P & C Care Limited

The Mount Nursing 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected The Mount Nursing Home on 5 January 2016 and the visit was unannounced. Our last inspection took place on 17 & 19 June 2015. At that time, we found the provider was not meeting the regulations in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, dignity and respect, good governance and staffing. We took enforcement action and found on this inspection some improvements have been made.

The Mount Nursing Home provides nursing care services for predominantly older people and people living with dementia. The home is a converted Victorian property and is located in a residential area overlooking Peel Park. The accommodation comprises of three double bedrooms and the remainder of rooms are single. Five rooms have en suite facilities and there are shared bathroom and toilet facilities on both the ground and first floors. Communal spaces are situated on the ground floor. The service is registered for 40 places. On the day of our visit there were 24 people living at the home and one person was in hospital.

There is a registered manager at the service. 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.

Staff understood how to keep people safe and we found there were appropriate systems in place to protect people from risk of harm.

We saw some improvements had been made to the premises and the registered manager told us these would be on-going. However, we found on-going maintenance issues were not always being identified or rectified.

People told us the cleanliness of the building has improved and we evidenced this during the inspection.

Recruitment processes were robust and thorough checks were completed before staff started work to make sure they were safe and suitable to work in the care sector with vulnerable people. There were enough staff on duty to make sure people's care needs were met, people told us they liked the staff and found them kind and caring. On the day of our visit we saw staff speaking calmly and respectfully to people who used the service. There were some activities on offer to keep people occupied but people told us they would like more to do.

Staff told us they felt supported and that training was available. However, we found some training and individual supervisions were not up to date.

People told us meals at the home were good. We saw people were offered a choice of meal and drinks and snacks were readily available for people. Staff monitored people's weights closely and if anyone was losing

weight we saw GP's and dieticians were involved for advice.

We found people had access to healthcare services and these were accessed in a timely way to make sure people's health care needs were met. Safe systems were in place to manage medicines so people received their medicines at the right times.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). However, we were informed some people were the subject to a Lasting Power of Attorney for care and welfare, but no evidence of this could be produced.

There were care plans in place for people but these were not always up to date.

We found the management of the home 'chaotic.' We found it difficult to access records or to find out which of the management team were accountable for specific tasks. Most of the people we spoke with thought the deputy manager was in charge.

We saw a variety of quality assurance systems had been introduced sine our last visit, however, the registered manager and operations manager acknowledged that these systems were not fully embedded. We found the systems in place were not effective.

At the last comprehensive inspection in June 2015 this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff understood how to keep people safe and the premises were clean. However, issues with the maintenance of the building were not always being identified and rectified.

Staff were being recruited safely and there were enough staff to meet people's needs.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were inducted, trained and supported to ensure they had the skills and
knowledge to meet people's needs. Although some members of staff were not up to date with their training or supervision.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). However, there was no documentary evidence for people who may have Lasting Power of Attorney arrangements in place.

People's health and nutritional needs were being met.

Is the service caring?

Good

The service was caring.

People using the service told us they liked the staff. We saw staff treated people with patience and kindness.

Staff knew people well and were aware of their individual preferences.

Relatives and visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always up to date.

There were some activities on offer to keep people occupied.

There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

The management of the service was 'chaotic,' records were not up to date or not available and were not sent to us following the inspection.

Although some quality assurance systems had been introduced these had not been embedded and were not effective.

The Mount Nursing 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 5 January 2016 and was unannounced.

The inspection team consisted of one inspection manager and three inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We asked the provider to complete 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. The provider had completed this document but had not been asked to return it until 15 January 2016 and our electronic system would not allow them to return it earlier. This document was emailed to us the day after the inspection visit.

On the day of our inspection we spoke with five people who lived at The Mount Nursing Home, three relatives, the registered manager, deputy manager, director, operations manager, clinical lead nurse, six care workers, cook and the housekeeper. Following the inspection we spoke with a research nurse, a GP and four more relatives.

We spent time observing care in the lounge and dining room to help us understand the experience of people using the service who could not express their views to us. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; eight people's care records, four staff recruitment files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in June 2015 we found staff were not recognising or reporting incidents of abuse between people using the service. On this inspection we found improvements had been made.

We spoke with the clinical lead nurse who had made two safeguarding referrals since our last inspection. They explained the number of incidents between people using the service had reduced because staff were always present in the communal areas and were able to respond quickly to diffuse any potential incidents between people. We saw during our visit there were staff present in the communal areas at all times. We also noted that if a staff member needed to leave the communal area they made sure someone else took their place.

We spoke with three care workers about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. They all said they would not hesitate to raise any concerns and would report these to the nurse in charge. The clinical lead nurse had a clear understanding of the safeguarding procedures and the process for making referrals to the local authority safeguarding team. This meant staff understood how to keep people safe.

When we inspected the service in June 2015 we found issues with the safety of the premises and equipment.

We looked round the home with the registered manager. Overall the home was clean and tidy and smelt fresh. We found refurbishment works had been completed in some areas of the home. For example, a new en suite bathroom had been installed in one bedroom, new flooring had been fitted in the dining room and the main communal areas and upstairs corridors had been redecorated. The registered manager told us people and their relatives had been involved in deciding the colour schemes. They said there was an on-going refurbishment plan, which included new carpets in the lounges, redecoration and refurbishment of bedrooms and the provision of en-suite facilities.

During our tour of the home we identified maintenance works which had not been completed. For example, many of the lights in people's bedrooms which were over sinks and beds were not working, the water temperature at the hot taps in some rooms was only lukewarm and the flooring in some bedrooms was torn and required replacement. Most of the radiators had guards fitted to protect people from hot surface temperatures but we found radiators in three bedrooms did not have guards and they were hot to touch where the air came out of the vents at the top. The heated towel rail in one bathroom was hot to touch and we found some people's beds had been made but the bedding was not clean.

When we looked in the maintenance book which the deputy manager told us was where staff recorded any work needing doing, we saw that only one light had been recorded as not working. This meant staff had not identified and reported the repairs we had noted when we looked around the building. This did not assure us the building would be maintained to a good standard.

We saw safety checks were recorded on a weekly basis for equipment including wheelchairs, nurse call

system, bed rails, hoists and hoist slings. However, we saw one hoist had been reported as 'Out of order' every week since 4 November 2015. The director told us they thought the hoist had been decommissioned but there was no evidence to support this. The hoist was being stored in an empty bedroom. When we asked how staff would know the hoist was out of order, the clinical lead said they would have been told verbally.

We saw up to date safety certificates in place for: the passenger lift; for four of the five hoists; portable electrical appliance tests records. We asked to see the landlord's gas safety certificate and electrical wiring certificate so we could check these were up to date. When we inspected in June 2015 we found the electrical wiring certificate had expired in March 2015. These were not made available to us during our inspection. We requested these to be emailed to us the following day. This did not happen. We emailed the registered manager and operations director again on 7 January 2015 and made the same request. The provider explained to us they had difficulties sending emails.The gas safety inspection report for the catering equipment and the electrical wiring certificate were emailed to us on 12 January 2015. We did not receive the landlords gas safety certificate and the electrical wiring certificate stated the overall assessment of the installation was unsatisfactory. This meant we could not assure ourselves services and equipment were in a safe condition.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in June 2015 we found the home smelt strongly of stale urine and there were areas of the home which were not clean.

On this inspection on arrival at 8:00am there was an odour of stale urine, however, this dissipated during the early morning. We noted an odour in one bedroom, which the registered manager was aware of and told us they were taking action to address this. The director told us they had been trialling new cleaning products which did not present any hazards at all and had been found to be very effective.

When we asked staff what improvements had been made since our last visit they all told us the home was cleaner and mostly odour free. We noted the home was cleaner than on our previous visits. We spoke with one of the domestic staff who told us they had good cleaning products and enjoyed working at the home. This meant appropriate cleaning regimes were in place to keep the home clean.

We found there were sufficient nursing and care staff to safely meet people's needs. We scrutinised the rosters for a four week period prior to our inspection and found the provider maintained staffing at the same level across the whole period. Where staff were not available for work at short notice, arrangements had been put in place to bring other staff in so that safe staffing levels were maintained. This included increasing the number of qualified nurses on a night shift when there had been insufficient care staff available. The deployment of staff in communal areas had resulted in a significant reduction in the number of incidents involving people who used the service.

We found an increase in ancillary and domestic staff since our last inspection had had a positive impact on the cleanliness of the home.

We saw staff were recruited safely. Prior to commencing employment staff were subjected to checks to ensure they were suitable to work with vulnerable people. This included obtaining references and completing Disclosure and Barring (DBS) checks to look for criminal convictions or cautions of staff. The provider maintained records of their pre-employment checks and staff told us they did not start in their role until these had been completed.

We saw people received their medicines when they needed them. Observation of the medicine's round showed us the nurse was patient with people, gave assistance as required and stayed with them to make sure the medicines were taken. Medicines were stored safely, securely and at the appropriate temperatures. Medicines requiring cold storage were kept in a fridge in a locked clinical room. We checked a controlled medicine prescribed for one person and found stock levels tallied with the medicine administration record (MAR) and the controlled drug register.

Safe systems were in place for the ordering and disposal of medicines. We looked at the MAR with the nurse on duty and found these were completed with no gaps identified. Arrangements were in place for people to receive time-specific medicines at the correct time. The nurse told us there were no people in the home who were given their medicines covertly. We found the stock levels for one medicine were not recorded on the MAR and were incorrect for one other medicine. However, the nurse acknowledged and explained the error which was due to miscounting. We found there had been no impact on people as they had received their medicines as prescribed and the nurse took corrective action to ensure the stock levels recorded were correct. We concluded medicines were being managed safely and people were receiving them as prescribed.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in June 2015 we found staff training was not up to date and was not always effective. We also found although some staff supervision had taken place the supervision programme was not consistent.

We saw from records that staff had received mandatory training. The provider maintained a training matrix to monitor the results of training and to identify when staff were due refresher training. Although the majority of training was up to date the training matrix showed some refresher training had been due between 30 September and 15 December 2015, which had not been completed.

Staff we spoke with told us about dementia training they had completed recently that had helped them better understand how to support people living with dementia. Staff told us this had been very worthwhile and had a positive impact on their practice. One staff member told us, "I loved it; it was super good."

We spoke with a new member of staff who told us they had completed an induction workbook prior to working with people and that they were shadowing experienced staff until they were able to work alone. When we asked about fire evacuation the new staff member was not aware of the action to take in the event of a fire. Although any risk was minimised as they were shadowing other staff at the time of the inspection we raised this with the provider in order for this to be addressed.

We saw from records that most staff had the opportunity for a one to one supervision meeting during 2015. However, 19 staff had only had one supervision meeting in this period. This did not meet the provider's supervision policy that stated staff would receive supervision every two months with an annual appraisal. The clinical lead told us this was a work in progress and they were currently arranging supervision meetings to consider communication, safeguarding of vulnerable adults and a revised key worker system. We asked if any staff received group supervision. The clinical lead told us the registered manager had facilitated some group supervision but this had not been recorded. Staff we spoke with all told us they felt supported within their roles. We recommend the service's policy on supervision is followed to ensure continued staff development.

Staff told us they felt they worked well as a team and this was strength of the home. One staff member told us, "The care staff team here are really good." Another staff member told us, "It is a very happy environment."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. 12 people who were being deprived of their liberty in order to keep them safe had been assessed by the supervisory body and were currently subject to an authorised DoLS. A further six people had been referred by the provider to the supervisory body for assessment. This showed the provider took action to ensure they were working within the requirements of the MCA.

The provider had properly trained and prepared staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS. Staff showed a good understanding of the MCA and were seen, where appropriate to seek consent before providing support to people. Where people refused assistance this was respected and staff returned later to offer support.

During our inspection we were informed some people were the subject of a Lasting Power of Attorney for care and welfare. We asked for confirmation of these arrangements but this could not be evidenced during our inspection. We recommend the provider ensures they are able to demonstrate they are meeting the requirements of the Mental Capacity Act 2005 Code of Practice where people are subject to an LPA.

We saw pictorial and written signs were displayed on doors which helped people identify their own rooms as well as bathrooms and toilets. The director told us they had plans to paint the doors different colours and would be involving people and their relatives by showing them samples of colours so they could chose the one they wanted for their bedroom. The director also told us of plans to improve the external areas of the home to provide people with a pleasant environment to enjoy in good weather.

People told us they enjoyed the food. One person said, "The food is good and they (staff) know what I like." Another person told us, "The food is good and there is plenty of it." A third person said, "I've been off my food a bit but I get energy drinks and I like them." One relative told us their family member was very fussy about food and had many dislikes. The relative said the person had previously lived in other homes where they had lost weight because of this; however, they had gained weight while they had been living at The Mount. Another relative said they thought the food was good and said they came into support their family member at mealtimes and saw they enjoyed the meals.

We saw people had choice of porridge, cereals, toast or a full cooked breakfast. Staff seemed familiar with people's preferences. For example one person told us they were expecting staff to bring their usual toast and marmalade because they knew that when they had cereal they would not want a cooked breakfast. We saw staff brought the toast and marmalade.

At lunchtime we saw tables had been set with placemats, crockery, cups and saucers and serviettes. Prior to the meal being served people were offered a choice of cold drinks. Some people took their meal in the dining room and others in the lounge area. Some people required a soft/pureed diet. When their meal was served we saw each component of the meal had been presented separately making the plate of food look as attractive as possible. We saw staff encouraged or supported people with their meal in an appropriate and patient way.

We saw staff were aware of individual people's preferences, for example, one person told us they were not keen on vegetables. When their meal was served staff brought them a jar of beetroot which they opened and helped themselves to.

We saw drinks and snacks were served throughout our visit, either as part of the normal daily routine or at the request of individuals. Staff we spoke with understood the need for people to have a good diet and for them to drink plenty to keep them hydrated. During the afternoon we observed the staff member who had supported people with drinks update people's fluid balance records in a timely way.

We spoke with the cook who told us they were currently catering for a range of diets including vegetarian, Halal and diabetic. They explained how they fortified foods such as mashed potato and custard with double cream so people got extra calories in their diet. They told us they could order whatever supplies they needed and could change the menu's to incorporate people's individual preferences.

We looked at everyone's weight records and saw people' weights were closely monitored and if someone was losing weight the GP was contacted and where necessary dieticians were involved. We saw from the records people were either putting on weight or maintaining their weight. We spoke with the clinical lead nurse who had a good overview of anyone who was nutritionally at risk and what action was being taken to mitigate that risk. We concluded people's nutritional and hydration needs were being met.

We looked at the medical section of eight people's care plans on the computer and found it was easy to see when people had been seen by GP's, district nurses and dentists. It was also clear what the outcomes of these visits had been and any treatment which had been prescribed. We saw when there was an issue with people's health, staff were taking appropriate action. For example, when one person had developed a urinary tract infection the GP had been contacted and antibiotics had been obtained.

We spoke with one GP who told us they had never experienced any problems with the home. They told us staff followed their instructions and made appropriate referrals.

We could not find any evidence of visits from the chiropodist or optician in the medical visits section of people's electronic care files. However, the clinical lead nurse told us the chiropodist visited the home every three months and people had an annual eye test. We found evidence in the paper files of the eye tests and the date of the last chiropody visit was established from their invoice.

We observed an interaction between one of the people who lived at the home and the clinical lead. The clinical lead had been called by care staff because they were worried the person was choking. The clinical lead came quickly and supported the person in a calm manner until they recovered. The clinical lead then discussed with the person whether they would like them to contact the dietician to discuss possible changes to their parenteral feeding regime so they would not need as much oral intake in order to feel satisfied. The clinical lead gave the person a good explanation of their options and made sure they understood.

The clinical lead nurse told us this person had previously been seen by the speech and language therapy (SALT) team regarding swallowing difficulties. They contacted the SALT team and were told as the person had been discharged a new referral would need to be made from the GP. This was done during our visit.

On the day of inspection one person had an outpatient appointment and was accompanied to this by a member of staff. The clinical lead nurse confirmed people would always be accompanied to any healthcare appointments. We concluded people's health care needs were being met.

Good

Is the service caring?

Our findings

When we inspected the service in January and June 2015 we found people were not always being treated with dignity and respect. On this visit we found improvements had been made.

One person using the service told us, "The staff are very good; you can ask them for anything, I have no complaints about anything." Another person told us, "Good staff, we get looked after here."

Relatives we spoke with praised the care provided to their family members and described the staff as 'lovely' and 'very good'. One relative said, "I'm more than happy with the care provided to (my relative). It's the way they look after not only (my relative) but me as well." Another relative said, "It's very good here, you can't fault the care. We're very happy with everything." Another relative said, "(My relative) has settled here really well. The home is a bit tired but the staff more than make up for it. They are very good and all call (my relative) by name and spend time with them." A fourth relative told us, "They (staff) have got (name) walking, talking, eating and putting on weight. When (name) moved in from hospital they didn't expect them to live longer than a month but they have come on really well. I asked staff to make sure (name) got their hair done and this is done now."

The research nurse we spoke with told us, "The staff are caring and attentive and there is a real sense of community amongst the residents."

We saw staff were kind and patient with people. Staff crouched down to chat with people who were seated so they were at eye level. We saw staff listened and responded to what people said and kept them informed. For example, one person was waiting for a cooked breakfast and repeated the same phrase continually while they were waiting. We saw staff reassured and updated the person, telling them their breakfast was being cooked and offering them drinks while they were waiting. Each time the staff member interacted with the person we saw the person smiled and relaxed.

We saw staff interacted with people in a relaxed, friendly but respectful manner. They were clearly familiar with people's needs and personal preferences. For example, we saw some people had their drinks in small cups, others had big cups and some had mugs. We saw a staff member bring a person a big cup of tea and the person said to us, "I like a big cup, more in it."

One person told us that staff helped them to retain their independence but supported them in other areas such as bathing. They said staff were respectful of their dignity and they were never made to feel uncomfortable when being supported with personal care.

Care staff we spoke with spoke positively about their role and the people they supported. One staff member told us, "I love my job, the care side, and the residents." Another staff member said, "The way I care for the residents. That's exactly how I'd care for my mum."

Where people who used the service were from minority ethnic groups and did not use English as their first

language, efforts had been made to ensure all staff were able to provide appropriate support to the person. This included information and guidance for staff to consult in relation to culture and religious requirements and detailed communication passports.

We saw one person whose first language was not English, engaged easily with the clinical lead who was able to converse with them in their first language.

Relatives we spoke with told us they were kept informed of any changes in their family members' conditions. One relative told us about a forum the registered manager was setting up for relatives, which they felt would be a good idea as issues could be discussed collectively and it would also provide support for families.

Prior to the inspection we received feedback from some relatives who had been to look around The Mount Nursing Home they told us, "What a lovely welcome my sister and I got from both staff and residents when we called without any prior notice to see if this home would be suitable for our lovely dad we, were very impressed nothing was too much trouble." We saw visitors were made to feel welcome. We found staff helpful and friendly and were offered drinks throughout our visit.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in January and June 2015 we found people were not always receiving safe care. On this visit we found some improvements had been made.

In June 2015 we found one person who used the service was verbally abusive to another person who lived at the home. Staff told us the 'trigger' for the abuse was the person who was being verbally abusive, thought the other had their zimmer frame. On this visit we saw the two individuals were sitting in different areas of the lounge and the walking frame for the person who had previously been verbally abused had been painted red. Staff reported this had stopped the verbal abuse and both individuals were more settled, our observations on the day of inspection supported this view. This showed staff had taken appropriate action to mitigate the risk of the individual being verbally abused.

In June 2015 we found some people used specialist mattresses in order to reduce the risk of them developing pressure damage. However, we found some mattresses were not on the correct setting for the person's weight. Again on this inspection we saw in one person's bedroom their mattress had been set to 50kgs, however, when we looked at their weight records we saw they only weighed 38.6kgs. This meant the therapeutic value of the mattress would have been reduced and could cause damage rather than prevent it.

When we looked around the building we saw one person had a crash mat in their bedroom. We asked staff about this and they told us they put it by the side of the bed at night. This was done in case the person fell out of bed. We looked in the care plan which stated the person had a sensor mat in their room. This is a mat which is linked to the emergency call bell system and gives staff early warning if someone was getting out of bed. This meant the care plan was not being followed as there was no sensor mat in the room..

One relative we spoke with told us they had never been involved in the care planning process. We spoke to the clinical lead about the care plans and they told us they were booking reviews for people and their relatives to develop the existing care plans. They also said they wanted to involve the care staff in the reviews as they knew what people's day to day needs were and about the way people liked their care and support to be delivered.

We concluded that care plans were in place, but these needed to be updated to reflect people's current needs and checks made to ensure actions needed to mitigate risks to people were properly recorded and actioned. We recommend care plans are up dated in line with the clinical leads plans.

One person said, "The only thing we are short of here is some activities. We used to play bingo but we don't play that anymore because people can't concentrate." They told us that they have one or two people with whom they could converse and engage in activities with; but thought that activities had stopped because many of the people at the home were living with dementia and unable to engage in some of the activities previously offered. They told us they really enjoyed it when staff joined in games with them and we saw this happened during the afternoon of our visit.

The same person told us that a member of staff had promised to take them to a Bradford City football match which they were really looking forward to. The registered manager told us they were arranging for one of the players to come to the home to visit this person as a surprise.

One person told us about how they enjoyed going out with their friend at the home to a local church for activities and lunch one day each week. They said they got taxies there and back and liked doing that because they were doing something independently. They also told us about how they enjoyed visits to the pub with their friend.

One person told us they would like to attend Church but didn't feel smart enough to go. When the Clinical lead asked them about this later, they could not recall our conversation. However, the clinical lead said they would ask them again about it. Care staff told us that the person's local priest did come to the home to see them in private.

There was very little information in the care files about what individual or group activities people may enjoy which provided staff with guidance about how to engage individuals in conversation or activity.

Relatives we spoke with said they knew how to make a complaint and would speak to the nurse or deputy manager if they had any problems. All were confident that issues they raised would be dealt with appropriately. We saw there was information in the entrance hall for visitors about how to raise any concerns, complaints, compliments or suggestions.

We were told two complaints had been received, one from a member of staff about another member of staff which was being dealt with by the director using the disciplinary procedure. The other complaint had been from a relative. We asked to see the complaints log so we could see what response was made to the complainant; however the log was not made available to us. This meant we were unable to assess the providers response to the complaint.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in June 2015 we found there were a lack of systems and processes in place to monitor the quality of the service.

The management team at the service consisted of the registered manager, operations manager, one of the directors, the deputy manager and clinical lead. When we asked people who they thought was 'in charge 'of the home most people told us it was the deputy manager.

On this inspection we found the management of the home 'chaotic.' We found it difficult to access records or to find out which of the management team were accountable for specific tasks. For example, On arrival at the service the clinical lead informed us some people were the subject of a Lasting Power of Attorney for care and welfare. We asked for evidence of the legal arrangements that were in place. The clinical lead informed us they did not have access to this but the registered manager would be able to provide this on their arrival. During the day we asked the registered manager and the operations manager for this information. They told us the deputy manager would be able to provide this information to us. When the deputy manager arrived they informed us the administrator / company director held information regarding LPAs but they thought this might only be in relation to financial matters. When we asked the company director for the information they told us they had seen the original LPA and taken a copy but this was at Head Office. This meant the provider could not demonstrate they were adhering to legal requirements in relation to consent. The lack of clear oversight of records required in relation to the Mental Capacity Act 2005 was an example of how chaotic management arrangements meant systems were not in place to ensure robust governance arrangements in relation to meeting legal requirements.

In June 2015 we asked for the residents' meeting minutes, but these were not made available to us during our visit. We asked the registered manager to email these to us following the visit but this was not done. On this inspection we asked the deputy manager for the residents' meeting minutes and again these could not be produced.

We asked to see the complaints file and the operations manager told us it was at the Head Office because they had been working on it. The operations manager rang the director and asked them to bring the file to The Mount Nursing Home. When the director arrived they had brought the wrong file. We asked for the complaints log to be emailed to us by 3pm the following day but we did not receive this information.

When we inspected the service in June 2015 we found chiropody visits were not being recorded in the medical visits section of the care plan. The registered manager told us these visits should be recorded in this section. On this inspection we looked at one person's care plan, who was a diabetic, to see when they had last been seen by the chiropodist. This information was not in the medical visits section or on the daily records. We could only establish the date of the last visit from the chiropodist's invoice. We also found visits by the optician were not being recorded in this section either. This meant even though we had highlighted the medical visit records were incomplete on our last visit the registered manager had not taken action to address this.

We asked to see the electrical wiring certificate, landlords gas safety certificate and portable appliance test records. All of these documents should have been readily available at The Mount Nursing Home, but could not be produced on the day of inspection.

We saw a number of systems were in place for auditing the safety of the environment. We saw a variety of quality assurance systems had been introduced. However, the registered manager and operations manager acknowledged that these systems were not fully embedded. We found the systems in place were not effective.

For example, we saw weekly hot water checks had been made for each water outlet. We saw the hot water check for the washbasin in one person's room had consistently recorded 'No hot water' since June 2015. We also saw the temperature of the hot water in one of the bathrooms had been recorded as below 40 degrees C since March 2015. The last dated check was 18 December 2015 when the temperature had been recorded as 38.8 degrees C. This had been recorded as 'OK' by the person completing the checks. Hot water should be available at approximately 43 degrees C to provide people with a comfortable bath.

None of the management team were aware of the problems with the hot water temperatures, which meant that the checks had not been audited. The registered manager made arrangements for a plumber to attend on the day of our visit.

The deputy manager showed us a recent, but at the time of our inspection incomplete, audit they had done of people's bedrooms. However, despite the audit including a section entitled plumbing, it had not identified the lack of hot water in one of the rooms checked.

In June 2015 we asked for the accident and incident analysis. We saw accidents and incidents were being analysed on an individual basis for each person who used the service, but there was no overall analysis. On this inspection we asked registered manager for the accident and incident analysis, which they said was on the electronic care system. The operations manager said the deputy manager would have this information which was kept in a file. We looked at the file provided by the deputy manager which contained details of individual accident reports for each month but no analysis. There were no accident and incident reports in the file from June to November 2015 and only one accident report for December 2015. We spoke with deputy manager who confirmed there was no analysis as there had been only one accident. The deputy manager said a new system was being introducing where they would complete a weekly report which they would send to the registered manager which would provide this information.

We saw an entry on one person's medical notes in December 2015 where a fall was mentioned. However no accident report had been completed for this person since our last visit in June 2015. We saw an entry in the care records where the individual had reported they had fallen into the bed board. This had not been documented on an accident report and there was no information about what had been done to reduce the risk of this happening again. If accidents were not being recorded they would not form part of any analysis.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were areas of the premises which required improvements. Regulation 12 (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality of the services provided. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Records had not been maintained in relation to the management of the regulated activity. Regulation 17 (1) (2) (a) (c) (d) (e).