Keychange Charity

# Keychange Charity The Mount Care Home

## Inspection report

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## Ratings

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| Overall rating for this service | Requires Improvement |

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| 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

Keychange Charity (known as "The Mount") is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Mount is registered to provide residential care and accommodation for up to 28 older people who may also be living with dementia. At the time of this inspection, 28 people were living at the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the last inspection in February 2018, the service was rated Good overall with Requires Improvement in the key question of Well Led.

At this inspection we found the rating of Good had not been sustained.

Medicine management required improvement and governance systems needed to be more robust. We found the laws which protect people's human rights were not always followed and best interest assessments were not always completed where required. We also found improvement was required to the range of activities available for people to reduce social isolation and improve well-being.

The service had a management structure in place, and quality assurance systems in place to help identify where improvements were required. However, these had not always been effective. Staffing vacancies and sickness within the provider's management structure had meant there had been increased pressure on the remaining management team. Although there was a quality assurance system in place, and these had identified the issues we found during the inspection, these had not been followed up to ensure improvement and compliance.

Feedback from people about the leadership team within the service was good. The provider, registered manager and head of care knew people well. Regular one to one feedback was sought from people and their relatives to ensure they were involved in the development of the service. Feedback was listened to, and the provider spoke to us during the inspection informing us of the changes which would be made.

Improvement was required to the management of medicines to ensure the systems in place were safe and people had their medicines as prescribed. During the inspection we found the medicine keys were not kept securely and prompt action had not been taken when one person's medicines had been out of stock. Most people's medicine records we reviewed were not accurate, particularly in relation to people's skin creams. This meant we could not be confident people had received their skin creams as prescribed to maintain their skin integrity. Where people had medicines "as required" (PRN) we found there were not robust protocols in place to ensure consistency in administration and guidance where these medicines had a variable dose. The

registered manager listened to feedback and took prompt action to improve these areas.

Staff understood the need to seek consent from people and when to provide care in their "best interests" however, the Mental Capacity Act 2005 (MCA) was not followed in full. Some people who lacked capacity and were unable to consent to their care and treatment, required care to keep them safe which was restrictive, for example bed rails and pressure mats to monitor their movement. However, we found the decision specific mental capacity assessments were not in place, which meant people's human rights may not always be protected.

There were systems in place to monitor accidents and incidents, however during the inspection period we found not all staff were following procedures to report incidents. The home was well kept and hygienic.

People had access to some group and individual activities and events they could choose to participate in. These were provided by staff, for example board games. People could choose to participate in bi monthly outings and activities in the local community but there were long periods of time people had little stimulation other than the television.

The service had links with some local community groups and institutions for example the local church. In the past there had been links with nursery children and a local scouts group but these had not been sustained.

People received person-centred care which was responsive to their specific needs and wishes. Each person had an up to date, personalised care plan, which set out how their care and support needs should be met by staff.

Assessments were regularly undertaken to review people's needs and any changes in the support they required. Any needs in relation to the Equality Act 2010 were specified in care plans and if required, assessments detailed any support people required in relation to the Accessible Information Standard (AIS). The Accessible Information Standard aims to make sure that people who have a sensory loss, disability or impairment get information they can access and understand.

When people were nearing the end of their life, they received compassionate and supportive care. People's end of life wishes were sensitively discussed and recorded where appropriate. Staff had received training in this area.

Staff were aware of people's communication methods and provided them with any support they required to communicate in order to ensure their wishes were identified and they were enabled to make informed decisions and choices about the care and support they received.

The service had appropriate arrangements in place for dealing with people's complaints if they were unhappy with any aspect of the support provided at the home. People and their relatives said they were confident any concerns they might have about the home would be appropriately dealt with by the registered manager and provider.

People were kept safe at the home, cared for by staff that were appropriately recruited and knew how to highlight any potential safeguarding concerns. Risks to people were clearly identified, and ongoing action taken to ensure that risks were managed well.

Staff were supported through training, supervision and appraisal. Staff worked effectively together to ensure

people's needs were communicated and supported them to access healthcare professionals when they needed them. Professional feedback was positive.

People enjoyed the meals available to them and were appropriately supported with eating and drinking. However, we found improved documentation and communication was required if people needed monitoring of their food / fluid or support with their meals.

The home was dementia friendly and met the needs of the people living there. Staff could demonstrate how well they knew people. People and their relatives were positive about the care provided.

People were treated with privacy and dignity and supported to be as independent as possible whilst any differences or cultural needs were respected.

We recommend the provider seek guidance on the Mental Capacity Act and best practice in this area and also recommend guidance is sought in providing activities for people with dementia. In addition, we recommend that the provider has an effective system that assures themselves that there are sufficient numbers of staff effectively deployed to meet people's needs.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People's medicine management was not always safe.

Overall, there were sufficient staff on duty to meet people's needs safely. However, some people felt that at certain times of the day, there could be more.

People's environment was clean and staff followed safe infection control procedures.

People had risk assessments in place to mitigate risks associated with their care and support needs.

Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People told us they felt safe living at the service.

Lessons were learned and improvements made when things went wrong.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always assessed in line with the Mental Capacity Act (2005) as required. Staff however did ask for people's consent when providing care.

People's nutritional and hydration needs were met, but when risks had been identified people's records were not always accurate.

People had their health needs met.

People were looked after by staff trained to meet their needs.

### Is the service caring?

**Good**

The service was caring.

People told us the staff were kind.

People were involved in their care.

People's privacy and dignity was prompted.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Some people told us there was not always enough to do socially. We observed people sitting for long periods of time without any social engagement.

People's had care plans in place so staff could meet their needs in line with their wishes and preferences.

People's knew who to complain to.

People were supported at the end of their life, with compassion.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The provider's governance system had failed to ensure robust oversight of the service.

People were not living in a service which was innovative, continually improving or able to sustain compliance with the Health and Social Care Act 2018.

People were cared for in a service which had Christian values and a positive culture. The registered manager had developed a culture which was open and inclusive.

People and staff said they were able to suggest new ideas for improvement.

People were kept up to date on developments in the service and their opinion was requested.

People, relatives and staff spoke well of the registered manager. People and staff felt the registered manager was approachable.

# Keychange Charity The Mount 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.

The inspection took place on 07 and 08 January 2019. The first day of our inspection was unannounced. The inspection was carried out by two inspectors and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who lives with dementia.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which 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 also reviewed notifications. Notifications are specific events registered people have to tell us about by law. The service had not been requested to send the Commission an updated PIR prior to this inspection.
During the inspection we spoke with 15 people and three relatives / friends of people. We reviewed eight people's records in detail. We also spoke with eight staff, this included five care staff, the registered manager, provider and head of care. We reviewed four staff personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the registered manager reviewed the quality of the service. This included a range of audits, a newsletter, questionnaires to people who live at the service, minutes of meetings and policies and procedures.

During the inspection period we received further feedback from six family members.

During and following the inspection we spoke with the Nominated Individual regarding future plans for the service and changes to the governance systems to ensure compliance with the Health and Social Care Act

2008. .A Nominated Individual a person that the provider nominates to act as the main point of contact with the Care Quality Commission (CQC). A Nominated Individual has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the services provided. We also received further information from the registered manager on action taken since the inspection in relation to medicine management and governance.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in February 2018 we found the service was safe. At this inspection we found aspects of medicine management required improvement.

People's medicines were not always managed safely. When we reviewed people's medicine records, we found routine / regular medicines had been signed for, but skin creams particularly had significant gaps for most of the people we looked at. The electronic recording system did not always correlate with the paper medicine records either. This meant it was difficult to be sure people had received their skin creams as prescribed to maintain their skin integrity. We spoke to the registered manager about this who intended to take immediate action to review the system in place, and ensure all staff undertaking medicine administration were competent and safe to do so.

We also found one person had a regular night medicine which had not been given for four days. We spoke with staff and it was found to be out of stock and had not been ordered. The registered manager took action during the inspection to order the medicine and reported this. The daily checks in place to ensure people had received their medicine had failed.

Some people were on medicine to be taken as and when needed (PRN). We found improvement was required for these medicines to ensure consistency when given. For example, if the person was on a variable dose dependent upon their symptoms. We also found PRN protocols needed to be developed to ensure all staff knew what the medicine was for, when it should be given, and provide clarity and consistency for staff administering medicines. The registered manager started to put this right during the inspection.

During the inspection we also found the keys to the medicine cupboard were not held securely. We were told by staff this was an exception and keys were usually held securely by staff responsible for medicine management.

Staff felt medicine management had improved, "I think medicines management has improved, if you tell the manager they act immediately. If I noticed something had not been signed for I would complete an incident form and check the stock level. I did my core medicines training in a different home then had six weeks of shadowing and competency assessments. The manager is very helpful". Unfortunately, our findings indicated this practice was not consistent across the staff team at the time of the inspection.

Staff told us, "I would know if any medicines were being taken because of weekly audits. I know what we have in the building at any time. They are securely stored. The medicine keys should be kept in the trolley then the team leader has the key to the trolley on a lanyard around their neck." However, the findings of our inspection indicated the checks had not been robust at ensuring medicines were safely managed in all areas.
Medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were processes in place to check medicines were managed, stored, given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Medicines were locked away as appropriate and, where refrigeration was required, temperatures had been logged. Staff were knowledgeable with regards to people's individual needs related to medicines. People understood the reason and purpose of the medicines they were given. Regular audits were in place to check medicines. When medicine errors had occurred, these had been followed up on, investigated and action taken to minimise further errors.

People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. Visitors also felt it was a safe place for their family member to live, "Yes, there is a good security system on the exit doors." One person said, "I feel very safe here"; and another person, "I feel safe here because staff are always there if you need them." Other people told us, "It reassures me that people can only come into the home if they are let in by the staff". Two relatives told us that they were confident that their relatives were safe. One relative commented "He is safe and well looked after here" and another said, "Mum is safe here; they keep in touch with me and tell me how she is doing". Relatives confirmed their family were safe, "He is safe and staff check on him at least once an hour to ensure he is comfortable. He spends his time in his room so this is especially important."

Four people mentioned that they generally felt safe living at the Mount but said that they were somewhat anxious at certain times. One said, "I feel safe in my room at the top because people who wander around don't come up there and it's not so noisy" another said, "I get frightened by another person who wanders into my room – so now I lock it". We fed these concerns back to the registered manager who told us she would speak to people about their worries.

People were protected from abuse, because staff had an awareness and understanding of signs of possible abuse. One person said, "I would tell anyone if there was an issue" and another said, "I would talk to the manager if there was a problem and I am confident that she would sort it". Information was visible around the service highlighting the importance of safeguarding people. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Staff were up to date with their safeguarding training and knew who to contact externally should they feel that their concerns had not been dealt with appropriately. For example, the local authority or the police. Staff gave examples of where they had raised concerns about people's welfare with the local authority. The service had a proactive approach to respecting people's human rights and diversity and this helped prevent discrimination that may lead to psychological harm.

Occasionally people became upset, anxious or emotional. Staff knew people well and knew how to reduce their anxiety and support them. People were complimentary of staff understanding their emotional needs. Relatives told us, "All staff are kind and patient with mum."

Regular staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. We spoke with the registered manager about ensuring all temporary staff were familiar with the process in place to report accidents and incidents. This was because we found one incident had been documented in the person's care records but agency staff had not completed an incident form so the registered manager was unaware. We saw incidents such as falls were recorded. Body maps were used to document where bruises had been sustained or skin tears. Walk arounds occurred to ensure the environment was safe and free of trip hazards, regular checks of bedrooms took place to ensure their safety.

People were supported to take risks to retain their independence whilst any known hazards were minimised

to prevent harm. For example, some people liked to mobilise independently but staff kept a watchful eye. Other people had continence needs they liked to manage themselves but staff were on hand and trained if support was required.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. For example, risks related to people's nutritional status, skin and mobility were noted and care planned for.

There were arrangements in place to keep people safe in an emergency. For example, fire procedures were known and people had personal evacuation plans in place. Staff told us, "People are most definitely safe here, there are regular fire checks and a weekly fire drill".

People and staff had confidence the registered manager would listen to their concerns and these would be received openly and dealt with appropriately. The registered manager and head of care had an open-door policy at all times. Relatives shared examples of when they had worked collaboratively with the management team to find solutions to care issues. They told us, "I can live my life knowing that [X] is safe, calm, clean and well monitored."

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager or provider, and were confident they would act on them appropriately.

People were supported by suitable staff. Robust, values based recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. The service undertook a risk assessment if staff were transferring with a disclosure and barring service (DBS) check from a recent post. Temporary agency staff were used at times, to fill staffing vacancies. However, some people told us they found this difficult commenting, "Staff are always changing - we need a board with pictures of staff and their names"; "Mostly enough staff but too many new faces" and another said "Some of the agency staff are unaware of some people's needs – so I make sure that [X… eats her meal and has her drink".

Overall, people told is there were sufficient staff to meet their needs safely. One person told us, "The bells are always answered very quickly by the staff." Others shared, "There are enough staff"; "There's always staff around if you need them" and "There are plenty of staff – they check on me in my room both day and night". The registered manager had systems which were flexible to ensure staffing levels were maintained at a safe level in line with people's needs and used a dependency tool. However, three people told us there were not enough staff at certain times of the day. Comments included, "If you come down for breakfast you have a long wait as there is not many staff, so now I have it in my room"; another said, "Staff have a lot to juggle and sometimes they have too much to do in the evenings" and another said "I get worried at night-times as not enough staff around". Staff told us there were enough staff for them to meet people's needs safely.

Staff carried out their work in a calm, unhurried manner during the inspection.

We recommend that the provider has an effective system that assures themselves that there are sufficient numbers of staff effectively deployed to meet people's needs.

People were protected from the spread of infection by staff who had received infection control and food hygiene training. Hand washing posters were in place to remind staff, people and visitors about good hand hygiene. Staff confirmed there was ample protective equipment such as gloves and aprons. People commented, "They try hard with the cleaning – my room and en-suite get cleaned three times a week"; "It is spotlessly clean here" and another said, "My room is always clean as is my laundry – the laundry lady is wonderful – she is lovely and friendly and has won an award". One relative told us, "The Mount is very clean and there are no nasty smells".

People were kept safe by staff who learned from incidents / or practice issues. These were reflected upon and discussed in resident and staff meetings. For example, following a medicine error where medicines had reportedly gone astray, procedures had been put in place to ensure all return medicines were counted before they were returned to the pharmacy.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in February 2018 we found this area was Good. At this inspection we found the processes in place to ensure people's legal rights were protected when they did not have the ability to consent to their care, were not always followed.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff gave examples of how a patient's best interests were taken into account if a patient lacked capacity to make a decision. However, we found the recording of people's capacity to make decisions was not recorded. For example, one person had bed rails to keep them safe. This was done to protect them from falls and in their best interest but there was no recording of this. Other people who had restrictions in place to keep them safe also had no record of how these decisions had been reached. This meant that people's human rights may not be protected. We spoke with the registered manager who started to put this right during the inspection.

We recommend the provider seek guidance on the Mental Capacity Act 2005 (MCA) and best practice in this area.

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). The registered manager had applied for DoLS on behalf of people however, many of these were awaiting review by the local authority designated officer.

People told us staff always asked for their consent before commencing any care tasks. We observed staff always asked for people's consent and gave them time to respond at their own pace. This included administering medicines and personal care. Staff offered to come back later if the person did not want the care at the time. Some people had been asked to sign consent forms to confirm they consented to the care they received, as described in their care plan.

Staff knew the people they cared for. They were able to tell us about individual's needs, likes and dislikes, which matched what people told us and what was recorded in individuals care records. Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. People and their relatives spoke positively about staff. Comments included, "The staff respect […] needs both physically and emotionally" and "Following two hospital stays my mother's health has certainly improved whilst being at the home."

New members of staff completed a thorough induction programme, which included being taken through all of the home's policies and procedures, and training to develop their knowledge and skills. Staff then shadowed experienced members of the team, until both parties felt confident they could carry out their role

competently. Staff told us this gave them confidence and helped enable them to follow best practice and effectively meet people's needs, with one member of staff commenting, "My induction was done by our registered manager. My training included first aid, manual handling, medicines management, infection control and fire safety. I have also done end of life and dementia training in the past. The training is good here. We can do a lot of training online like wound care."

Some staff had received training in equality and diversity. Recruitment processes didn't discriminate or reject people because of their perceived or known sexuality or disability. People with protected characteristics were welcomed and valued.

On-going training was planned to support staffs continued learning and was updated when required. This included core training required by the service as well as specific training to meet people's individual needs. Staff told us they had the training and skills they needed to meet people's needs. Staff were encouraged to undertake qualifications appropriate to their role. Some staff had undergone training to become "Champions" in specific areas for example diabetes, but these roles required embedding. One person told us, "The staff are good at looking after us"; "Staff get a lot of training here and are aware of people's needs" and another said, "Staff here are aware of current issues and do lots of courses".

Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had, "I get supervision whenever I need it. The manager is accessible and supportive". The registered manager discussed with staff when errors had been made to support their learning and development.

Most people were complimentary about the food, "Excellent food – with two choices available"; "The roasts are very good and I really enjoy the Friday Fry-up Breakfast." Another shared, "They are very flexible with the food and will buy in things I fancy" and another said, "The cook is very good as is the kitchen porter". Two people said that they enjoyed the food but would like a bigger portion. One said, "I could do with more to eat" and another said, "You don't get given a lot of food".
People were encouraged to say what foods they wished to have made available to them and when and where they would like to eat and drink. One to one meetings were used to discuss people's meal preferences so they could be incorporated within the menu. Kitchen staff met with people regularly to obtain their views, and people's feedback was acted upon.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs and any risks, for example choking. The food people disliked or enjoyed and what the service could do to help each person maintain a healthy balanced diet were also clearly recorded in their care plans.

Staff regularly monitored food intake to ensure all residents received enough nutrients in the day. Some people were on food and fluid charts, for example if they were at risk of weight loss. However, we found these were not always fully completed to give an accurate picture of people's intake. For example, two people we reviewed who we were told were having their dietary intake monitored had incomplete records. We found one person who was due to have one to one support with meals due to low weight did not have staff present with them at lunch. Staff told us this was no longer required. We discussed this with the registered manager and head of care who agreed to discuss improved documentation and communication with all staff. This would ensure food and fluid intake was accurately recorded for people at risk and care plans reflected people's current level of need. Following the inspection twice weekly checks were put in place to monitor this area.

People were referred appropriately to the dietitian and speech and language therapists if staff had concerns about their wellbeing. With people's consent, regular weight checks occurred where necessary.

We observed the dining experience. Tables were laid and condiments available for people. People were asked if they wanted clothing protection. Some people used adaptive cutlery and plate protectors to support them to eat independently. People were able to choose where they ate, for example the dining room, lounge or their bedroom.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals, for example district nurses, chiropody or mental health professionals. A relative old us, "Staff took immediate action when my mother's health failed and quickly arranged for her to be taken to hospital."
Staff told us, "We have good relationships with external professionals and we can self-refer to physios and district nurses."

People benefitted from living in a home that was regularly adapted and changed to meet their diverse needs. Handrails supported people to move safely around the premises and signage was in place to help orientate people to their environment.

Good

# Is the service caring?

## Our findings

The service remained caring.

People felt well cared for, they spoke highly of the staff and the quality of the care they received. "I would give the staff 10/10 for the care they give me"; "The staff are good here and they do a great job"; "The carers are very nice and are extremely good to me." Relatives and friends all told us that the staff at the Mount Care Home were caring and patient. One relative commented "The staff are very caring" and another said, "I am more than happy with the lovely staff here". One relative said "I am very pleased with how they look after my husband" and another said, "Mum's needs are met here which is reassuring for me".

People were treated with kindness and compassion in their day-to-day care. People told us, "Some people here are a bit difficult, they can't help it because they are poorly and staff do such a good job with them by being patient and reassuring".

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Staff shared how one person was particular about the day their room was cleaned. The cleaner would notify them when she went on leave to prepare the person that the cleaning schedule would be different. This thoughtfulness helped reduce their anxiety. People were reminded to dress appropriately for the weather if they were going out.

People told us the atmosphere was pleasant. People commented, "The staff are friendly, caring and stop and have a chat with you if they can"; "Everyone does a good job here"; and another said, "The senior staff here are very versatile and they can turn their hand to anything". Staff shared, "I have worked in care for 28 years. It's lovely here the residents are well cared for and the staff are a good team. It's a good atmosphere."

Information about advocacy services was available to people and we saw advocates had supported people in decisions where they had requested this.
People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. A relative commented, "The staff treat my mother with immense respect." Another shared, "Any mishaps […] has with toileting are quickly addressed and dealt with immediately with no fuss."

People told us they were able to maintain relationships with those who mattered to them. Family and friends visited throughout the inspection and were welcomed warmly. One person told us, "My daughter and grandchildren visit me and are happy with the care I receive here" and another said, "My visitors are always positive about the Mount when they visit". Other relatives said, "Staff are very welcoming and kind to me" and "The staff are lovely and always say hello".

People were cared for by staff who understood equality and diversity. Staff knew, understand and respond to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way.

People told us, staff listened to them and took appropriate action to respect their wishes. People were encouraged and asked for their views for example the recent newsletter asked people for their ideas on the supper menu and activities. There was also a comments book where people could share their views.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people's views and opinions were heard. If people required equipment to support them to hear or see information, staff were aware and arranged this. Staff adapted their communication methods dependent upon people's needs, for example using simple questions and information for people with cognitive difficulties. Information about the service was also available in larger print for those people with visual impairments.

Staff told us that people were encouraged to be as independent as possible. People were supported to stay mobile and participate in the care they were able to, for example washing areas they could reach, and using the bathroom with staff discreetly on hand if required. People's care plans also detailed how staff could help people maintain their independence, identifying what a person could do for themselves and what they needed support with. Staff members told us they gained satisfaction from supporting people to maintain or regain their independence.

Staff understood how to protect people's confidentiality. Personal records were stored securely and staff ensured conversations involving people's personal information were held in private. Information about data protection was shared where appropriate and staff understood confidentiality.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection in February 2018 we found this area was Good. At this inspection we found people did not always have opportunities for meaningful, and personalised social engagement.

People had some internal and external activities they could be involved in to provide cognitive stimulation, social interaction and the opportunity to leave the Mount Care Home. People were able to choose what activities they took part in, for example there were board games and boules available which care staff played with people if they wished. A pastoral volunteer visited to offer people companionship and another member of staff volunteered their time to do knitting with people, and take them to church. However, we observed eight people sitting in the lounge for long periods of time where people had little to do and sat in the lounge with minimal staff interaction.

Some people were happy with this and watched films. Three people told us that they got a bit bored as there wasn't anything to do other than watch TV and chat. One person told us that they occasionally played skittles with one of the carers. We saw one person spent most of the day restless with little staff engagement.

We recommend the provider seeks advice on activities suitable for people with dementia taking into account people's personal backgrounds and hobbies, individual preferences and disabilities to provide personalised, meaningful social engagement.

People had their needs assessed before they moved to the service. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care.

People, where possible, were involved in planning their own care and making decisions about how their needs were met. People had care plans that clearly explained how they would like to receive their care, treatment and support. People and where appropriate, those who mattered to them, were actively involved in the process to help ensure their views and preferences were recorded, known and respected by all staff. One person said, "I know all about my care plan and it gets reviewed from time to time" and another said "I know what's in my care plan as does my family".
Staff told us care plans were kept up to date and contained all the information they needed to provide the right care and support for people. Staff told us they involved people in developing their care plans so care and support could be provided in line with their wishes. Support plans were reviewed and updated regularly to help ensure people's wishes were being met.

People's faith needs were met. People were able to access external religious services and / or see the Pastor who visited the service. In addition, staff discussed with us how they met the individual needs of people with a range of religious beliefs, for example relating to individual spiritual support, dietary requirements and personal care if this was required.

In line with the Accessible Information Standard, policies and procedures across the service had been developed to ensure information was given to people in accessible formats when required. Staff were aware of the need to record, highlight and meet any needs in relation to people's communication.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The provider had used technology to improve the service. People's care records were electronic which help to enable timely recording of staff interventions.

The service had a policy and procedure in place for dealing with any concerns or complaints. This was available in different formats if required. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. One person told us, "I will talk to the staff about things that worry me and they do get sorted" and another said, "If I have concerns I talk to one of the members of staff".

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists.

Requires Improvement

# Is the service well-led?

## Our findings

The Mount had previously been rated inadequate in 2017 and placed into special measures. In February 2018, the provider had improved to good, with the well led domain remaining requires improvement. At this inspection we found although there were systems in place to monitor the quality of the service, these had not led to sustained improvements.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the nominated individual shared with us that the registered manager would be leaving their post shortly. We were also informed one of the compliance leads responsible for overseeing internal quality monitoring had been off work. The deputy manager had recently left the service also. This meant the management team had been under pressure and the systems which had been established to check the service were compliant, had failed.

Systems and processes to monitor the quality of the service were in place but these had not been operated effectively. For example, there was a range of daily, weekly, monthly and quarterly audits. There were also visits by the compliance team. These audits, for example the medicines audits, had identified the issues we found at the inspection but these had not been followed through so improvements had not been made to the identified areas. The provider shared their vision of how compliance would be monitored in the future to avoid this reoccurring. We were informed that plans included an external quality assurance team to monitor compliance.

The systems in place across the service did not consistently drive improvement. For example, training in champion roles had taken place but these skills had not been embedded into the service to improve people's care due to staff capacity. The management team and care planning audit and checks had failed to identify the lack of capacity assessments when best interest decisions were undertaken.

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

The Mount is a Christian based charity and we were told the values included, "Only the best will do, everyone is equal, waste not want not, justice for all and a fair process for everyone, individualised care."

The registered manager and head of care were respected by people and families. The registered manager told us they felt supported by the provider and that they spoke frequently. The provider had also visited the service recently and been involved in meeting with staff.

Not all people knew who was in charge at the service and feedback was mixed, "I know both the manager and the deputy – they are both fantastic" and another said, "I know who she is." Three people told us that they knew the manager but thought they were too busy to visit them, "I know who the manager is but they

are usually too busy to pop in to see me" and "Hardly ever see the manager or the deputy". Two people did not know who the manager was. One person said, "I'm not sure who that is" and another said, "I'm sorry but I don't know who the manager is".

The registered manager had an open door policy where people / their family and staff could come into the office and speak with them at any time. Residents meetings had not been successful at the Mount so we were told one to one discussions with people were held to gain their feedback of the service. The registered manager told us, "We are very focused on individuals as a staff team and as an organisation, we do our best to cater for individual needs whether it is to be their preference for church or food choices. For example, people's bedroom doors were painted specific colours."

The service worked closely with health and social care colleagues. The registered manager attended local forums where best practice was discussed for example, the local dignity and care forum and outstanding manager network. The registered manager had also completed the local authority leadership and management course.

People were kept informed through newsletters and asked for their views about the service. One person told us, "From time to time I get a questionnaire which asks for my views on living here".

Previously the service had links with a local nursery and a scout group had visited but these links had not been sustained. However, the local community were invited to celebrations such as the Summer fair. This event had raised significant funds for a new summerhouse.

The provider celebrated staff success through awards. One staff member at the Mount had been nominated for their contribution to people's lives. They had won and received an award and certificate in recognition of their dedication, time they gave and fundraising.

The provider and registered manager listened to feedback and started to make improvements where they could during the inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Service users medicines were not always managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The governance systems in place across the service were not effective in helping to identify and drive improvement. |