Mr & Mrs A B Satari

Castle Mount Residential Care 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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 1, 5 and 31 August 2016. Our last inspection took place on 21January and 4 February 2016 and the service was rated as 'Inadequate' and in 'Special measures'. The service was inspected within 6 months of the previous inspection to check the service had made significant improvements.

The home had a registered manager who has been registered with the Care Quality Commission since 2 November 2012. 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. There had been concerns at the previous inspection that the registered manager was not at the service on a daily basis in order to meet their regulatory responsibilities. We found at this inspection the registered manager was out of the country on two of the three inspection dates.

Since the last inspection the registered provider had employed a health and safety manager for 20 hours a week to improve this aspect of service delivery and this person had applied to the Commission to register as the manager at Castle Mount.

At our previous inspection we found the service was not safe and had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found significant improvements had been made in health and safety at the service.

The service had personal emergency evacuation plans (PEEPS) for people at the service with a copy in the main file and a copy in people's care files. In addition the service had purchased one evacuation chair to use with people who could not manage the stairs in the event of an emergency evacuation. The service had individual risk assessments in place and was in the process of improving these to ensure all risks were minimised.

At our previous inspection we observed moving and handling procedures which were not in accordance with good practice. We did not observe any poor moving and handling practice at this inspection and we observed staff using appropriate techniques to assist people to move. Information in two care plans relating to moving and handling had not been updated on the first day of inspection but this had been rectified immediately by the assistant manager.

We found the service was recording accidents and incidents but had not developed a system for determining the root cause of accidents or developing themes to prevent further incidents. And although there was a significant improvement in cleanliness, there were still areas such as the lack of liquid soap, toilet paper and hand towels when we arrived on our first day of inspection. This showed the systems in

place had not been effective although this had been immediately addressed and the system changed to ensure this was not repeated.

Staff demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. Records showed recruitment checks were carried out to ensure suitable staff were recruited to work with people at the service.

The service had systems in place to safely administer, store and order medicines appropriately and we found staff had undertaken refresher training and had their competence checked and recorded to confirm they were safe to administer medicines to people.

The service had previously breached the regulation in regard to consent and the Mental Capacity Act and had not referred appropriately for an authorisation when people had been deprived of their liberty. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence the service had referred two people to the local authority for authorisation and the local authority confirmed they had received these. However, we did not find any decision specific capacity assessments in the care files we reviewed for the three people we identified as lacking capacity to consent which was a breach of the regulation in relation to recorded capacity assessments. This was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food and those who required a more specialised diet were provided with this. Kitchen staff kept a record of people's dietary requirements on a board in the kitchen. People's nutritional and dietary needs were being recorded with the responsibility for monitoring these daily sitting with the most senior person in charge on the day.

Staff were receiving regular training, supervision and appraisal to ensure they developed in their role and the local authority workforce development team was supporting the management at the home to develop their staff to ensure a highly quality workforce.

Care plans contained information to enable staff to deliver person centred care such as people's preferences and views. They also had a one page summary at the front giving care staff an at a glance summary of people's support requirements. However, not all care plans were up to date on our first day of inspection.

People were provided with some activities that were meaningful to them and the service was working on their activity programme to ensure they provided activities which people enjoyed and improved their mental wellbeing.

The registered manager did not have a consistent presence at the home to be able to effectively monitor quality issues and this role had been undertaken by the assistant manager and the health and safety manager. The latter was in the process of registering with the Care Quality Commission. The registered manager intended to continue in their role as registered provider at the service.

Although systems and processes of governance in the service were improving, there were areas where there were gaps in the monitoring of quality and where the benchmark of quality had not been set such as the audits of care plans, observation checks of staff, cleaning rotas and the review of accidents and incidents. We found this to be a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what actions we told the registered provider to take at the back of this report.

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

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Improvements had been made in cleanliness at the home and to the safety of the environment but these were on-going and we found some issues around the cleanliness and the work to the environment was on-going.

Staff sickness had meant some staff working long shifts. The health and safety manager was addressing this issue.
Records showed recruitment checks were carried out to ensure suitable staff were recruited to work with people at the service.

Is the service effective?

Requires Improvement

The service was not always effective

The service had appropriately referred to the local authority where a person was deprived of their liberty under the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards, but we found a lack of decision specific capacity assessments in place for those people lacking capacity.

Staff were receiving regular training, supervision and appraisal to ensure they developed in their role and the service was supported by the local authority workforce development team.

People enjoyed the food and where necessary had their food and fluid intake monitored.

Is the service caring?

Good

The service was caring

People told us staff were caring, compassionate and kind.

Staff knew how to ensure privacy, dignity and confidentiality were protected at all times.

Staff recognised the importance of promoting independence in people's everyday lives.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans contained information to enable staff to deliver person centred care such as people's preferences and views. However, not all care plans were up to date on our first day of inspection.

People were provided with some activities that were meaningful to them and the service was working on their activity programme to ensure they provided activities which people enjoyed.

People knew who to complain to if they were not happy with the service. There had been one complaint which had been resolved to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service was not always well-led

Leadership at the service had not been sufficiently provided to ensure the service was proactive in quality monitoring. External and not internal audits had highlighted issues which led to the process of improvement.

We saw evidence that the assistant manager worked hard to improve the experience of people living there.

The health and safety manager was proactive in respect of this aspect of service delivery and we saw that there were some improvements in the management of safety at the home from the previous inspection.

Castle Mount Residential Care 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 1, 5 and 31 August 2016 and was unannounced. The membership of the inspection team consisted of three adult social care inspectors and an expert-by-experience on the 1 August 2016 and one adult social care inspector on 5 and 31 August 2016. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications. The registered provided had not been asked 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. We contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire service, environmental health, the Clinical Commissioning Group, and Healthwatch prior to our inspection to assist us in planning the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed all the information we had been provided from third parties to fully inform our approach to inspecting this service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with six people who lived at Castle Mount Residential Care Home and two relatives on the day. Three people contacted us after the inspection to give us feedback in relation to their relatives who were living at Castle Mount. One by telephone and two emailed information. We observed the lunch time experience in the communal dining area and an afternoon activity in which nine people were involved.

We spoke with the registered manager, the health and safety manager, the assistant manager, the cook, and four care staff. We observed care in communal lounges, the dining area, as well as observing an activity session in one person's bedrooms. We reviewed the paperwork and audits in relation to the management at the service and maintenance logs.

Requires Improvement

Is the service safe?

Our findings

People living at the service told us they felt safe. One person said "I enjoy living here and the staff always come straight away if you need them." We spoke with two relatives who told us they felt the home was safe and said they were always kept up to date with any changes in their family member's condition. One person said, "we are always kept informed."

At our previous inspection we found the service was not safe and had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found significant improvements had been made. For example, at our last inspection, the service did not have a fire evacuation policy and staff had not received any fire evacuation training. At this inspection we found the service had a fire evacuation policy in place and staff had received training. The service had documentation from the fire service to confirm they were no longer in breach of fire regulations and had completed the actions required. The service had personal emergency evacuation plans (PEEPS) for people at the service with a copy in the main file and a copy in people's care files. In addition the service had purchased one evacuation chair to use with people who could not manage the stairs in the event of an emergency evacuation. The health and safety manager had completed a risk assessment and specific evacuation plan using this chair for the two people cared for in bed. We asked whether the evacuation chair was required to be added to the PEEPS of other people at the service and we were told by the assistant manager and the health and safety manager, in the event of a fire when the stairlift could not be used to evacuate people, all the other people at the service could be assisted to walk down the stairs as outlined in their plans.

At our previous inspection we observed moving and handling procedures which were not in accordance with good practice. We did not observe any poor moving and handling practice at this inspection as staff were using appropriate techniques to assist people to move. We found inaccurate information in two care plans relating to moving and handling. The records for one person stated they required the use of a stand aid and two carers to stand when in fact they were dependent on a hoist for transferring. This meant that there was a risk that people could be handled inappropriately due to the lack of accurate detail in the moving and handling care plan. Although on discussion with permanent staff, they were aware how to support people at the service. We found the issue with inaccurate records at the last inspection. The deputy manager told us they were in the process of updating all the care plans and had completed two fully by the first date of inspection. The care plans had all been updated by the final date of inspection.

We saw records which showed moving and handling equipment was regularly tested to ensure it was safe to use and the stair lifts were under a maintenance contract and had been inspected the week prior to this inspection.

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They told us they would report any concerns to the assistant manager in the first instance. Staff also knew the principles of whistleblowing (the duty by a staff member to raise concerns about unsafe work practices or lack of care by other care staff and professionals). They assured us they knew

the whistleblowing process and would not hesitate to report any concerns

We asked the assistant manager how they determined staffing levels and whether they used a dependency tool. They told us they did not use a dependency tool and they worked out staffing levels on their knowledge about the needs of the people using the service and would change staffing levels if people needed to be escorted to appointments. However, we found a dependency tool in all the files we looked at which was reviewed monthly by the assistant manager. There was no guidance to accompany this and there was no evidence to support this was being used to determine staffing levels and this was confirmed during our discussions with the registered manager. The registered manager told us they discussed staffing levels each week with the assistant manager to determine the appropriate staffing levels.

Prior to the inspection we had been notified there had on occasions only been two care staff at the service and they had been supporting people elsewhere in the building leaving the communal areas without staff. We discussed this with the assistant manager and the registered manager who told us the rota's had recently been changed as people using the service were choosing to go to bed later which meant the night staff were assisting people to bed and also assisting them to get up. The rotas had been changed so the night staff started work at 10 pm and a day care staff started work at 6 am to assist the night staff to get people up. On review of the recent rotas this change had not yet included the weekends but we were told they were still in the trial period. We noted two members of night staff had covered 16 hour shifts due to staff sickness but the health and safety manager told us they were implementing a system to proactively manage sickness at the service.

The service had used agency staff to cover shortfalls with staffing due to sickness. The health and safety manager told us the agency staff received an induction into the home and signed to say they had read the fire risk assessments. They told us agency staff do not assist with the administration of medicines.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. There had been 13 accidents and incidents recorded in the previous four months mainly consisting of falls. We could find no evidence to support an analysis of the information to determine the root cause and to prevent future incidents. The associated documentation did not assist the registered manager to determine any trends or patterns in relations to incidents. The health and safety manager told us the incidents were not at present analysed. The assistant manager told us people who had fallen were put on observation following falls but we saw evidence that this had not been the case in every situation.

As part of our inspection process we look to see how the service managed medicines. We observed the morning and lunchtime medicine round. We inspected the ordering systems, supply, storage, stock control, administration, training and auditing of the home's medication and found an improvement from our previous inspection. At our previous inspection we found the home did not undertake competency assessments for care staff to ensure they were competent to administer medicines. At this inspection we found the service had undertaken refresher training and staff had their competence checked and recorded to confirm they were safe to administer medicines to people. The home had recently changed supplier of their monitored dosage system and supplier of medicines. The new supplier as part of their contract aimed to complete three unannounced inspections a year to ensure the service was meeting the national guidance on medication administration in care homes.

At our previous inspection we found issues with cleanliness and maintenance of the environment and the service was found to be in breach of Regulation 12 and 15 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. Improvements had been made to both the environment and the cleanliness.

We found substantial improvements had been made and an on-going plan of refurbishments in place. The health and safety manager audited the environment on a weekly basis. Area had been repainted and replacement of carpets was on-going. We still found issues in some rooms with bedside lamps not working, no bedside tables and some vanity lights not working but these were being monitored. At the previous inspection we found trailing extension leads and overburdened electric sockets. The health and safety manager and the registered manager informed us an electrician had been commissioned to install new electrical sockets at the service and by the 31August 2016 these had been installed.

The home employed one cleaner during the week who was employed 9 am-5 pm. At the weekends and other times carers were expected to undertake all the domestic work with the assistance of an apprentice carer. At this inspection, we found significant improvements in cleanliness and we were told there had been a deep clean at the service the week before our inspection and extra staff had been brought in to the service for this purpose. There were still areas which could be improved and which were issues at our previous inspection such as dust on the stairlift footrests and the oven had some burnt on residue. On the final day of inspection the cook showed us their cleaning rota for the oven which showed it was cleaned with a special solution once a month and maintained by an external company who was present on the day of the inspection to replace the oven door. We were also shown a new responsible person checklist which was a weekly checklist the responsible person had to complete to ensure full compliance with the necessary infection control standards which the health and safety manager monitored.

We found no toilet paper, liquid soap or paper towels in the downstairs communal toilet and missing liquid soap, drying towels and toilet paper in some of the en-suite facilities. When the assistant manager approached the staff member responsible they were told that had looked for replenishments but could not find the stock. Both the registered manager and the assistant manager agreed this was not acceptable, there were plentiful supplies at the service and they told us as a last resort staff could have gone to the local shop. They told us they always had a backup of supplies for both PPE and products to ensure the service did not run out. However, the lack of these facilities on the day of our inspection demonstrated the service did not have effective systems in place to ensure the spread of infection was minimised. By the final day of inspection, the assistant manager had improved the system for checking supplies and we found these to be present in the communal toilet and in the bedrooms we re-checked.

Requires Improvement

Is the service effective?

Our findings

We asked people living at Castle Mount whether they liked the food and they all told us they enjoyed their meals. People told us they could have snacks in between their meals, and one person told us there was "a fruit bowl that always has fresh fruit in". We observed the lunchtime experience at the home and found there to be a good rapport between people at their table. Meals were brought from the kitchen ready plated with gravy at the table served by one of the people living at the home. One person changed their mind at the table and was offered an alternative choice. People had a choice of two desserts and were offered a drink during the meal.

People who required a more specialised diet were provided with this and the kitchen staff had people's dietary requirements on a board in the kitchen. One person said, "The staff make sure I don't have the sugary stuff like chocolate and sweets". We observed this person after the afternoon activity in which other residents were given sweets and biscuits and this person requested scrambled eggs instead." One relative who wrote to us said, "[Relative] has special needs now and she is checked on constantly and always encouraged to drink and eat." People who required assistance to eat and drink had their fluid and food recorded. The health and safety manager was undergoing further work on this form to ensure the responsible person on each shift totalled the information recorded to evidence the service was actively monitoring the desired range for each person on a daily basis and actions were put in place when necessary, such as contact with the GP or dietician.

We observed two snack times during and after the afternoon activity. People could choose whether to have a piece of fruit, some sweets, and a biscuit or could request a light snack such as toast. This demonstrated the service was adequately ensuring the nutritional and hydration needs of people at Castle Mount were being monitored and met.

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 Deprivation of Liberty Safeguards, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence the service had referred two people to the local authority for authorisation and the local authority confirmed they had received these.

At our previous inspection we found the service was in breach of Regulation 11 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014. Need for consent as care and treatment was not provided with lawful consent. The registered manager provided us with an action plan advising the service would be compliant by June 2016. We found the majority of people at the service had capacity to consent to care and treatment. Although there was a lack of written consent in people's care files to evidence consent had been sought, we saw staff consistently seek verbal consent throughout the day. We saw evidence in the care plans of written consent in relation to photographs.

At this inspection we looked for the evidence to support people at the service, their visitors and visiting professional had consented and were aware of the CCTV cameras but this evidence could not be found. In addition, the stickers alerting to the cameras had been purchased but not placed on the cameras to alert people to their presence. The stickers were placed around the building during our inspection by the health and safety manager. When we revisited on 31 August 2016 the service had obtained signed consent forms from people using the service who could give informed consent. Care staff had also signed to consent to being filmed.

Three people lacked capacity to consent to care and treatment. The home had requested families provided them with a copy of their registered power of attorney. We saw that the provider had been supplied with a copy of the relative's registered Enduring Power of Attorney. We advised the assistant manager this gave the attorney the power to manage property and financial matters on their behalf and not health and welfare decisions. They advised us they would inform the families of these people as the families were unaware of this. Without a lawful power of attorney there is a requirement to follow the Mental Capacity Act to ensure the service obtained the lawful consent in relation to health and welfare decisions, and we found they had not. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had not obtained the lawful consent of all the people using the service.

We checked at this inspection whether the service was working to the principles of the MCA. We did not find any decision specific capacity assessments in the care files we reviewed for the three people we identified as lacking capacity to consent, apart from those in relation to DoLS and we were told by the assistant manager and the registered manager they had not completed any. Both were not able to demonstrate a working knowledge about the application of the Mental Capacity Act apart from the Deprivation of Liberty Safeguards and the assistant manager told us if a person needed a capacity assessment "They would contact the person's social worker." However by the third date of inspection this lack of knowledge had been rectified by the assistant manager and they with the assistance of the health and safety manager had an action plan in place to ensure those people requiring assessment had a recorded assessment in their files. All staff had been booked onto a refresher course with the local authority. However, the lack of recorded capacity assessment demonstrated a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told all staff had completed the Care Certificate or the Common Induction Framework but as the service was in the process of changing to a new training provider, all staff would be completing an on line tool to ensure staff new and old were working to the same standards. We were told staff were in the process of starting and completing Level 2, 3,5 and 7 NVQ in care and management to ensure they had the skills to develop the service. The local authority Workforce Development Team was supporting the service with an action plan to ensure the workforce developed in line with national good practice.
We were shown the training matrix which showed staff had received or were in the process of attending all the mandatory training required in the health and social care field. The assistant manager told us staff received four supervision sessions each year. We saw the supervision matrix which showed all staff had

received supervision and staff confirmed they had received supervision. However, the records of supervision were not held at the service and we could not therefore verify the quality of the supervision staff received to support their development. The registered manager was responsible for undertaking staff appraisals and staff had received an appraisal annually.

We found the service was working with other health and social care colleagues to ensure the best outcomes for people. Staff told us they worked with district nurses, GP's, speech and language therapists and the dietician to ensure people were supported to maintain their health. We saw evidence of this in the care files we looked at and from our discussions with people using the service. One relative told us, "If there is a problem or mum is unwell the doctor is called immediately."

The lack of wheelchair accessibility around the home for people living at the service was a concern. The registered manager told us they had sought permission from the local authority to install a through floor lift, but had been advised they could not make the alterations required due to the Grade 11 listing status. There was only one shared bedroom on the level with the communal facilities and the ramped access to the rear of the property. All other areas were accessed by a stairlift. There were two people cared for in bed on the first floor and they did not have access to the communal areas situated on the ground floor or access in and out of the home as this was provided on the ground floor.

We had concerns during this inspection regarding the space in the dining room. We observed one person abandon their walking frames in the communal lounge to walk into the dining area because of the lack of space to walk around the fire place and between the tables. Another person was advised to hold onto the medicines trolley as there was a lack of space for their frame in the dining room. When this issue was raised with the management team they agreed to investigate an alternative dining area to reduce the risk of trips and falls for people living at the home. The home was in the process of improving access to the downstairs communal toilet on the last day of inspection and the doorway had been widened to improve access with a Zimmer frame. As part of the consideration of improving space at the home, the health and safety manager told us they would look again at the feasibility of installing a wheelchair accessible ground floor toilet.

Good

Is the service caring?

Our findings

We asked people using the service whether the staff were caring when providing support. All the people we spoke with commented on the caring nature of the staff. One person told us, 'The staff always help if I've got any problems. I always feel like I can talk to them'. Another said, "The staff here is lovely. Some of us even got invited to one of their weddings the other week." Other comments included, "I get on well with all of the staff. The night time staff seem to have less time for you but they're alright. But during the day you can't fault them."

One relative who wrote to us following the inspection said, "The staff led by [assistant manager] are so caring, for me being a distance away I never have to worry. I am always kept informed as to any changes in [relative's] health and am phoned on the rare occasions that [relative] asks about me which is very reassuring." Another relative who wrote to us following the inspection said, "The home is amazing, and keeps the true values of what the word Home means to every single human being."

People told us there were no restrictions when family could visit. One person said "Family can visit whenever they want". We asked people whether their spiritual and religious needs were being met. One person told us, "'I can't go to church anymore unfortunately. I would like to go on Sundays but I would need a lot of support as I struggle to walk". We discussed this with the registered manager who was surprised at this comment as they were supportive of this person's religious needs and staff were always available to take this person to church but they declined. This was also verified by one member of staff we spoke who told us there was a group of people who used to go to church but the group has reduced to one person, and even though they encourage the person, they have told the staff they no longer want to go to the church.

The assistant manager and the health and safety manager told us they spent time observing staff and their interactions with people using the service. They had a formal observation for staff when administering medicines which included whether this was done with respect to privacy and dignity and they were to extend this process to a more formal recorded observation during care interactions.

We saw the importance of dignified and respectful care provision was written into people's care plans to remind staff how they liked their care provided and to ensure curtains were drawn whenever privacy required this. Staff told us they always respected people's privacy and dignity such as ensuring people were covered during personal care and both the curtains and doors were shut and we observed this during our inspection. For example, we saw staff knocking on people's doors and discreetly asking people if they required assistance to use the toilet. We observed moving and handling practices where staff explained to people what they were about to do to ensure the person was fully involved in the process. We also saw people being supported to eat appropriately and discreetly. These examples, demonstrated the staff were providing dignified care during our inspection.

Care staff told us they encouraged people to be as independent as possible throughout personal care. We

observed people being encouraged to get up and walk during the day and staff told us they encouraged people to maintain their level of independence during activities of daily living.

The service had limited capacity to support people at the end of life due to the layout of the building and lack of accessibility between floors. However, they had plans in place to support people at the end of their lives where this had been identified.

Requires Improvement

Is the service responsive?

Our findings

We asked people living at the home whether the support provided was responsive to their needs. One person told us, "I always get support when I need it and they always try to support me if I want to go out such as to get my pension. I need to give them a bit of notice but they do help me."

The assistant manager told us they always assessed people before accepting them to the home to ensure the home could meet the needs of the person. They told us the night before our final inspection date, they had been contacted late at night by the local authority encouraging them to take a person without first assessing them due to a crisis in the person's care arrangements. They told us they recognised the importance of a pre-admission assessment to ensure the safety of the people at the service and to enable them to be responsive in providing care to the person. They advised the caller they would not take the person which showed us they understood their responsibility in relation to accepting people to the home.

We looked at five care plans as part of our inspection. Care plans contained information to enable staff to deliver person centred care in areas such as nutrition, medication, mobility, tissue viability, cognition. Information was person centred and detailed information about how to care for person and information such as what the person liked to wear and whether they were able to choose their clothing. There was detailed information in how people liked to wear their make-up and what face creams they liked staff to use. The assistant manager had completed a summary of care sheet at the front of the care plan to summarise how the person liked to be cared for. Where completed these were detailed and provided a good profile for staff to follow at a glance. We found the odd section which required further clarification as one record in relation to brushing teeth stated "refuses to brush their teeth" without a further explanation of how this person could be encouraged with oral hygiene. We noted all care plans had been reviewed and relatives told us they could inform the review and contribute to the process.

Whilst we saw evidence of effective personalised recording, on the first day of our inspection not all the records had been completed to this standard, as the assistant manager explained, there had been so much to improve, and staff holidays and sickness to cover, they had not managed to complete this task and some records contained out of date information which posed the risk of inappropriate care provision. The assistant manager had updated the records by our final date of inspection but this demonstrated a lack of oversight from the registered manager to ensure this important aspect of care was completed to the highest of standards and monitored for sustained improvements. We discussed the quality of paperwork completion with the registered manager who acknowledged they still had further improvements to make around paperwork and they had plans in place to ensure this was improved. This included developing staff in their care plan writing skills and also using tablets to assist recording. The local authority was assisting with the provision of training and development in this area.

We found bedrooms were personalised and people had been encouraged to bring in items from home. Personal items such as photographs, ornaments and bedding decorated people's rooms. Furniture which had been in a state of disrepair had been repaired. People's choices and preferences were recorded in their

care plans such as what they liked to eat, what they didn't like to eat and where they liked to sit. People told us they were able to exercise choice during the day in how they wanted to be supported and they told us they could get up and go to bed when they wanted.

We asked people and their relatives if they knew who to complain to if they were not happy about an aspect of care. One person told us, "I can tell a member of staff if I have any concerns. I don't know who the manager is though… [name]- something I think". People told us they would speak with the assistant manager but they told us they had not had any concerns. The service had received one complaint which we had been made aware of and this had been resolved to the satisfaction of the complainant, although it was not easy to see this from the records held at the service. The service had received many compliments although the many cards pinned on the notice board, had not been date stamped to verify when these had been received.

During our inspection we asked people whether they were supported to undertake meaningful activities during the day. One person said, "There's always lots to do" and another person said "We don't seem to go out a lot here". We reviewed the minutes of the latest residents meeting which considered outings and five people out of the fourteen had shown interest in more outings, although other people were not interested. Other comments were positive about the exercise class and another person said, "I can amuse myself." The management team were looking at more variety with activities and were taking the comments from people on board. Activities were provided Monday –Friday for two hours with volunteers from the local school assisting at the weekend. We spoke with the person providing activities during the week and they told us they had reviewed all the activities on offer and had renewed the timetable of activities. However, they were due to leave to take up studies and the assistant manager told us they were to employ an apprentice to provide activities going forwards. We observed the activities person undertaking one to one activities with one person cared for in bed and chair games with a group of people. We could see people were enjoying themselves and partaking in the programme. The assistant manager told us they had recently organised a birthday party for one person who lived at the service. This person wanted to choose their birthday cake, balloons and decorations and the assistant manager had taken them to the shops to facilitate this. They also had an entertainer to the service for a birthday sing-along. The assistant manager told us the improvements around activities was a work in progress and the home was determined that all people living there would be involved in activities that would have meaning to them to ensure their mental wellbeing.

Requires Improvement

Is the service well-led?

Our findings

We asked people at the service and their relatives whether they thought the service was well-led. One person told us, "'I'm always asked if I'm alright but I don't do any surveys or anything". One relative told us, "I don't know who the line manager is. Apparently she has another job as well". Another relative told us, "I can speak to the deputy manager a lot and I'm always kept informed as to how my mum is doing. If I have any concerns I can raise them with [assistant manager]."

There was a registered manager in post. They had been registered since 2012 and had been the registered provider since purchasing the home 15 years ago. The service provides the regulated activity of accommodation for persons who require nursing or personal care. This regulated activity is required to be supervised by a registered manager. However, we found the registered manager had limited on site presence at the home and had full time employment elsewhere and was often not in the country. Day to day running of the home was undertaken by the assistant manager with additional support provided by a health and safety manager who was present for 20 hours a week on a Wednesday, and at the weekend. We were told this manager was in the process of registering with the Commission as the registered manager at the service and the current registered manager would de-register and continue in the role of registered provider. Effective leadership at a service is essential to drive up the standards of care and to continuously promote improvements in quality of the service provided. We found this leadership lacking at Castle Mount due to the regular and frequent absence of the current registered manager which meant that the service had not been adequately monitored.

The lack of leadership from a registered manager meant the service was reactive and not proactive and we saw that improvements had been made as a result of audits from the local authority, infection control, the fire service and the Commission's inspection rather than from the service's governance arrangements. However, the registered manager had determined since our previous inspection that they required a registered manager in post with a strong presence at the location to ensure the service sustained improvements made against these external audits and it was evident at our inspection that systems and processes were starting to be changed. The system of audits was improving to show effective monitoring although it was too early to determine their sustained effectiveness. The service had yet to monitor themselves against the CQC fundamental standards of care but we were told these audits would take place in the near future.

Staff told us the assistant manager was supportive. They also told us the health and safety manager had made a difference and had improved how the service was run. One member of staff said "Things are better now. There was nothing wrong with the care side but we have improved in the recording and evidencing of what we are doing."

At our previous inspection we found the service to be inadequate and in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made at the service, but further improvements were still required. We found significant improvements in the management of health

and safety at the service. This had been of great concern at the last inspection and we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The health and safety manager had implemented systems around maintenance and checked reported issues with the environment had been completed. They had ensured the breaches in relation to fire safety and the lack of PEEPS had been addressed and we saw the evidence the service was no longer in breach of fire regulations. Staff had also received the necessary fire evacuation training. They undertook a walk around once a week to check each room and communal area to ensure maintenance work had been completed and to identify areas requiring improvement. These checks were documented and we saw the evidence of these.

We asked the assistant manager and the health and safety manager how the registered manager and registered provider were kept involved with the running of the home when they were not at the service. They told us they provided feedback to the registered manager on a weekly basis, either in person or over the telephone and they had set up a cloud based document store. The feedback from the weekly meetings was not recorded to demonstrate it was used to effectively monitor the quality at the service. The management team had monthly meetings at the service and we were sent the minutes of the three previous monthly management meetings following our inspection which showed that issues around improving the service were discussed and that actions had been allocated for completion.

We did find specific quality monitoring areas which required further improvements such as a more effective system to identify potential issues with infection control practices and the analysis of incidents and accidents. We found the system to check the toilet paper, liquid soap and paper hand towels had not been effective as we observed this to be lacking in the communal toilets and in some en-suite's on the first day of our inspection. Improved systems were in place on the final day of our inspection, but these changes needed to be embedded and sustained to ensure they were effective. We found the analysis of accidents and incidents to determine themes had not been completed and the health and safety manager told us they would take on this role to determine themes which would enable them to put in measures to minimise future incidents.

Policies and procedures had been updated but still contained reference to out of date legislation For example, the home's statement of purpose had been updated in March 2016 but included out of date references to the Care Standards Act and national minimum standards. Improvements to the audit of care plans needed to be put in place to ensure these were continually monitored for quality.

We found that although various competency checks on staff were recorded as undertaken but lacked detail to evidence what they were measuring against. For example, the moving and handling competency check for July 2016 records "Moving and handling techniques are ok." And the infection control competency observation records "Observed no issues with infection control." This was an improvement on our last inspection when we found competency checks on staff were not happening. However, more detailed information was required to benchmark what the checks were measuring.

The above evidenced a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was not assessing, and monitoring the service against a baseline to ensure they continually improve the quality of the service provision.

We asked the assistant manager about the culture at the service. They told us "I enjoy the atmosphere, the residents. I feel happy in myself helping others. I go out of my way to help people to enjoy the lives they have." They shared their vision for the service, "I want to improve the quality of life for the residents. How they are living their lives and how we can improve it."

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. These were happening at the service and we reviewed the minutes of the latest meetings which showed they were being used appropriately to inform staff about the service and give the staff an opportunity to feedback to the management about how the service was run. We also saw the minutes of a residents meeting which had been held on 25 May 2016 which looked at various issues of service provision. People using the service and their relatives had also completed a service user satisfaction questionnaire, and on reviewing this we found the service was effectively monitoring the views of people using the service to drive up the personal experience of people living at the home.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in line with lawful consent for people at the service who could not consent to care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack or recorded decision specific capacity assessments Failure to adequately monitor and audit the service to improve the quality of the service provision