Adiemus Care Limited

Mountwood

Inspection report

11 Millway Road,
Andover,
Hampshire
SP10 3EU
Tel: 01264 333800
Website: www.orchardcarehomes.com

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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?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 23, 24 and 26 June 2015 and was unannounced.

Mountwood is a care home in Andover that provides nursing and residential care for up to 39 older people who have a range of needs, including those living with dementia. At the time of the inspection there were 30 people using the service.

There was no registered manager at this location. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A long standing member of staff had been promoted to the position of manager three weeks before the inspection and were in the process of becoming registered.

Summary of findings

People using the service told us that they felt safe. Safeguarding training was delivered annually and staff were able to identify and recognise signs of abuse. Staff understood and followed guidance to recognise and address safeguarding concerns.

Staff were not always knowledgeable about the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were undertaken by nurses for people who lacked capacity to make specific decisions. Records demonstrated that staff acted in accordance with the Mental Capacity Act 2005. People received care they had consented to.

When risks were identified people were supported to remain safe. Staff were able to recognise when people were at risk and change their care accordingly to manage these risks.

Thorough staff recruitment procedures were in place so that people were protected from the employment of unsuitable staff. The provider did not always ensure that staff were receiving refresher training in mandatory areas such as manual handling and safeguarding vulnerable adults. However staff were able to evidence and demonstrate that they were able to provide safe care which met people's needs.

Nurses were responsible for supporting people with their medicines. They had received additional training and supervisions to ensure people's medicines were administered, stored and disposed of correctly.

People were supported to eat and drink enough to maintain a healthy balanced diet. People at risk of malnutrition and dehydration were assessed to ensure their needs were met. However daily records for people who required food and fluid intake monitoring were not always completed fully. As a result it could not always be identified whether people were eating and drinking sufficiently to maintain their health. People told us that they were provided with a choice of meals and when declined acceptable alternatives were provided. However there was a risk that people with documented allergies were not always provided with meals that did not include these allergens.

When changes were identified in people's health the manager engaged with other healthcare agencies and professionals to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These are legal safeguards which are in place to ensure that people do not have their liberty restricted unlawfully. Appropriate DoLS applications had been submitted and authorisations obtained from the supervisory body to ensure that people were not being unlawfully restricted.

People told us their care was provided to a standard which met their needs. Staff demonstrated that they had taken the time to know the people they supported. People were encouraged and supported by staff to make choices about their care on a daily basis.

People told us staff treated them with respect and their dignity was respected at all times. We saw that on most occasions this was happening. However, one person we saw did not have their dignity respected whilst receiving medicine to control their diabetes. This was identified at the time to the manager who took action to address this and we did not see this action repeated.

Most care plans were personalised to each individual and contained detailed information to assist staff to provide care in a manner that respected that person's individual needs and wishes. Relatives told us and records showed they were actively encouraged to be involved at the care planning stage, during regular reviews and when their relatives health needs changed.

People knew how to complain and told us they were happy to do so if this was required. Procedures were in place for the provider to manage and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service provided during regular meetings with the manager and to voice their concerns to care and nursing staff.

Even though the provider had quality monitoring processes in place these were not always efficient in identifying issues such as gaps in the completion of records. When audits had identified areas for improvement we noted that the manager took action to address these.

Staff told us that they felt supported by the new manager. After an unsettling period when the home had several managers in quick succession staff told us they were looking forward to working with the new manager.

Summary of findings

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The 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 always safe.

People with documented allergies were not always provided with food that did not include these allergens thereby presenting a risk to their health.

People were safeguarded from the risk of abuse. Staff were trained to protect people from abuse and harm and knew how to report incidents if they had any concerns.

There was a robust recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

Contingency plans were in place to cover unforeseen events such as a power loss or fire.

Medicines were safely stored and administered by nurses who had received appropriate training and regular assessments of their competence.

Is the service effective?

Requires improvement

The service was not always effective.

Staff knew the people they were supporting and the care they needed.

The provider had not ensured that people were supported by staff who had the most up to date knowledge available to best support their needs.

People were supported to have sufficient to eat, drink and maintain a balanced diet.

Staff supported people to seek healthcare advice and support whenever required.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff were motivated to develop positive relationships with people.

People were encouraged to participate in creating their care plans. When they did not want to engage relatives were involved with the provider in planning and documenting people's care, allowing them to express their family members' needs and preferences.

Overall care was given in a way that was respectful of people and their right to privacy whilst maintaining people's safety.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's needs had been appropriately assessed. Staff reviewed risk assessments on a regular basis with additional reviews when people's needs changed.

People were encouraged to make choices about their care which included where and how they wished to spend their time at the service.

There were processes in place to enable people and their relatives to raise any issues they had about the service via the provider's complaints procedure. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Requires improvement 

The service was not always well led

The home promoted a culture which was focused on providing person centred care. People and relatives were actively encouraged to provide feedback to improve the quality of their experience at the service

The manager was visible in the home. People told us they would be able to approach them to raise concerns. Staff felt supported by the manager and told us they provided good leadership.

Detailed quality audit systems were in place but had not always been effective in identifying areas which required improvement. It could not always be identified that care had been provided due to people's records being incomplete.

Mountwood

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 function. This inspection checked whether the provider was 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 the 23, 24 and 26 June 2015 and was unannounced. The inspection was conducted by two inspectors and an Expert by Experience who spoke with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of family who had received nursing care.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at the provider's website to identify their published values and details of the care they provided.

The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people and four people's relatives, one nurse, one member of care staff, the activities co-ordinator, who was also senior care staff, the maintenance man, the manager and the provider's project manager. We looked at nine people's care plans, five of these people's and four other people's mini care plans, four staff recruitment and training programme files, five people's medication administration records (MARs) and three staff supervision and training records. We also looked at staff rotas for the dates from the 8 June to the 12 July 2015, quality assurance audits, people and relative meeting minutes, staff meeting minutes, policy and procedures, risk assessments and complaints. During the inspection we spent time observing staff interactions with people including a lunch time sitting and during a medicine administration round.

Following the inspection we also spoke with an additional two members of care staff.

The service was previously inspected on the 17 July 2013 and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with told us that they felt safe living at Mountwood. Interactions between staff and people were positive and relaxed. On person said, "I feel very safe I have never been treated like it before, I love it". A relative told us, "I come every day, sometimes twice a day, I have no concern about the home, my wife is very safe here".

Concerns had been shared with the CQC prior to our inspection that staffing levels were not always sufficient to meet people's identified needs safely. Staff told us that they felt that they did not always have sufficient numbers to support everybody in a timely way. However, whilst they were busy they were still able to deliver person centred care safely. This is care which is individualised to people and delivered in a way that they want and need.

Staff told us they would have liked to have had more time with people to engage them in conversation away from the delivery of personal care. This had been identified by the manager and provider and there had been recent recruitment for additional staff. The recruitment for additional nurses to support in the event of leave and absence was on-going. During our inspection most people told us there were sufficient staff available. One person told us, "there are so many carers about I feel safe, they pop in to see me". Although one person told us they sometimes experienced delays with staff responding to the use of their call bell we did not observe any such delays during our inspection.

The manager explained how the provider considered people's identified needs when agreeing staffing levels for the home. The required staffing levels were based on safely meeting the assessed needs of people (dependency). People's dependency was reviewed on a monthly basis. The manager told us they had more than the required number of staff and nurses to meet people's needs safely. The provider had recently introduced a twilight shift which was from 7pm until 1am to assist in supporting people with their night time routine.

We reviewed staff rosters from 8 June to 12 July 2015 which demonstrated that the provider was working with above the minimum staffing levels required in order to meet people's needs safely. When gaps in staffing rosters were identified the provider used care and nursing staff from the same agency to fill these available positions This ensured consistency and that people were cared for by staff who knew them and their needs and were able to meet these safely.

People were not always kept safe when it had been identified that they had specific food allergies. One person had a number of food allergies which were detailed in their care plan. The interim chef was aware of who required a soft/pureed/diabetic diet but was unaware of these documented allergies. He confirmed that he had cooked with these items since being at the home a few weeks prior to the inspection but was unable to say on how many occasions. Nursing and staff were aware of the person's allergies and confirmed that this person had suffered no ill effects as a result of consuming these food items. Not having effective procedures in place to safely manage the risks associated with food allergies put these people at risk of harm to their health.

The provider had not protected people from the risk of harm by taking all reasonable practical actions to safely manage the risks identified to people from their allergies to certain food. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When other risks to people's health were identified, such as risks of falling, appropriate actions had been put in place by the provider to reduce the risk of harm. All care plans had assessed areas of risk including people's mobility and nutritional risks. When it was identified that people were at risk of dehydration or choking for example, appropriate risk management plans were created and followed to maintain people's health.

Robust recruitment procedures ensured people were supported by staff with appropriate experience and suitable character. Staff had undergone the required recruitment checks as part of their application and these were documented. These records included two previous employment references and a completed Disclosure and Barring (DBS) check before they started working in the home. A DBS check enables employers to make safer recruitment decisions by identifying those staff who may be unsuitable to work with vulnerable people.

Staff we spoke with were able to demonstrate their awareness of what actions and behaviours would constitute abuse. Staff were also knowledgeable about

Requires improvement

Is the service safe?

their responsibilities when reporting safeguarding concerns. The provider's own policy provided guidance for all staff on how and where to raise a safeguarding alert. Staff were able to demonstrate when they had raised concerns these had been acted upon by the provider who had implemented disciplinary procedures where necessary.

There were robust contingency plans in place in the event of unforeseen emergencies such as a loss of utilities or fire which minimised the risk of harm to people. In the event of an evacuation people using the service would be moved, temporarily to care homes nearby. These plans were detailed and ensured that the potential risk of harm was minimised whilst maintaining people's continuity of safe care. Fire drills were also practiced with all staff on a regular basis to ensure that in the event of an emergency they would know their roles and responsibilities. During the inspection an unexpected fire alarm was heard to sound and all staff were able to demonstrate that they knew the right actions to take to account for people, staff and visitors that would ensure their safety in an emergency.

People received their medicines safely and knew what they were receiving and why. One person said, "I do take medication, they (nurses) tell me what it is for". Nurses who were responsible for administering medicines had their competency assessed annually by the deputy manger who was also a registered nurse. There were clear arrangements in place to ensure that people were protected from receiving the wrong medicines. The provider used the medication administration record (MAR) chart to record medicines taken by people and codes were used to denote when people refused to take their medicines. We saw the majority of medicine was administered using a monitored dose system mainly from blister packs which made it easier to see if people had missed a dosage. Arrangements were in place with the nurses to audit medicines when they were delivered or disposed of with the local pharmacy.

There was a medicine fridge which was kept at the appropriate temperature for storage. Records confirmed that regular checks were completed by the nurses and safe temperatures maintained. All medicines were stored securely. Medicine stocks we check correctly corresponded with stocks recorded. Controlled drugs medicine stocks were audited twice daily at the end of the working shift, which records confirmed. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. Controlled medicine stock levels were correct and corresponded with the controlled medicines record.

Concerns had been raised before our inspection that there were not adequate procedures in place to ensure people were protected against the risk of acquiring an infection. During this inspection we found that the majority of areas within the home were clean. However, there were some identified areas which required additional cleaning. In the dining room the floor was stained with food, drink and by general foot movement through the area. When this was brought to the attention of the manager immediate action was taken to ensure that this area was cleaned. One member of housekeeping staff was not working during the time of the inspection. As a result the remaining housekeepers were prioritising cleaning people's rooms and communal areas were completed last. We saw that there was an improvement in the cleaning of the common areas during the remainder of our inspection.

Most staff had either completed or had commenced infection control training and we saw evidence of safe infection control practices. Appropriate protective clothing such as disposable aprons and gloves were used when staff delivered people's care. Hand washing instructions, soap and antibacterial gel were available throughout the home to promote good practice and minimise the risk of infection. The sluice, which is wear soiled linen is washed, required refurbishment to ensure that risks of infection control were minimised. This had been raised as an issue with the provider and we saw evidence that this had been requested for action. People were protected from the risk of infection.

Requires improvement

Is the service effective?

Our findings

Most people were positive about the staff having the ability to meet their care needs effectively. We observed staff seek people's consent prior to the delivery of care and they were able to meet people's health needs. One person told us, "they are very polite and always ask my consent".

Staff confirmed they had received an induction to their role and could seek additional support before delivering personal care unsupervised. One new member of staff told us that they had received a period of shadowing before they had started working with people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their role. This allows new staff to see what is expected of them. However, records showed that not all staff had completed the skills for care common induction standards or their replacement the Care Certificate. These are nationally recognised standards of care which care workers need to meet before they can safely work unsupervised. The provider had identified courses that had to be completed by staff during their induction period prior to commencing working with people. These included courses in infection control, moving and positioning and safeguarding of vulnerable adults.

Staff we spoke with also told us that they were able to seek additional training and support if they wanted and would ask the manager to provide this. For example one member of staff wanted more in-depth diabetes training which was provided. Staff we spoke with told us, "we are offered training all the time". However, the provider had not ensured that staff had completed all of the required refresher training. Records identified that only seven out of 40 members of staff had completed recent moving and handling training, Even though we did not observe people being transferred unsafely by staff during the inspection there was a risk of harm to people from unsafe moving and handling practice from staff we had not observed.

The manager told us they had identified a deadline for the completion of all the required training by staff. Following this deadline of 10 July 2015 any staff not completing this training would not be rostered to work.

People were not always supported by staff who had received appropriate training to enable them to meet people's needs effectively and safely. The failure to provide staff with appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2014 (Regulated Activities Regulations 2014)

Most of the residents at the location were living with dementia. Whilst staff had not received specific training in relation to dementia care they were able to demonstrate effectively through care practice observed during our inspection how to best support people living with dementia. This involved spending additional time with people, for example not rushing them when asking for a response and explaining at all times what they were doing. The activities co-ordinator was in the process of organising a summer fete where they had asked a member of the Alzheimer's Society to come along so staff, people and relatives were able to ask questions and gain a greater understanding of dementia.

Staff were receiving regular supervision and appraisals with the manager and senior care staff. Supervision and appraisals are processes which offer support, assurances and learning to help staff development. Staff we spoke with could not recall attending regular supervisory meetings with the nurses or the manager. They told us that this had been as a result of having a number of different managers in the last six months. The records demonstrated that staff had been receiving regular appraisals but there had been a delay in some receiving these after February 2015. However, all spoke positively about the support they received from each other, senior staff and the new manager. The manager had been in post three weeks and was reviewing the system of supervision to prioritise those staff who had not had one recently. Staff received appropriate support and supervision to enable them to raise and discuss concerns and identify training needs which made them feel supported.

Staff responded effectively to ensure people's freedom was not unlawfully restricted without authorisation. The Care Quality Commission (CQC) monitors the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using the service by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. There had been a four authorisations at the time of our inspection with another four applications made. Records showed that these people

Requires improvement

Is the service effective?

had had a mental capacity assessment completed prior to the application of the DoLS. We found the manager had a good understanding of DoLS and was able to identify those persons who required an application in order protect their freedom and rights and used the least restrictive options to support people appropriately.

People's views and decisions were respected. Not all the staff were knowledgeable about the requirements of the Mental Capacity Act 2005. However, nursing staff, who were responsible for completing mental capacity assessments for people, were able to demonstrate the principles of the MCA 2005. Where people had been assessed as lacking capacity to make specific decisions about their care the provider complied with the requirements of the MCA 2005. The MCA 2005 is a law that protects and supports people who do not have the ability to make specific decisions for themselves. This included an assessment of the person's mental capacity, discussion of their care needs in a best interests meeting with those who were able to represent the person, such as family and health professions, and a decision reached. Care workers were able to demonstrate that whilst they were not involved directly in the completion of mental capacity assessments they knew what best interest decisions were and how to best act in order to support people and their needs. Care plans were detailed and included consent to care documentation. Staff told us, which our observations confirmed, that they would gain people's consent prior to the delivery of their care.

Most people we spoke with were complementary about the food provided. One person told us, "I wolf down what is put in front of me…they know what I like" with another saying "there is too much to eat and drink". People were given choice regarding what they ate although some people did not feel the menu completely suited their needs, "Oh it is not the food for me, what is spaghetti bolognaise? I don't know what the food is". We saw that simple options such as sausages and mash were available to people if they wanted. People were given choice and staff told us that they were able to prepare additional snacks and meals for people if requested. The chef was able to accommodate requests and if they did not have the ingredients they would source them locally.

We observed people enjoying their food at lunchtime. Care and nursing staff were knowledgeable about who required a pureed, soft and normal diet. Snacks and drinks were readily available for people. In all rooms people had fresh water and squash available which was regularly being offered by staff in order to keep people hydrated. People were supported to have sufficient to eat, drink and maintain a balanced diet.

People could access health care services when needed. The chiropodist attended to people's foot care needs on a regular basis, every six to eight weeks, and we could see that people had recent appointments with an optician. A relative told us, "they are very aware of mum, they always get a doctor for her if she is not well". Documentation showed that when required additional healthcare support was requested by staff. For example, when one person had been identified with a pressure sore immediate advice had been sought from the Tissue Viability Nurse and a short term care plan put in place to effectively manage this person's pressure sore.

Good

Is the service caring?

Our findings

People told us, “the carers are very caring”, and, “they are lovely to me”. People appeared relaxed whilst in the company of all staff at the home.

Staff were knowledgeable about people’s personal histories and preferences and were able to tell us about people’s interests and hobbies. Staff took time speaking with people as they moved around the home. People responded positively and were happy to talk with them. Staff bent down to make eye contact when speaking with people to encourage meaningful interaction. During meal times the staff who supported those to eat did so in a caring way. There were personal conversations about families and people were not rushed by staff when eating their meals.

People were treated with compassion and kindness when upset. During the inspection a person who was restricted from leaving the home became distressed whilst sitting in the reception area. They were becoming increasingly frustrated and stated that they did not want to be at the home anymore. This person was subject to a DoLS and for their own safety were unable to leave the home without constant supervision. This was at a lunchtime whilst staff were busy assisting people with their meals. A member of staff approached this person and gently explained that they would not be able to leave at the moment and distracted them by asking about going to the person’s room to see pictures of trains. This visibly comforted and calmed the person. All staff displayed affection for people they supported by touching them whilst speaking to them, holding their hands when offering to assist or to comfort them and people were smiling as a result. Staff knew how to diffuse situations that could escalate to behaviours that may challenge others.

People were treated as individuals and encouraged to make choices about their care. This included how they wanted to spend their day, where they would like to sit to rest and eat, as well as their choice of food. People were also able to choose what time they wanted to get up and go to bed in the evening. One person told us, “they encourage me to be independent; I go to appointments on my own”. Not all people felt that they were involved in making decisions about their care but we could see that where Power of Attorneys (POA) had been identified for health and welfare decisions that they had been consulted in planning the care provided. A person who has been provided with POA is there to make decisions for people when they unable to do so for themselves.

Most people were treated with respect and had their privacy maintained. However, we observed one incident where a person’s dignity was not taken into consideration when administering their medicine. One person was asked to provide a blood glucose test by the nursing staff, whilst they were eating their lunch in the dining room. This person then had their blouse raised so that medicine for the treatment of their diabetes could be administered by injection into their abdominal area. This was brought to the managers attention at the time and was not repeated during the inspection.

People told us staff always knocked on their doors asking permission to enter and we saw that this was happening. Staff were able to provide examples of how they respected people’s dignity and treated people with compassion. Bedroom doors were always closed when personal care was being delivered. We found that signs were hung of the back of people’s doors to identify that personal care was being delivered to protect people’s privacy and dignity.

We saw that when people were being assisted with their bathing needs that they were treated with dignity and fully covered whilst being taken to and from their room and the bathroom. One person told us, “they always knock on the door and are very respectful”.

People were also respected by having their appearance maintained. People were well dressed, clean and their hair was tidy. One person told us, “they wash me thoroughly and I never feel rushed”. Another person told us “they treat me with dignity and respect”. Apart from the one incident, we observed staff respecting people’s dignity whilst providing their care.

Good

Is the service responsive?

Our findings

People told us the staff took the time to know how they were and addressed them as individuals. People's relatives confirmed that the staff took the time to know people and learn about their interests. People not able to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided. People who had been appointed Power of Attorney had been consulted regarding the delivery of care.

People's care needs had been fully assessed and documented before they moved into the home. This planning took into account people's history, interests, routines, preference for care and likes regarding food. Only one of the care plans reviewed did not contain personal history information for a person living at the home. However all staff at the home had taken time to know the people they were supporting. We saw engaging conversation between people and staff which displayed knowledge of people's personal preferences. The care plans gave staff an understanding of the person they were caring for and how they could best meet their needs.

Staff handovers between shifts were held on each floor. These were held between the nurses and this information was then shared with staff. The handover sheet had recently been reintroduced to the home which contained specific and detailed information in relation to people's needs. This enabled agency nurses and new staff to obtain a greater understanding of the people they were caring for and their required needs.

However staff said told us that they felt that the daily routine of handovers was not detailed enough. We viewed a handover between the night nurse and the day nurse and senior carers where people's health needs during the night were discussed. However, a lot of people were described as being "fine". For staff who had been away on annual leave it was difficult for them to immediately obtain an understanding of what had been happening to certain people when they had been described as fine. One Nurse told us that the use of a communications book for nurses on both floors would be beneficial as it would be an easy way for them to immediately access the information they required when they had been absent for any length of time. This was brought to the managers attention and was going to be provided in future for staff to refer to.

Records showed that people's care plans had been reviewed on a monthly basis, although the provider and manager were aware that some of these plans had not been reviewed since April 2015. The nurse and staff were able to demonstrate a very good knowledge of people's needs but had not signed the care plan to say that this review had taken place. This had already been identified by the provider prior to the inspection and was in the process of being addressed with nursing staff.

The provider sought to engage people in meaningful activities however not all people felt like they were involved. One person told us, "I never go out here not even in the garden. I sit here all day which is why I'm bored". The manager was aware of this person's needs and had been visiting them on a regular basis to actively encourage them to participate. However, when asked they did not wish to. Other people were positive about the options available to them. One person told us, "I like puzzles, words searches and competitions, I have won money and jewellery". One relative told us, "mum goes out on trips all the time, sometimes there are more (people) in the lounge, the carers don't force the residents, if they want to stay in their rooms they can". There was one activities co-ordinator who was working within the home. An activities programme for a typical week was viewed which included light exercise, picnic in the garden, skittles, gardening, one to one, and a sing-a-long. People were also able to have external trips, with the activities coordinator having recently taken a resident into town for breakfast. Where people were unable to leave their rooms, or unwilling to do so, they were encouraged to participate in activities in their rooms such as reading or card making for example. The manager had raised with the provider that it would be beneficial for residents to have a completely secure garden area for them to use without supervision. This would enable more people to enjoy the outside space available when they wanted. This request was still awaiting approval at the time of the inspection.

People told us they would be happy to make a complaint if required. One relative told us, "I have never had to complain, I would speak to the nursing staff if I needed to". Another person told us, "I would talk to the manager". People were provided with information on how to complain in their introductory records when they moved to the home and details of the complaints procedure were

Good

Is the service responsive?

visible in the reception area. The provider kept a complaints folder and two complaints had been raised in 2015. These had both been resolved, with an appropriate investigation and response to the complaint.

People and families had sent the staff complementary cards and letters of thanks and these were displayed in the office walls.

Requires improvement

Is the service well-led?

Our findings

The manager was visible to people, their relatives and all staff. One person told us, "the manager is the lady in the office, she is very good". One relative said, "I think this home is well managed, the management staff are very approachable, we would recommend this home to everyone".

At the time of the inspection the provider did not have a registered manager in post. A registered manager is a legal requirement of a provider's registration in order to carry out a regulated activity. The previous manager left the home three months before the inspection. The provider had immediately addressed the issue by sending a project manager to the home in order to provide managerial support to nursing staff whilst a new manager was recruited.

The newly appointed manager was a previous long standing member of staff who had been at the home for nearly 17 years. They were able to demonstrate that they had a good understanding and knowledge of the home and of the people who lived there. The provider was making additional managerial support available to them in order to support them with their role. Staff told us they were looking forward to the new manager becoming established and were pleased they had been promoted.

We found that records were not always fully or accurately completed. People's care plans did not always fully document that people were being repositioned at specified times as part of managing the risk of pressure sore development. One member of staff told us that in relation to body repositioning charts "they (people) are being turned but it's not being written down on the paperwork". Records for two people showed that they were at high risk of pressure sores and as a result required repositioning every two to three hours. The body repositioning charts in their care plans did not always reflect that this was happening. There were two occasions on two people's charts when no entries had been recorded indicating that they may not have received this care. The provider could not always be assured that the identified actions to manage this risk were always carried out by staff.

Nursing staff had not always accurately signed people's records to identify whether people's topical medication, creams, had been administered appropriately. We found discrepancies between people's topical medicine charts kept in their rooms and their Medication Administration Records (MARs). On people's topical MARs) there were gaps which suggested that topical medicines may not have been administered. However, the corresponding MAR chart entries were signed by the nursing staff as being administered. As the nurse had not completed both documents at the same time they did not know whether or not the cream had been administered but had signed the document assuming they had been administered by other staff. People were at risk of harm because the provider could not be assured that people always had their topical medicines administered as prescribed

The failure to ensure accurate and complete records were maintained in relation to each person was a breach of regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The provider had a set of written values for the service outlining the standards of care that was required of all staff. These included the promotion of providing person centred care which was not rushed. The manager was keen to instil a culture where staff saw people living at the home as members of their family and to treat them as such. These values were provided to all staff when they started working at the home. Additionally this information was available to view in the downstairs administration office where the manager was situated. The new manager told us she had not yet been able to formally embed the values of the home into the staff supervision processes to ensure that staff understood what was required of them. However we could see that these values were being adhered to by all staff though their interactions with people living at the home.

The provider promoted a positive, supportive and inclusive culture within the service. Staff we spoke with felt that their concerns about staffing levels had been sufficiently listened to by the provider. As a result staffing levels were being increased with the recruitment of additional care staff. Staff told us that due to there being three managers at the home in the period of six months this had been unsettling for staff. However they told us that the promotion of the new manager had increased morale at the home and that staff were a lot happier as a result. One member of staff told us, "the manager is approachable, she listens…she's always said to us that her door is open".

Requires improvement

Is the service well-led?

Another member of staff told us that at a recent staff meeting the manager had been keen to hear their views on how to improve the service which made them feel included and respected.

Staff were positive about the new manager and the support they received to do their jobs. Staff we spoke with said that the registered manager was open to their concerns and needs. Prior to promotion staff told us they had always been able to approach her and be confident that she would be proactive in dealing with issues raised. Staff told us that the manager was available if they needed guidance or support, one said "if I need someone to help me, I always get support". Another member of staff told us they received support, "oh yes, especially now (the promotion of the manager". The manager was described by one member of staff as, "she's been the heart of Mountwood, she's very approachable and a lot of people are pleased she's now manager".

Staff had the confidence to question practice and report concerns about the care provided. Prior to the inspection we reviewed the notifications which were received from the location. A member of staff had raised concerns regarding a staff member who was alleged to have assaulted three people. This had been raised to the previous manager but when it was felt no positive action had been taken it was reported directly to the provider. The member of staff was supported throughout the subsequent investigation and processes when staff members were dismissed. The provider had processes in place to ensure that staff were supported to raise concerns and that they would be thoroughly investigated.

The manager told us that audits were completed in relation to various aspects of the service. These included service quality assurance audits, which records confirmed. Where audits had been undertaken actions were recorded for completion. A Quality assurance audit was conducted on the 15 June 2015 by the provider's Compliance Officer, which included an audit of infection control. It had been identified that the sluice area required tiling to ensure compliance with infection control guidelines. The manager was waiting for agreement for this work to commence.

The quality of the service people received was monitored through surveys, meetings and audits. Records showed that regular meetings with the provider, people and their relatives had taken place. were being offered. During such meetings in May and April 2015 people were encouraged to ask questions about the running of the home which were answered by the provider. One person raised concerns about the housekeeping in one particular room. This had already been identified by the provider and they were able to give an update that the situation was being resolved. This showed that the provider was identifying areas of concern before they were being raised by residents and relatives through the use of quality assurance processes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider did not ensure that they were doing all that was reasonably practicable to mitigate any identified risks in relation to food allergies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1)(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good governance The provider did not ensure that complete, accurate and contemporaneous records were maintained in respect of each service user in relation to the treatment provided and management of assessed risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing The provider did not ensure that staff received appropriate training as is necessary to enable them to carry out the duties they are employed to perform.