks associated with control and prevention of infections. Regulation 12 (1)(2)(h)

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 People who use services were not protected against the risks associated with abuse and improper treatment because of inconsistent approaches towards safeguarding processes. Regulation 13(2)

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

This section is primarily information for the provider

Action we have told the provider to take

People who use services were not protected against the risks of being deprived of their liberty or of receiving care that was not lawfully in their best interests because staff lacked understanding of the Mental Capacity Act 2005.

Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People who use services and others were not protected against the risks associated with poor nutrition because of inadequate nutritional assessment and monitoring. Regulation 14

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used this service were placed at risk of receiving poor quality services because the provider did not have effective systems in place to effectively ensure compliance with the requirements and to effectively monitor and improve the quality and safety of the service. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with unsafe or inappropriate care and treatment because staff did not receive adequate support to monitor their practice and understanding of any training provided. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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