Coverage Care Services Limited

Montgomery House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 27 June 2017. Montgomery House provides nursing and personal care for up to 90 people. Some people were living with dementia. At the time of our inspection 72 people were living there.

The home is a new build and this was the first inspection of the service. There was a registered manager in post. 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. The registered manager was away from work and was not present at this inspection.

The systems for assessing the quality of the service were not consistently used or reviewed by the provider to ensure lessons were learnt and improvements made.

There were varying opinions about staffing levels from staff, people and relatives. The provider had assessed people's dependency levels and provided some agency staff when the service fell short of that needed to meet people's needs.

We found that people may not always be protected against the risks associated with abuse. Care staff understood what abuse was and how this was to be reported. Referrals had been made to the local authority, but not consistently.

People were protected against the risks associated with the unsafe management of medicines. There had been an error and management had responded to this and medicines were available as prescribed.

People were protected against the risks associated with meeting their nutritional needs. People were assessed for nutritional risk and appetising meals were provided.

People were able to make choices and decisions and staff supported them to do this. Healthcare professionals visited when required and clear records were kept of the visits. There was evidence of communication from the mental health team and their guidance was followed.

People were supported by staff that were trained and had access to training to develop their knowledge. Most people were treated with kindness and care. We observed most staff engaged with people in a positive way and they were caring when they supported them. Relatives felt welcomed in the home and told us the staff were kind but could do more to engage with people to get to know them well.

People had some activities to choose from. The provider intended to make better links with the local community so people could socialise outside the home.

Staff meetings were starting to be held. Resident and relative meetings were yet to start. People had not been able to formally contribute to the running of the home.

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 entirely safe.
People may not be protected from harm or abuse because procedures to do so were not consistently followed.
Risks to people's health and safety were assessed and support provided to minimise risk.
People were supported with their medicines safely.
The provider operated recruitment processes which helped to ensure that staff employed to provide care and support for people were fit to do so.

Is the service effective?

Requires Improvement

The service was not entirely effective.
Some staff did not engage with people or provide the reassurance they needed.
People were supported by staff who had received training in order to carry out their duties.
Staff understood people's healthcare needs and supported them with these. People were supported to make decisions about their care.

Is the service caring?

Requires Improvement

The service was mostly caring.
Most interactions we observed were supportive but some were not.
People's care records were stored in a manner that promoted confidentiality and privacy.
Staff talked about people in a manner that promoted respect or dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People did not always receive the care needed to meet their needs in a personalised way.
People and those that mattered to them were involved in their assessments of care.
The provider had a system in place for people to raise any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The management of the service had not been consistent so it lacked the vision needed to develop and improve the way people received their care and support.
There was a lack of systems in place to obtain the views of people who used the service and staff.
Quality monitoring systems had not been consistently implemented so were ineffective and did not identify where improvements were needed.

Montgomery House

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 visit took place on 27 June 2017 and was unannounced. The inspection was carried out by two inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses services for older people.

Prior to our inspection we reviewed information we held about the service. This included a Provider Information Return (PIR) completed by the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law.

We contacted commissioners who fund the care for some people and Healthwatch and asked them for their views.

During the inspection we spoke with 21 people who used the service and seven relatives. We also spoke with six care workers, three senior care workers, domestic staff, the operations director and the operations and performance manager.

We considered information contained in some of the records held at the service. This included the care records for four people, staff training records, two staff recruitment files and other records kept by the registered manager as part of their management and auditing of the service.

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

Requires Improvement

Is the service safe?

Our findings

One person told us, "(Person) is here as they were not safe at home. We are very happy as a family with the way they are looked after here. We have no worries at all about their safety and security or the risk of them falling. They (staff) seem to take care of them well and staff always say (person) is happy." Another person said, "I only have to ring the bell and they are there." A third person who was a wheelchair user said, "Everything is easy for me here, I can get around on my own, it is all level, it is all safe." A relative told us they felt their relation was safe. They said, "When there were enough staff on duty". A visitor commented, "There are two agency staff here today. They would not normally have these. They would be short." Another relative told us, "(Person) is settling down here and likes it. We are broadly happy but I think they have staffing issues. (Person) likes a regular bath but says they are not getting one. I have raised this with staff and they do not like answering. They have inferred it is because it sometimes is not safe to bathe them because of not enough staff on the unit."

Past rotas showed that there had been some shifts over recent weeks when the service had been below the number of staff assessed as required on a unit. We were told by the management that there had been staff sickness and annual leave to cover. Regular agency staff were used when available. When these could not be booked, staff were used from other units in the home and the on-call team were available for guidance.

A staff member said, "There is more pressure on us when there are not enough staff on our unit and we can't do everything. We borrow off other units but that takes away from their (people's) quality time. Quality time is important. People need stimulation." Another staff member told us, "It's not as easy to give everyone the care they need with less staff on." Another staff member said, "Relatives visit for an hour and that's all they see. They don't see it when people get upset and disturbed and it's difficult to cope when you are stretched."

The provider had systems in place to ensure that all staff were able to record and report any safeguarding concerns. Staff referred to a recent incident that had taken place in the service where a person was at high risk of choking. The care plan stated that staff should know this person's whereabouts at all times. We saw this person walked about the unit unobserved by staff and go into other people's rooms. This person also had a bruised eye that staff were unaware of how it had happened. There was no record of the injury in the person's care record or on the electronic management system or any referral to the local authority safeguarding team. The management on duty were unaware of the incident as staff had not reported it to them. This person's care was not being managed as assessed.

Whilst action had been taken to resolve other safeguarding situations that had arisen, there was no analysis of the situations that had led up to these to prevent such situations from reoccurring. This posed a risk that if a safeguarding concern was identified this would not be reported to the authorities as required or learned from.

Care staff we spoke with were able to describe the different types of abuse and harm people could face, and how these could occur. They described indicators that could signify a person had been abused and told us they would report any concerns they suspected or identified to the registered manager or another senior

member of staff on duty.

The staff identified risk and a care plan was put in place that described the risk and the measures needed to reduce it. When a change was identified in a person's care needs, the risk assessment, and care plan was updated to reflect that change. Risk assessments included falls, skin integrity, manual handling, diet and nutrition.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicant's suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. We viewed staff recruitment files that showed the necessary recruitment checks had been carried out.

People were supported to have any medicines they needed when these were required. One person who used the service told us, "We get them (medicines) on time." We saw staff administering medicines to people during mealtimes and this was done safely.

The systems in place for the storage and administration of people's medicines were followed to ensure these were managed as safely as possible. Senior management had worked with external professionals to ensure that the procedures were as robust as possible. The provider used an electronic recording system and relevant staff had been trained in the use of this. This included agency staff used. Between shifts, staff completed a medicine handover to check that no medicine administration was outstanding. They also checked that none had expired and were in stock. This check had been introduced as a learning point from a previous medicine error.

We observed that a senior member of staff explained to a member of care staff how to log into an individual's medicine record and how to bring them up to date following a short stay in hospital. The person's medicine had significantly changed. They went into the person's records on line and changed what was necessary. Each of them then individually counted the tablets in, of the new medicine. Once the number of tablets was agreed they were entered on line. They did this methodically and with precision. Following on from this the care worker was told to go and log her computer on line so that the record would update across the system.

Requires Improvement

Is the service effective?

Our findings

Some people we spoke with considered those supporting them had the relevant skills and knowledge to meet their needs. One person felt the staff did not know them as a person. A visitor commented that staff had to be told by them what they should be doing for their relative. They said, "Why should you have to point out to care workers what needs to be done. Why have they got to be told? They should know." Another commented, "They (care workers) get them (people) up and stick them in the chairs and put the TV or radio on. They don't ask people if it is what they want." One person said, "(Person) came here for respite and really liked it. They did a brilliant job whilst we were away. They are looking after them so well here. The one thing missing is someone to talk to (person), they need a life history recording, they are so animated when they talk about their life. No one here has time to listen."

Staff told us they had an introduction to their role when first starting at the service. One staff member said, "I worked alongside another member of staff. It helped me find my way around the premises and understand where things were and how to care for people." Staff told us they had access to on-going training they needed to support people as they required.

Staff told us they had formal one-on-one meetings arranged with the registered manager. Other staff said they had not received supervision. We were shown the matrix for reviewing staff development. There were many gaps where dates were not planned in for staff to meet with their line manager. During these sessions staff should be able to discuss aspects of their work including what had gone well and what could be improved. In addition to formal sessions, staff told us they could seek advice and support from their colleagues and the registered manager at any time they needed. Some staff felt they were not listened to, but others considered the support was good and that they could approach senior staff as needed.

We saw people were supported to make their own decisions and were given choices. People were given the information in a way they could understand and were allowed the time to make a decision. For example, arrangements had been made to assist people to vote. The layout of the main lounges on the units offered communal space for people who liked sitting together with discreet seating for four or five people and a couple of places with only two seats. This layout allowed for people to choose their space and also offered a choice. We saw people being offered choices and making decisions where they would like to sit and what to eat and drink.

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. We checked whether the service was working within the principles of the MCA. At this inspection, we could see that the registered manager had trained and prepared staff in having an awareness of the requirements of the MCA and the process of 'best interests' decision making.

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 saw records of staff training and staff confirmed their awareness of this subject.

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. We saw DoLS applications had been authorised by the relevant local authority. The provider held a copy of the lasting power of attorney where people had these in place. We found evidence of mental capacity assessments and best interest decisions in people's care plans.

Staff followed current guidance regarding do not attempt cardiopulmonary resuscitation (DNACPR). People's views and the opinions of those that mattered to them were recorded. Decisions were clearly displayed in people's personal files and staff knew people's individual decisions.

The atmosphere in one of the dining rooms was friendly and cheerful. The staff chatted to people as they arrived in on their own or when they assisted them in. Drinks were poured out in advance and a jug of squash left on each table and refilled once or twice upon request. There was no menu visible on one unit and we asked to see one but staff couldn't find one.

On other units we saw a choice of food, although a lot of people had either forgotten what they had ordered or changed their mind when they saw the other option. People were all able to have what they wanted on the day and they also had a choice of seconds. The staff went around with meat, chips and veg and a number of residents took up the offer of extra food. Lunch was served in a calm, unhurried manner and there was talking and conviviality throughout. One staff member said, "Would you like any help? Shall I cut the meat in half for you?"

One visitor said, "The care here is brilliant and is very homely and social which (person) enjoys. The food is always good. I eat with (person) and they do not eat a great deal but what they do eat, they enjoy it very much and I have found the food good." When people's diet and nutrition needed to be monitored for health reasons, this was recorded by staff supporting them. If necessary, details were passed to a dietician for their guidance and support. Staff explained how they were supporting one person to take supplements to enhance their nutrition. Menus were on display in picture formats so people could make their choice of meal.

One person commented, "(Person) has been here now for a short time and we think it is pretty impressive. They require quite heavy nursing and had to see the GP frequently and we are not aware of any problems at all. Everything is always done with a smile." We saw in care files that people had access to healthcare services, including GP, opticians and chiropodist and were supported to maintain good health. People told us that staff knew and understood their specific medical conditions, which was reassuring to them.

Requires Improvement

Is the service caring?

Our findings

People described staff at the home as kind and caring. Comments included, "They are lovely carers," "The staff here are all lovely but they are so rushed all the time. When they bring you a cup of tea they are almost gone before they can put it down." "During this inspection we observed examples of positive and negative caring interactions between all staff at the home and the people they supported. A visitor commented, "Some staff spend more time with some people than with others." We noted examples throughout the day where, on one unit, staff members provided minimal interaction with the people they supported. We also noted that some staff approached people without a smile or offering emotional comfort. We observed a care worker observing a person along the corridor. They said, "I don't like walking past (person), they have such difficulty getting going, it might put them off their stride."

Care staff could describe people's likes, dislikes and preferences and it was clear they knew most people well as individuals. One staff member said, "(Person) is very rude to staff. They are in bed all of the time but wants to get up. I don't stand any nonsense from them and the staff do not like them or dealing with them." This showed that not all people were cared for equally.

People we spoke with told us care staff respected their privacy and dignity. One person said, "I admire their respect and professionalism and they are always cheerful no matter how much they have got on. I am never left wet or anything as soon as I call they come", and a second said, "The care given here is satisfactory bordering on good. I am mobile and shower myself but if I require help it is given and I find my dignity is always respected I have no concerns in that area. They are all very respectful of my need for privacy and that is very important to me." We saw people were dressed appropriately for the time of year and appeared well groomed. Care staff told us they respected people's privacy and dignity when supporting them with personal care. One care worker said, "We close the doors and keep people covered up during personal care." We also saw some care staff communicated well with people and asked for their consent before providing support.

Each unit had a staff area where people's care records and other management information was stored. People's private information was always stored securely.

Staff could describe how and when to refer people to advocacy services. Information was available to people about how to access advocacy services. Records showed people had been supported by advocates when they needed them. This meant people had access to independent support to make decisions when they needed it.

We looked at how the provider promoted equality and supported people's diverse religious and cultural needs. We saw the assessment process was used to ask about people's religious and cultural needs. We found the staff were knowledgeable about the religious and cultural requirements relating to aspects such as food and the gender of care staff. One staff said, "We speak to individuals to find out how they want to be supported. We ask people who they want to know about their preferences."

The staff provided end of life care to people if the home was their preferred place of death and their needs could be met. We saw training was provided on palliative and end of life for staff. We asked care staff what they thought was important in terms of care and support for people near the end of their lives. Replies included, "We need to respect their wishes. It needs to be dignified. We manage any symptoms. It's private and we look after the family as well", and, "It's making sure they're comfortable and meeting their needs. We need to understand their family background and manage their symptoms." This meant staff could demonstrate an awareness of the important aspects of good end of life care.

Requires Improvement

Is the service responsive?

Our findings

People's relatives told us they felt that on one unit there could have been greater degree of communication and interaction between the staff team and the people who used the service. One relative told us, "The staff could be more positive and enthusiastic. They [staff] provide good physical care but there is more they could do to relate to people. Sometimes I feel that people would benefit if there were more staff available to provide social interaction with people" Another person on a different unit said, "I am very disabled, they have to do so much for me and I am very happy with how they respond to me. They are all so very kind and genuine."

People did not always have a personalised care experience. We observed on one unit that staff worked in a task centred rather than a person centred way. For example, on one unit a person got up from the table at lunch time and walked up and down the corridor with their napkin and cutlery. They were not offered support to return to the table and continue their meal. Another person, at risk of choking, was seen to get up from the table and take other people's drinks and staff did not intervene. A person who used the service had on occasions urinated in a small private lounge. The provider's response was to close the lounge off and so none of the people could access this facility. On another unit for people living with dementia, we saw people being seated carefully at the tables, so people could not pick up other's drinks. A care worker was close by and supported people as they needed it.

A person told us that they had asked about certain activities they would like to do. They felt that their ideas fell on 'deaf ears' with the management." Another said, "I spend most of my time in my room, I do not care for the TV and I do get bored." People enjoyed using the activity room but said the staff showed them how to make or do something but they did not have an opportunity to try for themselves. A visitor commented, "There is nothing to keep them occupied, no activities. I think they need something to stimulate them." People were provided with some opportunities to follow their interests and take part in social activities. For example, gardening club, summer fete, school children came in to read to people. A list of planned activities was on display in the management office. However, no activities were planned to happen on the day of inspection on any unit. The provider was in the process of recruiting new staff to provide this service. They stated that they were reviewing activities to improve what they provided for individuals. We saw people on a unit caring for those living with dementia had nothing to do. People living with dementia walked around freely but those at risk from their behaviours were not engaged or supported to fulfil their time otherwise. Staff said they gave the choice of DVDs or played quizzes with them and reminisced.

People on other units were seen to be provided with personal attention and support. For example, one person was getting rather anxious and the staff member offered for them to go for a walk in the garden. They agreed together that they would go and get their coat and go out for a walk. Another person had wanted to stay in bed for a while. The staff member checked on them and offered them some breakfast and a drink when they were ready.

People and their relatives told us they had been involved in developing people's care plans. One relative said, "I am involved and they tell me about everything." People's care plans were reviewed regularly to help

ensure they continued to reflect people's current needs. We saw that people's relatives were involved in review meetings where appropriate.

A relative told us, "We are broadly happy with the care but it's the small things like clothes going missing and there is never any water in the room. It is always 'on its way up'." People were informed about how to make a complaint. Pictorial information was on display in reception. A person told us they would tell, "The ones who are in charge" if they had a complaint but added that they were, "not always around". The provider had received complaints which had been responded to by the registered manager. It was not always clear what action had been taken to learn from issues to prevent them happening again. Relatives had complained about the laundry system. We saw that the system was still an issue for one person who showed us that their relative had received the wrong clothes back on several occasions. Staff did not attempt to support this person or provide an apology.

Requires Improvement

Is the service well-led?

Our findings

The provider held monthly managers meetings to share information across all their care homes and to learn from any shortfalls in service provision. We found that an audit plan was in place for assessing, monitoring and improving the quality and safety of the services provided. This had not been consistently carried out. People could not be assured that the provider reflected on their practice and tried to make improvements. For example, the laundry issue had been formally complained about on two occasions. The laundry service had not been audited by the provider to try to ascertain where things had gone wrong or if any improvements needed to be made. People were still showing dissatisfaction in this aspect of the service. There had been auditing of people's care plans and risk assessments to ensure these were accurate and up to date. The medication system had been assessed and changes implemented to make it safer. The operations and performance manager told us that the provider was reviewing the audit tools they used.

A person who used the service told us, "I don't think we have any (residents meetings) I've not been to one." We found there had been limited opportunities for people who used the service and staff to discuss issues. They had not been able to put forward suggestions and ideas for the service. This was so that any problems or other issues that needed to be addressed could be identified and action taken to improve the service. We saw that two staff meetings had taken place and management said they planned to hold them every two weeks. The provider was yet to start 'resident meetings' so that people's opinions and views could be heard.

Staff were aware of their duty to pass on any concerns externally should they identify any issues that were not being dealt with by the provider. Staff said they had a dedicated 'whistleblowing' telephone line they could use.

Some staff told us that the management was not always supportive and did not listen to what they had to say. Other staff felt the management were approachable and gave good support. Some staff said that they sometimes saw senior management on the units and that the Chief Executive had visited to talk to them.

The provider had a system to obtain feedback from people and their relative via a regular survey. People we spoke to and visitors did not seem to know if they had taken part in any surveys or meetings to give any feedback at all. As this was a new service the survey had not been completed yet.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that action had been taken.