P & C Care Limited

The Mount Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We inspected The Mount Nursing Home on 17 & 19 June 2015 and the visit was unannounced. Our last inspection took place on 8 January 2015. At that time, we found breaches of 11 regulations; consent to care and treatment, staffing, safeguarding, respecting and involving service users, care and welfare, safety and suitability of the premises, cleanliness and infection control, supporting staff, complaints, records and assessing and monitoring the quality of service provision. We told the provider to make improvements by 30 April 2015. On this visit we found very little improvement and identified continued breaches of the regulations.

The Mount Nursing Home is a 40-bed service and is registered to provide accommodation and personal care for older people, people living with dementia or mental health conditions. Nursing care is provided. At the time of our visit there were 27 people using the service.

The accommodation for people is arranged over two floors. There are single and double bedrooms and some rooms have en-suite toilet facilities. There are communal bathrooms and toilets throughout the home. The communal rooms are on the ground floor and consist of two interconnecting lounges and dining room and separate lounge.

Summary of findings

The home has a registered manager who is also one of the owners. 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 and staff were not recognising or reporting incidents between people using the service which we judged were abusive and were not taking action to keep people safe.

The environment was not well maintained, with some areas unsafe due to lack of maintenance. Some equipment servicing and checks on electrical safety were overdue.

On both days of the inspection the home smelt strongly of stale urine and we found areas of the home were unclean.

The staff recruitment process was robust and there were enough staff on duty to meet people's needs. However, not all of the staff were up to date with their training and some had completed training but had not achieved the required 'pass' mark.

The systems in place for managing medicines were good and people received their medicines at the right times.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's views about the meals were mixed but we saw people's weights were closely monitored to make sure people were getting enough nutrition. The records also showed people were being seen by a range of health care professionals.

Although we saw individual care workers treat people with kindness and patience, people were not always being supported to live a dignified and independent life.

The risks to individual people using the service were not well managed and appropriate action was not always being identified or taken in order to reduce those risks.

There was complaints procedure in place but no concerns or complaints had been recorded.

We found the service was not well led. The quality systems in place were not effective and some records were not readily available. The visitor's survey had highlighted areas of the service people were unhappy with but no action plan had been developed to show how improvements would be made.

Overall, we found significant shortfalls in the care and service provided to people. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

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

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

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

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

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not recognising some incidents between people using the service as being abusive and were not reporting them to the local authority safeguarding team.

The environment was not well maintained, there were areas that were unsafe and areas that were not clean.

Staff were recruited safely and there were enough staff on duty to meet people's needs. Medicines were managed safely and people received their medication at the right times.

Is the service effective?

Requires improvement

The service was not always effective.

Not all of the staff had completed the training they needed to care for people effectively and safely.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Meal times were not well organised but staff were monitoring people's weights closely and taking appropriate action when people were losing weight.

Records showed people had regular access to healthcare professionals, such as GPs, psychiatrists and chiropodists.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always being supported to live their life with dignity or to maintain their independence.

We individual care workers treat people with patience and kindness. People using the service and visitors told us they liked the staff and found them caring and helpful.

Relatives told us they could visit at any time and were always made to feel welcome.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were completing some assessments to identify risks to individuals but were not always taking appropriate action to reduce those risks.

Summary of findings

There was very little on offer to keep people occupied, stimulated or entertained. We found people just sitting in the lounge areas or walking around.

A complaints procedure was in place but no complaints or concerns had been recorded.

Is the service well-led?

Inadequate 

The service was not well led.

We saw the results of a visitor's survey which had been completed in January 2015. There were areas of the service people had said they were unhappy with. There was no plan to show what action was being taking to make improvements based on this feedback

Some of the records we asked for were not readily available and were not sent to us following the inspection. Due to this we were unable to confirm whether some key quality processes took place.

Although there were some systems in place to look at the quality of the service these were ineffective and had not identified many of the areas for improvement that were identified during our visit.

The Mount Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 & 19 June 2015 and was unannounced.

On the 17 June 2015 the inspection team consisted of two inspectors and one expert by experience in older people and older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the 19 June 2015 the inspection team consisted of three inspectors and one inspection manager.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams and the fire service. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the days of our inspection we spoke with; 18 people who lived at The Mount Nursing Home, five visitors, the registered manager, company secretary, deputy manager, two nurses, two night care workers, five care workers, the maintenance person, chef, laundry assistant and housekeeper.

We spent time observing care in the lounges and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; eight people's care records, staff recruitment records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

When we inspected the service in January 2015 we found staff were not recognising or reporting safeguarding concerns. We issued a warning notice telling the provider and registered manager they must make improvements by 14 March 2015.

On this inspection we again found staff were not recognising and reporting safeguarding concerns.

One person using the service told us, "It's like hell. I wouldn't put even a dog in here. I'd rather shoot it. There's nothing to do. Sometimes I like the food, but it's rare. The staff aren't bad, but it's everyone for themselves. People are arguing. Coming here is the biggest mistake of my life. I'd rather be dead than here. It's terrible. The staff are alright but there's nobody to talk to."

On the first day of our visit we heard one person being verbally abused by another person who was using the service. This happened on a number of occasions and involved the use of offensive language. The only intervention staff made was to call the person who was being verbally abusive by name. On the second day we told the registered manager about the abuse we had witnessed and they asked us if we expected them to contact the safeguarding team every time someone swore. The registered manager also told us this was not their usual behaviour and that the presence of the inspection team must have been the cause. When we spoke with staff they told us the behaviour was not unusual and they used diversion to reduce the person's swearing.

Staff we spoke with were able to tell us the triggers for the person's behaviour and how this could be prevented. This demonstrated a lack of understanding of the nature of the verbal abuse and the need to protect other people from being subjected to this. Staff who witnessed the verbal abuse did not identify it as a safeguarding issue and took no action to protect the individual being sworn at. We looked at the daily records and the nurse had written, "Mood remains variable and they were reassured and supported was shouting and swearing at fellow resident," but there was no further intervention or strategy recorded to prevent a re-occurrence.

Another person living at the home told us they felt, "Harassed" by another individual living there. This was because the person was walking in and out of the lounge where they were sitting. Staff confirmed this was why the person felt harassed; however, there was no plan in place to manage this situation and meet the person's emotional needs

On the first day of the inspection we saw two males who lived at the home masturbating in the communal areas. This was not identified by staff. We asked the registered manager about this and they told us one person did masturbate but only did this in the privacy of their bedroom and disputed our feedback regarding the second person stating this could not have happened.

Staff we spoke with confirmed some of the behaviours we had witnessed on the first day of our inspection were not out of the ordinary. When discussing one person who we had seen expressing disinhibited sexual behaviour one staff member told us, "It is every day nearly, but sometimes he just puts his hands down his trousers." The staff member explained how they managed the situation in a discreet and sensitive way. However, they told us they were not aware of any care plan in place for this person to inform all staff on how best to support the person.

We made safeguarding referrals to the local authority after our visit on the first day so someone independent of the service could look at these issues.

Staff we spoke with were clear they would report any incidents of abuse involving staff practice. One staff member told us, "Although we are close [as a team] we would not tolerate anything in others." However, it was not clear that staff recognised incidents of abuse when these were perpetrated by people who used the service.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in January 2015 we found the premises were not well maintained. We issued a compliance action and asked the provider to send us a report telling us what action they were going to take to make improvements. On the action plan we were sent the provider told us they would be compliant with the regulation by 17 April 2015.

On this inspection we found the following issues; In two bedrooms the sash windows were bolted open. We undid the bolt on one and the window closed with force, this could have caused an injury if someone using the service

had done this. In one ground floor bedroom the window opened wide enough for someone to climb in or out of the bedroom. On the ground floor there was a sloping piece of floor in the corridor there was no indication of this and could be a hazard. The lighting level in bedrooms was poor, with low energy bulbs in use, and some wall lights were not working. For anyone with poor vision this could pose a risk. In one room the seat of the commode was split, staff confirmed this was in use by the person in the bedroom. This could have caused the individual an injury.

Signage around the service was poor and there was very little in place to assist people to find their way around. Some laminated 'red arrows' had been put up to assist one person to find their way to the toilet. There were no orientation boards and the menu was not on display. The carpets in the lounge areas were heavily patterned and not suitable for people living with dementia.

The servicing of the hoists was overdue. They should have been tested 18 May 2015 and the electrical installation tests should have been completed in March 2015. This meant the necessary tests to check continued safety had not been made.

We saw there were two files which contained the personal emergency evacuation plans (PEEPS) for people using the service. These plans detailed what support people would require in the event of a fire to keep them safe. At the time of our visit there were 27 people using the service. We noted in one file there were 22 (PEEPS) and in the fire folder there were 25. This meant some of the evacuation plans were not available should an emergency arise. This could put people at risk of not being evacuated in an emergency.

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

When we inspected the service in January 2015 we found areas of the home that were not clean. We issued a compliance action and asked the provider to send us a report telling us what action they were going to take to make improvements. On the action plan we were sent by the provider, they told us they would be compliant with the regulation by 17 April 2015.

On this inspection we found the home smelt strongly of stale urine on both days of our inspection. The lounge carpet was dirty and sticky in places. We found some mattresses, cushions and chairs which smelt of stale urine.

We also found some dirty and stained commodes. The protective bumpers for bedrails were worn exposing the padding. This meant they could not be cleaned effectively. The underside of the bath chair was dirty and there were no lids on two clinical waste bins.

In some of the bedrooms it was very difficult to get the paper towels out of the dispensers. This meant it would be difficult for staff to get them out to dry their hands.

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

Following our visit on 8 January 2015 we contacted the fire officer and asked them to visit as we had concerns about fire safety. The fire officer served an enforcement notice requiring the provider to make improvements. We contacted the fire service before this visit and they told us the improvements they had asked for had been completed. We spoke with the night staff who were able to give a good account of the fire procedures and about the practical training they had enjoyed. However, some of the other staff we spoke with had a limited knowledge of what they should do in the event of a fire breaking out.

When we inspected the service in January 2015 we found there were not enough staff on duty to provide people with the care and support they needed. We issued a warning notice telling the provider and registered manager they must make improvements by 14 March 2015.

On this visit we found more consistent staffing levels were maintained. Some staff had recently transferred from another home owned by the provider. Rotas showed that adequate staffing levels were planned and that there had only been reduce staffing on occasions where staff had rung in sick at short notice. Staff we spoke with told us there were always enough staff to meet the needs of people who used the service. One staff member told us, "I like to spend an extra five minutes with people."

We looked at the recruitment files for five members of staff. There was evidence that safe recruitment practices had been followed with pre-employment checks carried out before staff started work. The provider regularly checked the pin numbers of registered nurses to ensure they were still registered to practice. This protected people who used the service from the risks associated with employing people who were not suitable to work with vulnerable adults.

Inadequate

Is the service safe?

People received their medicines when they needed them. There were procedures in place for the safe administration of people's medicines which we observed in practice. We saw people's medicines were securely stored in appropriate cabinets and trolleys and were administered by registered nurses. A member of staff said, "I have not worked here long therefore I ask experienced care staff when I am unsure of people's identity even after I check their photograph." We witnessed this throughout the second day of our inspection. We looked at medicine administration records and noted medicines were recorded when received and when administered or refused. This gave a clear audit trail for us to see. We checked a random sample of stock balances for medicines and these corresponded with the records maintained. Protocols were in place for the administration of 'as required' PRN medicines. Protocols also existed for the administration of variable dose medicines such as Warfarin. This meant people received appropriate medicines when needed and ensured people received a consistent approach from the staff who supported them.

Requires improvement

Is the service effective?

Our findings

When we inspected the service in January 2015 we found staff were not receiving supervision and staff training was not effective. We issued a compliance action and asked the provider to send us a report telling us what action they were going to take to make improvements. On the action plan we were sent the provider told us they would be compliant with the regulation by 21 April 2015.

The majority of staff we spoke with told us they received regular training that they believed equipped them to do their work to the required standard. Much of the training was delivered via Social Care TV and on-line. One staff member told us "We had dementia training via Social TV – the sections are from one to three minutes in duration. You get five questions and then you're done." Another staff member was able to talk in detail about night-time fire evacuation procedures. A third staff member told us, "I've been late with mine so they've chased me to do it. They were on my case." The registered manager told us they had also been working with staff using role play to help them understand their role. This included supporting people refusing care interventions.

We found that the training that had been completed had not always been effective and that some shortfalls had not been addressed. For example, three staff we spoke with were not aware of the evacuation procedures to be followed in the event of a fire despite having completed their fire awareness training. The results of training assessments also showed that staff might not have understood the training they had completed. For instance 20 percent of qualified nursing staff and 50 percent of care staff had failed to reach the required standard on the promoting continence assessment. The provider's training matrix also showed that training was still outstanding. 27 percent of nursing staff had not completed training in infection control or moving and handling. There was no one subject area where training was fully up to date. One member of staff told us they felt staff would benefit from additional support and guidance around behaviour management plans and the approach to use with specific individuals to help them manage their behaviour and prevent avoidable anxiety. When referring to one person who used the service they told us, "I sometimes just don't know what to say to him."

Most staff told us they felt supported and had received supervision. We looked at the records of supervision meetings that showed most had been completed since March 2015. We saw that a common theme was the need for more training. Although 15 staff had received supervision in March 2015 we saw this had reduced to four in April, two in May and three in June. One staff member who had transferred from another location told us they had received an induction but had not had any other form of supervision since transfer. One staff member told us there were staff meetings but they had not attended the last one and needed to, "Catch up."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with one person, on two separate occasions, who told us they were fed up and described wood by the bed that was preventing them from getting up. We looked in their bedroom and saw bed rails were in place. We spoke with their relative who told us they thought the bed rails were the best option as they were concerned about their relative falling out of bed. We asked the deputy manager where the consent for using bedrails would be and they gave us the persons file. We could not find the consent form and asked the registered manager. No consent form was produced. This meant it was not clear how the decision to use bedrails had been made or how consent had been gained.

When we inspected the service in January 2015 we found the Deprivation of Liberty Safeguards legislation was not being met. We issued a warning notice telling the provider and registered manager they must make improvements by 14 March 2015.

On this visit we found improvements had been made. The registered manager and senior staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards DoLS. We saw all those people at The Mount who staff thought might lack capacity had received a mental capacity assessment which demonstrated 22 people were lacking in mental capacity. The manager confirmed they had submitted applications to the relevant supervisory bodies for authorised DoLS relating to the restrictions on people who were not free to leave the premises without support and for those who required supervision and control. Three authorisations

Is the service effective?

without attached conditions had been received. We saw a further three applications for people who had recently transferred to the home where DoLS were in place immediately before transfer.

People told us the meals were good and one visitor told us their relative had put on weight since they moved into The Mount Nursing Home.

Meal times were not well organised and we saw on the first day of our inspection some people had only finished their breakfast a short time before lunch was served. We also saw some people who required assistance with their meals had to wait for one member of staff to finish assisting another person before they could have their breakfast. In one case this meant one of the people waiting to be assisted was sitting at the dining table watching another person eating. At 9:55am one of the care workers was assisting one person and told us they still had another two people who were waiting.

At lunchtime some people ate in their lounge chairs in one of the two lounges. Most ate in the dining room. Some people had not long finished their breakfast, and were asleep in the lounge chairs around the edge of the dining room. Serving started around 12.20pm. Some people were served but others were still waiting at 12.55pm. Three care workers staff were assisting people with eating in the dining room and one care worker was assisting someone in the middle lounge.

There was a choice of chicken Kiev or gammon. Both came with mashed potato, peas and carrots. One person said they did not fancy either of the choices. They were offered steak pie, which they accepted. There was a pudding of apple pie and custard. One person refused to eat their pureed pudding, and one of the care workers said, “Would you like me to get you a banana from your room? I know you like bananas.” The individual said they would like a banana and the member of staff returned shortly after with a banana sliced on a plate which the person ate.

People were being encouraged to eat, but with some people shouting and general hubbub, it was not a relaxing or enjoyable experience. As one person was repeatedly shouting another said, “Good heavens, it's enough to frighten anyone to death.”

We saw two people who used the service walking around the lounges and dining room with little for them to find to engage with. During the lunch service the Nurse asked a colleague, “Can you give this to (Name) because I want them to settle down.” The staff member had to break off from assisting one person to eat in order to try and engage the second person with their meal. During this they were asked repeatedly to sit down to finish their meal. There was no provision for finger foods or items to which people could help themselves. If these had been available it would have balanced the need for people to maintain their food intake with their preference not to remain seated.

On the second day of our inspection we asked one person what was for lunch and they told us it was chicken Kiev, which was the same as the choice on the first day of our visit. They also said sausages had been on the menu three times in one week. When we spoke to the chef we found there was no system in place for the catering staff to communicate what had actually been served at lunchtime. This meant there was a risk of meals being repeated.

We asked staff about how peoples’ weights were monitored. One staff member told us, “We do weights the first Monday of every month. If we have concerns about anyone they get weighed weekly.” This person was able to tell us about people whose weight had caused concern but who were now improving. Another member of staff told us “I am not sure about weights. If we have concerns about someone we weigh them once or twice a week. I like to make extra food at night. I like to make porridge for people.” When we looked at people’s weight records these showed people were maintaining or putting on weight. This meant staff were taking appropriate action to make sure people had enough to eat.

When we looked in people’s care files we saw people had been seen by health care professionals such as GP’s, psychiatrists, chiropodists and dieticians. We saw GP’s had been contacted, for example, when staff thought someone may have a urine infection and needed treatment. This meant people’s health care needs were being met.

Requires improvement

Is the service caring?

Our findings

When we inspected the service in January 2015 we found people were not always being treated with dignity and respect. We issued a warning notice telling the provider and registered manager they must make improvements by 14 March 2015.

We saw practices that showed a lack of respect for people. We saw beds had been made with dirty linen and some sheets were very thin and had holes in. One person had a television in their bedroom but it was not connected to an aerial, so would not work. Carpets were being cleaned at lunchtime and the machine was very noisy. One member of staff commented, "Whatever possessed them to clean the carpets at lunchtime?"

On the first day of our visit we saw one person sitting in the lounge, by an open window for one and a half hours. When we went to speak with them their hands were cold. We found a member of staff who offered to close the window.

In the back lounge we spoke with one person who was watching the television. They told us there was no remote control and the television would go off and then they would have to wait for staff to turn it back on again. We noted this happened whilst we were talking to them. This meant the television programme they were watching was interrupted.

When we looked around the building we saw toiletries in one person's bedroom which had two lots of initials marked on them in black marker pen. One set of initials had been crossed out. We asked one of the senior care workers about this and she said the toiletries had belonged to someone who had died. This showed a lack of respect for both individuals.

We saw some staff supporting people to maintain their independence, for example, one care worker was supporting someone to walk to the dining room whilst another followed with a wheelchair, just in case the individual got tired. However, we also saw practices that undermined people's independence. For example, we saw one of the nurses who was giving out medication on the first day of our visit was abrupt with people and was trying to hurry them. We saw them administer two people's medication and hold the person's drink to their mouths. Both of these people were able to hold their own drinks but were not given the opportunity to do so.

At lunchtime the same nurse intervened with a person who was eating independently and cut up their food without asking if this was needed or preferred. The nurse then fed the person one forkful of food before leaving them to continue to eat independently.

Another person was being assisted by a care worker. When the registered manager came into the dining room they intervened and asked, "What's going on? (Name) can feed themselves."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked two staff members to tell us about the care needs of three named individuals. Both were able to talk about their needs and preferences and ways in which they helped them live their lives. One staff member said, "I'm not sure there's much information about peoples' past lives in their care plans, but these are being updated."

People we spoke with told us that they liked the staff and felt they were competent and caring. One person said, "We've always had good staff. They know what they're doing. They're well trained, I think. I like to put bets on horses. Only those ones that are on the telly. The laundry woman puts the bets on for us." Another person told us, "I am happy here. The staff are all lovely. All of them." One visitor said, "I am very happy with the care my relative gets, it's second to none." Another visitor told us, "The staff are lovely."

We saw one person had an itchy back. Staff noticed and offered to help them scratch their back. Whilst staff did this they engaged the person in conversation and shared a joke. The person's mood had visibly lifted through this interaction and they remained smiling for some time.

We observed one person being supported to use a hoist to transfer from a wheelchair to an easy chair in the lounge. Staff were gentle in their approach and gave verbal guidance throughout. Once the person was seated in their chair staff used cushions to support the person and make sure they were comfortable. However, the person was unable to reach the floor with their feet and was not provided with a footstool or anything to prevent them from becoming uncomfortable due to their feet not resting on anything.

Requires improvement

Is the service caring?

We saw staff bring another person into the lounge and saw them assist the person to transfer from their wheelchair into an easy chair. There was warm conversation and clear instruction given before the staff member undertook any assistance. When the person remarked that they were not happy with the cardigan that they were wearing the staff member instantly offered to get an alternative. They were able to discuss the person's clothes with them in order to decide what they would like to wear. Another staff member talked to a person before assisting them to put on a tabard before lunch, saying, "We don't want to spoil that nice top." However, most conversations which took place with people were when staff were providing assistance to people rather than specifically to provide companionship or emotional support?

Relatives and friends could visit freely and told us they were made to feel welcome. We spoke to one relative who said, "My relative has already been somewhere that closed suddenly. It was devastating. If I didn't think it was alright here we'd move heaven and earth to move them. They've always treated them with dignity and respect. The staff are approachable and kind. There are small housekeeping things. The carpet and stuff like that.... that could be better but the important thing is how they're treated. The office people and other staff have been very supportive to me and to my relative. They've gone beyond what is required. The bottom line is – these people value people. I have always been listened to. They've earned my respect. It would be nice if they could go out – you know, in a minibus."

Requires improvement

Is the service responsive?

Our findings

When we inspected the service in January 2015 we found people's care and welfare needs were not always being met. We issued a warning notice telling the provider and registered manager they must make improvements by 31 March 2015.

We saw a number of people using the service had specialist 'air mattresses' on their beds. These were in place to reduce the risk of people developing pressure damage. We looked at three people's weights to check if their mattress was on the right setting for their weight. We found all three were not set for the current weight of those individuals. This meant the therapeutic value of the mattress would have been reduced and could cause damage rather than preventing it.

We saw in one person's care plan staff had identified the person did not like to be alone in their bedroom in the dark. When we looked in this person's bedroom we found they had no bedside light and the light over the wash hand basin was not working. We asked a member of staff about this and they told us they left the main bedroom light on. This meant the person would not have any control over the lighting in their room.

The same care plan also stated staff should engage the person in group activities and one to one chats. The only contact we saw this person have with staff, on the first day of our inspection was when they were offering them assistance with care tasks.

The same person's care plan also specified they should be seen by the chiropodist every six weeks, but we could find no evidence of this happening in their care records. We asked the registered manager about this and they said chiropody visits should be recorded in the medical notes. They checked the records and agreed there were no entries regarding chiropody. This meant the provider was unable to evidence the care plan was being followed.

In another person's care plan we saw it recorded that the individual could be physically and verbally aggressive towards staff and other service users. When this happened it stated, "Staff to use diversional activities if (name) presents as angry, inform the nurse on duty and document." It also stated, "Staff to record potential trigger and antecedents to mood disturbance for future prevention."

We saw this person being verbally abusive towards another person who used the service. We did not see staff use any diversional activities or take any action to protect the person being sworn at. The only intervention staff made was to call out the person's name who was being verbally abusive. This meant that staff were not following the agreed plan of care.

When we looked at the daily record we saw the nurse had written, "Mood remains variable and they were reassured and supported was shouting and swearing at fellow resident." We did not see staff offer any reassurance or support.

One member of staff told us the 'trigger' for the verbal abuse was the person thought the other individual had their zimmer frame. This meant staff knew what was likely to upset the individual but had not put any measures in place to prevent this from happening again.

The registered manager told us they did not think there was a risk between these two individuals and said they had never heard any verbal abuse taking place. This meant staff had not taken action to reduce the risks to either individual to keep them safe.

We looked at the care plan for the person who had been verbally abused and saw staff had recorded, "(Name) is very repetitive and has a limited vocabulary. Offer reassurance and offer therapeutic activity." There were no details of what the 'therapeutic activity' might be. We did not see staff offering them any reassurance whilst they were being verbally abused and did not see them engaged in any activity.

A member of staff told us this person got upset when the television was switched off because they liked to watch it all of the time. We saw them getting upset at lunchtime when the television was switched off in the dining room. This caused the person next to them to use aggressive language towards them. A member of staff shouted across the room, "(Name) Your lunch is coming." When they continued to vocalise another member of staff told them, "The TV is off, you know this. As soon as we've had lunches we'll put it back on." This intervention did not diffuse either the vocalisation or the responses to it. When another person seated at a table challenged the person who was shouting the member of staff seated next to them stated, "You know they do it all the time."

Requires improvement

Is the service responsive?

There was nothing in this person's care plan about this. We noted the television was left on in the lounge. However, this individual was not asked if they would like to go to the lounge so they could continue to watch television. This meant although staff knew turning the television off would cause them distress they had not put a plan in place or made adjustments to stop this from happening.

When we looked at the accident records we saw one person had fallen twice in their bedroom and once in their toilet over a four day period. We looked in their care plan to see what action staff had taken to reduce the risk of falls. There was nothing in the care plan to indicate any action had been taken to reduce the risk of falls. When we looked in this persons bedroom there was no assistive technology in place which could have been used to alert staff when this individual was getting out of bed, so they could offer assistance quickly.

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

One person using the service said, "There's no activities. There are four of us that play dominoes on an afternoon – that's about it. Well that and television. That's one thing that's lacking. Something to do. They used to have trips out. Bolton Abbey and that. But we haven't been for a long time."

We were told the activities organiser had left at short notice and their replacement was not due to start work until July 2015. We saw there was very little on offer to keep people occupied or stimulated. The activities that were on offer only included a small number of people. We saw a lot of people sleeping and some walking around the communal areas.

When we inspected the service in January 2015 we found concerns and complaints were not being documented. We issued a compliance action and asked the provider to send us a report telling us what action they were going to take to make improvements. On the action plan we were sent the provider told us they would be compliant with the regulation by 21 April 2015.

We looked at the complaints log and saw no complaints had been recorded. One person told us, "I complained in the office about cold food. I sometimes have to send it back to be warmed up in the microwave. It got better for a while, then it went off again." This showed us complaints had not always been recorded in order to address shortfalls in the service.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in January 2015 we found there were a lack of systems and process in place to monitor the quality of the service. We issued a warning notice telling the provider and registered manager they must make improvements by 30 April 2015. On this visit we found there were still breaches of regulations in relation to; safe care and treatment, safeguarding service users from abuse and improper treatment, dignity and respect, staffing and good governance. This demonstrated ineffective leadership as these issues had not been fully rectified.

We received mixed views about the management of the service. One member of staff told us the service was not well led and the staff we had spoken with on the first day of our inspection had all been questioned by the registered manager to find out what we had asked them. They also said the deputy manager was a, "Gossip" and they would not tell them anything confidential and this was why some staff had left. Another member of staff told us the deputy manager treated groups of staff differently based on their ethnicity. They also told us they did not feel able to make suggestions about the way that care was delivered and believed the deputy manager was a barrier to improving the service, telling us, "They are pulling down the standard because of their attitude. They are harsh and oppressive. I have been told more than once "watch your mouth.'"

One staff member told us they thought the deputy manager was, "A good team leader" and that one strength of The Mount was, "The Mount has a good team and feels like a family." Some staff told us they felt they were able to raise any concerns with the deputy manager and that these would be addressed.

We spoke with the provider about the low scores for some staff in their training assessments. They told us they thought this was due to staff having completed the on-line learning without the use of audio so the training had not been as effective as it would have been if completed properly. We asked if there were plans in place for staff to undertake further training. Although the provider gave verbal assurances this would be the case there was no action or documentary evidence to support this. The provider told us where there were themes and trends identified the deputy manager would devise some, "Words of wisdom" to address staff shortfalls. Although we saw a template for this it was blank. We were therefore unable to make a judgement about how additional training needs would be met.

We asked to see the accident and incident analysis. We saw accidents and incidents were being analysed on an individual basis for each person using the service. This analysis did not give an overview that would pick up any common themes or trends. For example, it did not analyse the total number of falls per quarter.

We asked if there were any audits of dignity in care and were told there were not. We also saw dignity in care was not discussed at the last staff meeting on 20 May 2015. This meant there was no system in place to ensure people were living a life with dignity. We found a number of issues around dignity and respect which should have been identified by the registered manager.

We looked at the one care plan audit the deputy manager could produce. We saw issues with the care plan had been identified for example the need for consent for photographs to be taken and for the care plan to be written in a person centred way. However, there was no action plan put in place following this audit to show how the deficits in the care plan were going to be addressed and who would be responsible. Given the issues we found with the care plans these audits were not effective.

We saw the last environmental audit had been completed on 11 March 2015 and had identified repairs which needed to be undertaken and timescales for their completion. However, we found the timescales were not always being met. For example, we saw the broken sash cord in one bedroom which should have been repaired by 27 March 2015 had not been done.

The handyperson also completed environmental checks and made their own list of repairs with timescales for improvement. However, when we checked we saw many of the repairs identified had not been completed. For example, the lights above the mirror in one bedroom had been identified as not working on 18 February 2015. The timescale for completion had been given as four – six weeks. We found this light was still not working on our visit. The systems for identifying and attending to repairs was not sufficient to keep the premises in good order.

The registered manager gave us a copy of the visitors' survey which was dated 23 January 2015. We saw there

Inadequate

Is the service well-led?

were areas people had identified they were unhappy or very unhappy with. People had identified they were unhappy with the outside appearance of The Mount Nursing Home, the front entrance and reception areas, the access to the gardens/patio, the dining area, the disability access, laundry service, odour, social and recreational activities, personal hygiene needs, grooming and personal presentation. Some people had said they were very unhappy with the front entrance and reception area, the lounge areas, bathroom, visitors toilet, odour, social and recreational activities, personal hygiene needs, grooming and personal presentation and medicines management. People had also been asked where they thought improvements could be made and had identified the following areas; activities, administration, maintenance, laundry, housekeeping, kitchen staff, health care assistants, qualified nurses, patio, gardens and internal fixtures and fittings. We did not receive any plan of how the registered manager intended to address the areas people were unhappy about.

As no complaints or concerns had been recorded there was no analysis available. However, the results of the survey indicate people's dissatisfaction with some areas of the service and as such should have contributed to the concerns and complaints log.

When we inspected the service in January 2015 we found some records could not be found or located promptly. We issued a compliance action and asked the provider to send us a report telling us what action they were going to take to make improvements. On the action plan we were sent the provider told us they would be compliant with the regulation but did not give us a date.

On this visit we found some records were not readily available for example, resident meeting minutes and the satisfaction surveys results. We asked the deputy manager for the care plan audits, but only one could be found they told us the file was 'missing.' We asked the registered manager at the end of the second day of our inspection to email us the minutes from the residents meeting, care plan audits and the results from the satisfaction surveys. Although we sent a reminder email four days later we only received the survey results.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as the registered person had not done all that was reasonably possible to assess the risks to the health and safety of service users or to take action to mitigate any risks; the premises being used were not safe; some equipment was not safe; the risks in relation to the spread of infection were not assessed, prevented, detected or controlled. Regulation 12 (2) (a) (b) (d) (e) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and systems and processes were not in place to prevent abuse of service users. Regulation 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Records had not been maintained in relation to the management of the regulated activity. The provider did not act on the feedback they received from relevant persons. Regulation 17 (1) (2) (a) (b) (c) (d) (e).
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect and were not supported to be independent. Regulation 10 (1) (2) (b)