

M G L Health Care Limited

Mont Calm Residential Home

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Inadequate



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

Mont Calm Residential Home Limited provides accommodation and personal care for up to 39 older people. There were 27 people living at the service during our inspection. People had a variety of complex needs including people with mental health and physical health needs and people living with dementia,. Staff told us and records confirmed that some service users needed the support of two staff for personal care, to move around the home and for support to eat and drink.

Accommodation was provided in two adjacent houses. There was a passenger lift between floors in each house.

The service did not have a registered manager. The previous registered manager had ceased working at the service in December 2014. The provider told us that a new manager was being recruited. Interim management arrangements were in place.

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.

Summary of findings

This inspection took place on 19 and 20 January 2015 and was unannounced. The previous inspection was carried out in May 2014 when we found the service met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. People were not safeguarded against abuse. There were not enough staff to keep people safe and meet their needs. People did not always receive the medicines they need. Staff were not adequately trained to meet people's needs. Advice from health professionals was not followed. People were not adequately protected from risk of malnutrition or dehydration. People did not receive personalised care. People's dignity was not protected. People were not provided with meaningful activities. Complaints were not acted on in a timely manner. Quality assurance systems were not effective. Communication was inadequate and records were not accurate.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replace the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people made complimentary comments about the service they received. People told us they felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Most of the relatives who we spoke with during our visit were satisfied with the service. A number of relatives were not and they had contacted us to tell us about concerns they had about the care of their family member.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had not submitted Deprivation of Liberty Safeguards (DoLS) applications for any service users, although they were aware of the requirement to do so. The premises were locked and an internal door in one of the houses was kept locked. People were kept safe, but their freedom to leave the premises or move around freely in one of the houses was restricted.

The provider had not taken adequate steps to make sure that people were protected from abuse. We witnessed incidents of abuse during our visit which we told the provider about and reported to the Local Authority safeguarding team. The local authority safeguarding team shared concerns with us about the safety of people at the service before our visit. Most of the staff were trained in safeguarding but they did not have access to guidance they needed and along with the managers had failed to identify, respond to and report possible abuse.

Staff did not effectively care for people whose behaviour was a risk to themselves and others. There were plans of care in place which guided staff in how to care for people but these were not being followed. Staff did not have the skills they needed to communicate effectively with people who were living with advanced dementia.

The provider did not have an effective system to check how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times. Staff told us and we observed that there were not enough staff to meet people's needs. The provider followed safe recruitment procedures to make sure staff were suitable to work with people.

Not all staff had received the essential training or the updates required to meet people's needs. This included training in the Mental Capacity Act 2005 (MCA) and preventing and managing behaviours that were a risk to the person or others. Staff were not trained in how to promote people's privacy and dignity or value their equality and diversity. Staff did not consistently protect people's dignity.

Care staff had not received the support, supervision and appraisals they needed to enable them to carry out their roles effectively. Staff told us that morale was low because they did not feel supported by the management and did not feel they were listened to.

People did not always receive the medicines they needed when they needed them. People's weights were not being monitored accurately to make sure they were getting the right amount to eat and drink so there was a risk of people experiencing malnutrition. There were mixed views about the meals provided. Some people were complimentary but other people told us they did not like the meals.

Summary of findings

.Advice from health professionals was not always followed to prevent people becoming unwell and prompt action was not taken when people showed signs of illness.

Staff were very busy carrying out tasks and mostly did not have time to initiate conversations with people other than when they were providing the support people needed. Most of the staff were kind, caring and patient in their approach and had a good rapport with people.

People did not always know who to talk to if they had a complaint. Complaints were not passed on to the right person or recorded. There was no system to make sure prompt action was taken and lessons were learned to improve the service provided.

People living with dementia were not provided with meaningful activity programmes to promote their

wellbeing. People's spiritual needs were not taken into account or met. People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time.

Quality assurance systems had not been effective in recognising shortfalls in the service. Improvements had not been made in response to accidents and incidents to ensure people's safety and welfare. Records relating to people's care and the management of the service were not well organised or adequately maintained.

People were not consulted and their views taken into account in the way the service was delivered. There had been no recent residents or relatives' meetings or customer satisfaction surveys.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe

People were not protected from abuse or the risk of abuse.

There were not enough staff employed in the home to meet people's needs.

Risks to people's safety and welfare were not identified or managed to make sure they were protected from harm.

People did not consistently receive their medicines when they needed them.

Inadequate



Is the service effective?

The service was not effective

The provider had not met the requirements of the Deprivation of Liberty Safeguards. There were no clear procedures in place in relation to the Mental Capacity Act 2005.

Staff did not have all the essential training or updates required to meet people's needs. Staff did not receive the supervision and support they needed to carry out their roles effectively.

People were not supported effectively with their health care needs.

Staff did not have the knowledge and skills to make sure people were getting enough to eat and drink. People were not being offered a choice of a suitable and nutritious diet that met their needs.

Inadequate



Is the service caring?

The service was not caring

People were not always consulted about their own care.

People's dignity was not consistently protected.

Staff were not always kind, caring and patient in their approach or supported people in a calm and relaxed manner.

Inadequate



Is the service responsive?

The service was not responsive.

Complaints were not managed effectively to make sure they were responded to appropriately.

People had not had their needs properly assessed before moving and when they did move in their needs were not met. People's care had not been planned or updated when there were changes in their health.

People living with dementia were not supported to take part in meaningful, personalised activities. People were supported to maintain their relationships with people who mattered to them.

Inadequate



Summary of findings

Is the service well-led?

The service was not well led.

Communication was ineffective and did not make sure that people were protected from unsafe or inappropriate care and treatment.

Quality assurance systems were not effective in recognising shortfalls in the service. Action had not been taken, to make sure people received a quality service.

Records relating to people's care and the management of the service were not well organised or adequately maintained.

Inadequate



Mont Calm Residential 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 checked 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 19 & 20 January 2015 and was unannounced.

The inspection team included two inspectors and an expert-by-experience who had personal experience of caring for older family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority and previous reports. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about. We looked at information relatives, staff and the local authority safeguarding team had sent us about the service.

We would normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks for some

key information about the service, what the service does well and improvements they plan to make. However, this inspection was planned in response to concerns we had received and there was not time to expect the provider to complete this information and return it to us. We gathered this key information during the inspection process.

We observed care in communal areas in each of the houses on both days; looked around the home and spoke with 17 people, eight visitors, the deputy manager, six care staff and provider's representative. We also received information from the local authority safeguarding team, health professionals who visited the service, a whistle blower and relatives before our visit.

We looked at incident/accident records; daily records and handover records; five people's care files; five staff recruitment files; staff training records; staff rotas; medication records; food, fluid and repositioning charts and records of night checks. We asked the provider to send us information about staff supervision and appraisals which were not available during our inspection. We had not received these records by the time this report was written.

The previous inspection was carried out in May 2014 when we found the service met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service safe?

Our findings

People who were able to answer our questions told us they felt safe. They said, “I do feel safe, and secure, here” and “Yes, I think I do feel safe here”. There were mixed views from relatives about how safe they felt their family members were. Two relatives contacted us about concerns for the safety of their family members. One relative told us their family member had fallen twice and sustained injuries that they were not informed about. They told us their family member had been admitted to hospital immediately after returning from the home because they were, “In a very poor state”. The safeguarding team at the local authority are aware of and investigating this relative's concerns. Other relatives said, “When I’m not here, I’m confident she’s not maltreated in any way and gets the help she needs” and “I think she is safe”. Relatives we spoke with during our visit told us they felt their family members were safe.

Two people were behaving in a way which placed themselves or others at risk of harm. One person threw a hot cup of tea over a person who was asleep. Another person was walking up and down, swearing and opening the double fire doors in the lounge to walk into the garden several times. They struck another person on the arm. People in the lounge were exposed to cold air from outside when the double fire door was left open near where they were sitting. The staff did not respond appropriately to either incident because they had not been trained to understand how to protect people or care for people with advanced dementia.

One person was very unsettled when they were walking around the shared areas of the home shouting. This behaviour caused disturbance and distress to other people who were sitting in the lounges. Staff repeatedly led the person to a chair instructing them to sit down. The guidance in their plan of care stated that the person should not sit next to other people as they could ‘lash out’. Staff placed the person next to other people on several occasions which placed them at risk of harm. This person’s plan of care included how staff should respond when they were distressed and moving around a lot. This said to support them to go into the garden for a walk. Staff did not follow this guidance and continued to tell the person to sit down.

We looked at records to make sure that the incidents above had been recorded and reported to the local authority safeguarding team in accordance with the Local Authority

procedures for safeguarding vulnerable adults. The incidents had not been recorded or reported. We asked the provider if these incidents had been reported in accordance with the Local Authority Safeguarding Adults Procedures and the service’s own policies and procedures. The provider confirmed they had not been reported. Although most of the staff had training in safeguarding, they did not have access to all the information they needed about how to report abuse, including contact details for the Local Authority safeguarding team.

One person who moved to the home shortly before our inspection had been placed in a shared room with someone who was a risk to others due to their behaviours when they became unsettled. The deputy manager told us they had realised that this was not a suitable arrangement and were discussing moving the new person to another room. In the meantime this person’s risk assessment stated they should be checked every hour when they were in their room and if they were awake they should be checked more regularly. Records showed that checks were only carried out every 2 hours whether the person was found to be awake or asleep. Inadequate monitoring and supervision meant that the person who had recently moved into the shared room was at risk of physical and emotional abuse.

People were not safe because staff training was inadequate. Training did not make sure staff had the skills to care for people whose behaviours were a risk to themselves or others. The trainer told us that the training provided included ways staff should remove themselves from physically aggressive contact by people rather than understanding, preventing or managing behaviours that threatened people’s safety.

The examples above showed the provider had not taken steps to identify the possibility of abuse and prevent it before it occurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives had differing views about whether there were enough staff. They said, “They have been short staffed here. They all work hard. For example, the laundry person hasn’t been here and so they have to do it all”, “They are not sufficient here. You need to be able to talk to someone”.

Is the service safe?

One relative told us, “I think there’s enough here. They seem to have a pool of workers they can draw on, so there are familiar faces. If there’s an emergency, they can get staff in quickly.”

There were not enough staff on duty at all times to make sure that people were protected from harm or received the individual care they needed. The number of staff employed was not based on an analysis of how much time was needed to provide appropriate levels of care and activities for people. Staff told us morale was low and there were not enough staff to meet people’s needs.

Our observations showed there were not enough staff with the appropriate qualifications, skills and experience to provide appropriate care which ensured people’s safety and wellbeing. There were periods of time of up to ten minutes when there were people in the lounges without any staff present. One person told us, “I’m waiting to go to the toilet they told me there wasn’t anyone to help”. When we found a member of staff they confirmed they had said this because they were supporting another person with their personal care.

There were not sufficient numbers of suitably qualified, skilled and experienced staff to keep people safe. The examples above were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In most cases people were given their medicines as prescribed and intended by their doctor. Some people were prescribed medicines, including sedatives or pain relief medicines ‘to be taken as required’. There was individual guidance for staff to follow to make sure a consistent approach was taken in deciding when to offer the medicines.

One person was not receiving the medicines they needed and because they were in pain they behaved in a way that put themselves and others at risk. They relied on staff to notice the signs that they were suffering but no pain relief had been given for several days. Records were marked with a code which showed they had refused the medicine. There had been no consultation with health professionals about how to ensure the person received the pain relief they needed. We have made a recommendation regarding medicines.

The records relating to medicines showed these were received, disposed of, and administered safely. The medicine administration records for all the people who were on prescribed medicines were correct. Medicines were stored securely. Suitable arrangements were in place for obtaining medicines. This meant that medicines were available to administer to people as prescribed by their doctor.

Safety checks were carried out at regular intervals on all equipment and installations. Although there were systems in place to make sure people were protected in the event of a fire, a fire risk assessment of the premises had not been carried out by a suitably qualified person. Instructions were displayed throughout the home concerning what actions staff should take in case of a fire. There was equipment in place in case of fire such as extinguishers. Fire exits were clearly marked and accessible.

We recommend that the provider seeks advice from a suitably qualified person to ensure any risks of fire are identified and minimised.

We recommend that medication administration is reviewed to make sure people receive the pain relief they require when they need it.

Is the service effective?

Our findings

People made negative comments about the way the staff cared for them and met their needs. However, one person made a more positive comment. People said, “Staff are good but the backbiting between them can be a bit much”, “They want to do it this way or that way. I find it a little bit over the top”, “The trouble is, there’s a lot of youngsters coming. Some think they know it all”.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No-one living at the home was currently subject to a DoLS, although we found that there were restrictions imposed on people where their best interests had not been considered. People were not able to leave the premises as all external doors other than to the garden were locked. A lock was also being used on an internal door which led from a lounge to bedrooms and stairs to the first and second floors. Staff told us this door was locked to prevent one person from accessing the stairs. This restriction also prevented other people from accessing their rooms through this door. There was no evidence of consultation with people, their representatives or the local authority about this practice.

There were no clear procedures in place or guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. The provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act 2005, and the specific requirements of DoLS. Less than half the staff had attended Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. The staff were unable to describe their responsibilities in supporting people to make decisions or in seeking advice when people were unable to do so.

The provider did not have suitable arrangements in place for obtaining and action in accordance with people’s consent. This and the examples above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Twenty one staff had either had no training or no recent training in how to provide people with adequate nutrition.

People had lost weight without staff monitoring this or providing the diets they needed. Eighteen staff had not had up to date medication training. Medicines were being managed properly but in one instance staff had not responded to a person’s need for pain medicine. This meant that for some key areas staff were not adequately trained to effectively meet people’s needs or protect them from harm.

Staff training records showed that none of the staff had training in how to promote people’s privacy and dignity or value their equality and diversity. Staff were not trained to provide care for people with specific needs such as Parkinson’s disease, mental health needs or sensory loss. People with these needs were living at the service and had moved in on the understanding that staff had the training they needed to meet their needs. The staff were unable to describe the specific care they should provide to meet these people’s needs.

Although most staff had some dementia awareness training they did not demonstrate an understanding of how to communicate with people in a way which allayed anxiety and met their needs. One person was continually calling out, “Help me”. This resulted in verbal abuse from another person. On several occasions staff tried to provide reassurance by asking the person what they needed help with and saying things like, “I can’t help you if you don’t tell me what you want me to do”. The deputy manager confirmed that this person was unable to communicate their needs. This meant that the person’s anxiety levels increased because they were unable to answer the questions staff kept asking causing them further distress.

Staff told us they did not feel supported and they felt stressed and there was low morale amongst the staff team. We asked the provider to send us supervision and appraisal records after our inspection but these had not been received at the time of writing this report. We were not therefore able to make a judgement about whether staff had been formally supervised. Staff were not meeting people’s needs and they were not following guidance so any supervision that did take place had not been effective.

Staff were not provided with adequate training or support to carry out their roles. The examples above were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service effective?

There were mixed views from people about meals and mealtimes. One person said the food suited them because staff made them a salad every day, which they preferred. All the other people who were able to answer said the food was, “All right”, or “Better” and “Ok”. One person told us the food was, “Excellent”. Everyone said there was enough for them. Comments included “I’m certainly never hungry”, and “There’s plenty of food here”. Some people commented on the limited choice, “There’s not really much choice”, “Now and again there’s a choice.”

A relative came to the home to help his family member with lunch every day and they told us, “The food is okay. They’ve been on the (name of supplier) meals for two years and there’s a lot less waste.” The relative felt these meals gave “a balance of protein and calories”. They told us they maintained a record of the person’s weight with the help of staff. The relative showed us how they got the person’s prepacked dessert, reading the labelling before opening it to allow it to cool. They described the food as, “A higher standard of ready meals”.

We observed a member of staff spending time encouraging one person to drink staying with them until the drink was finished. Other staff provided drinks but did not take time to make sure people drank the drinks they were given. Some people who were identified as being at risk of malnutrition or dehydration had food and fluid charts to record what they ate and drank. These were not completed accurately to show whether people had received what they needed. People who chose to spend time in their rooms did not have drinks made available and within reach. This meant that people were not adequately protected against the risk of dehydration or malnutrition.

Staff were not monitoring people’s weight effectively to identify any risks or malnutrition and ensure that prompt action was taken. When people needed staff to check their weights weekly this had not been done. One person continued to lose weight on the few occasions they had been weighed but a check on weights had inaccurately recorded they had gained weight. This person had food supplements prescribed twice a day but staff told us the person would not drink them because they did not like them. No action had been taken or advice sought to make sure this person was eating enough. Staff did not know how to fortify and enrich foods and drinks to boost the calorific value. None of the pre prepared meals delivered by the supplier were fortified.

People were not offered a choice of what they ate for lunch. Other people were told about the choices although some people could not respond to this. People were not shown the two meals on offer to be able to indicate their choice. The main meal was sausage or beef casserole. People did not have any control over the content of the meal or portion size. The meal was plated up out of sight of where most people were sitting. One dining room had nothing written on the blackboard headed ‘menu’, and the other had a menu dated ‘9th January’. There was no information in care plans about people’s likes and dislikes to help staff offer people the foods and drinks they preferred.

The examples above showed people who were living with dementia were not offered a choice of food or drinks in ways they could understand. People were not provided with the support they needed to eat and drink the right amounts to protect them from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an example of care where one member of staff was helping a person to eat their lunch. This staff member did not rush and gave them time to enjoy their meal. They talked with the person about how they liked the person to smell the food to help their appetite. They knew what the person was able to swallow and how to provide the support they needed. A pleasant relaxed atmosphere was created by the member of staff which meant this person ate well.

Prompt action was not always taken and the advice of healthcare professionals was not always followed when people needed support with their health. Guidance in one person’s care plan stated that they were prone to urinary tract infections (UTI). This person was also prescribed pain relief for other health conditions. The guidance stated that when the person was unsettled a urine test should be arranged.

On five occasions over a two day period we asked staff and managers whether a urine test had been done for this person. On the last time of asking a manager told us no test had been done because there were no dip test sticks or

Is the service effective?

sample containers at the service. This put the person at risk of further health problems and no medical advice had been sought in the two day period even though staff knew this person was prone to infections.

Two people had wounds on their legs and one person's legs were very red and swollen. The person told us their legs were painful. They said that although they reminded staff to be careful they often hurt them when they were providing care. There were no care plans in place in relation to wound care management. Advice given by health professionals such as G.P's or district nurses who were involved in the treatment of people's wounds or other conditions or illnesses was not recorded. This meant that staff had no guidance to refer to about how to provide appropriate care and treatment.

People were referred to health professionals but not always promptly when people needed medical attention or advice. People had seen G.P's, district nurses, community psychiatric nurses (CPN) and dieticians for support with their healthcare needs. One person was visited by the CPN in the morning of 19 January 2015. They left written instructions with staff about actions they should take to improve the mental health and wellbeing of the person. These instructions were not passed on to staff on the afternoon shift. On 20 January 2015 their care plan had not been updated to show the CPN's instructions to make sure staff knew how to deliver the care this person needed.

The CPN said they were concerned about the care people received and our observations confirmed that staff did not

understand how to provide the support people needed. The CPN told us they gave advice about how to manage people's behaviours in a way that would allay anxiety, calm and prevent behaviours that were a risk to themselves or others. They said that staff did not follow the advice and consequently people's mental health deteriorated unnecessarily.

The examples above mean the provider failed to plan and deliver care that protected people's safety and welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives who were visiting the service told us that G.Ps were called when needed. People said, "They are marvellous when I need a Doctor, they call straight away and he comes. It's fantastic, and district nurses and everything"; "They are very good when I'm not well. I've seen a Doctor here"; "They don't mess about. A doctor straight away" and "I always see a Doctor".

Relatives told us, "They called us when he fell. He ended up needing to go to hospital for a chipped bone, and they handled it all well", "They do get a doctor if she needs one" and "We've seen a nutritionist and I have it all in writing. And I've seen the Doctor here on a number of occasions". People and their relative's positive views about the healthcare that was provided were not consistent with our findings that staff did not always seek medical support promptly enough or follow treatment advice.

Is the service caring?

Our findings

Most people told us they were treated with dignity and respect. However, comments from some people and our observations did not always match the positive descriptions people had given us. People did confirm that staff made sure that doors were closed when they helped them with personal care. Staff were not always discrete in their conversations with one another and with people who were in shared areas of the home.

Most people were satisfied with the way their care was given. They said, “I get on with most, we laugh and joke”, “Very caring”, “I like them”. “They are very good here”; “All the girls are all right” and “A wonderful bunch of people who seem to be naturally devoted to the old people”. “I’m very thankful for all the care. It couldn’t be better here”. Other people told us about less positive experiences of the way staff cared for them. They said, “Only yesterday, a lady (staff member) thought I was nothing but trouble but it soon blew over. I do find if I hesitate for a few moments, it can be a problem”. One person said they had a “Love/hate relationship with them. On the whole, the staff are good”.

Some relatives made positive comments about the care. They said, “They are all very friendly and so concerned about all the residents”, “If there was a member of staff with no compassion, they wouldn’t be here long. In the last 5 years, I haven’t seen bad care at all”. Other relatives had made complaints to the provider about the care and told us they were not satisfied.

One relative commented that no one had combed their family member’s hair that day. We observed that other people had not had their hair brushed or combed. One member of staff on the afternoon shift noticed that a person’s hair had not been combed. The person was walking around the lounge at the time. The member of staff commented “You’ve not combed your hair this morning” and proceeded to comb their hair as they stood in the shared area in front of other people. This did not show the staff had not considered the person’s dignity. A relative told us they were pleased with the regular hairdressing service.

One person was wearing pyjamas all day and was unshaven. Another person who was not able to move around independently was brought to the lounge in short nightwear. When seated this meant their legs were exposed to the level of their underwear. When we intervened staff

covered them with a blanket. Staff explained the person was due to have a bath which was why they had not been assisted to dress that morning. This meant that people’s dignity and privacy had not been respected or considered.

Staff told us that they would like to have time to talk to people more but, “There was too much to do and not enough time to do everything” and “No time to chat and spend more time with the residents”. They said they were very stressed because they could not give people the attention they needed. They told us they had raised their concerns about but felt they had not been listened to. Staff did not spend time with people, other than when they were carrying out support tasks. Most of the staff were kind, caring and patient in their approach with people and supported people in a calm manner. However there were times when a small number of staff spoke sharply in angry tones to people when they were finding it difficult to manage people’s behaviours.

People were not treated with dignity or respect and the examples above were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been involved in planning their care and they could not remember if they had been asked to contribute their views about their own care. People’s care plans did not include a record of any discussions with them or signed agreements relating to their care. Most people had a ‘My Plan’ document in their individual care files which had been completed by relatives. This included information about people’s interests and social histories. Information from this document was not used to plan meaningful activities which took account of people’s individual interests and abilities.

Two people talked to us about their faith. One person told us about a church they had attended in the past and how important their faith was to them. People were not supported to attend a church and there were no church services or pastoral visits arranged at the service. The section of people’s care plans which was intended to provide guidance about how to meet their spiritual needs only had information about family relationships. Where there was information in ‘My Plan’ this was not used to make sure staff understood people’s spiritual needs and how to meet them.

Is the service caring?

The examples above showed that people were not involved in planning their care and their spiritual needs were not taken into account. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Relatives were aware they could visit at any time. They said, “The man (The provider’s representative) said, come any time. They have an open policy here”; “The door is always open. We can come in at any time and see the manager or any one” and “I’ve been in at any time”.

Staff knew people well but they did not always know how to care for people or they did not follow the guidance to care for them. One member of staff made a joke with a person about the amount of sugar they preferred in their tea. The person said, “They do know me”. A relative said, “They’ve noticed things about her, like she eats better away from the others. And she comes into the lounge every day now so they can keep an eye on her”.

Is the service responsive?

Our findings

One person told us they had, “No serious complaints. It could be worse but it’s very fragile at the moment, you don’t know who to go to”. Other people said, “I would go to (The nominated individual for the company) if I had a complaint or I might ask for the deputy manager”; “I talk to my son” and “I would talk to (The deputy manager)”. Not everyone knew how they could make a complaint or who to speak to if they wished to complain. There was no complaints procedure on display to assist or encourage people or their relatives to make complaints

Relatives knew how to make a complaint. They said “I’d go to the deputy or the owner”; “There’s nothing we are unhappy with” “If I have a problem, I go directly to them. I’ve had minor ones. They’ve been sorted out”; “They’ve been more queries than problems”. Complaints relatives raised with us included people being taken out without appropriate clothing to protect their dignity; missing personal property and people leaving the home with other people’s clothing. This showed that not all complaints were investigated thoroughly and recorded or used as an opportunity for learning and improvement.

Systems for handling complaints had not been effective in ensuring that people were listened to and their complaints dealt with effectively. Relatives told us about complaints they had raised but these had not been recorded in the complaints system so people could not be assured these had been properly reported, investigated or responded to. The management team were not aware of some complaints relatives had contacted us about despite relatives saying they had complained to staff. An up to date log was not maintained of any complaints raised by people or their relatives. This showed that not all complaints were investigated thoroughly and recorded or used as an opportunity for learning and improvement.

The examples above showed that people’s and their relative’s complaints were not identified, handled or responded to effectively. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People moved into the service without a full assessment of their needs, behaviours or the resources available to

manage their care. Pre-admission assessments had been completed with basic details about people’s medical histories and needs. However, following the basic assessment due consideration had not been given to the level of support, the number of staff or the training they needed. A number of people had complex needs which staff were not trained or supported to respond to.

Pre admission assessments did not take account of the needs of people already living at the service or how behaviours would affect them. A decision to move a person into a shared room was made without consideration of the effect on the person moving in, or the person already in the room. The deputy manager told us the decision was made because this was the only ground floor room available. They said they had recognised this was having a negative impact on the new person’s wellbeing.

Each person had a care plan which contained limited information about how people wanted their care delivered. Staff had limited guidance about how to provide care and support in a personalised way. Information supplied by relatives in the ‘My Plan’ document, had not been used by the staff to give people personalised care or to plan meaningful activities for people.

People’s preferred routines were not included in their care plans, such as what time they wanted to get up or go to bed or when they would like a bath or shower. When asked about baths or showers one person said, “The facility is there, and I have occasionally, but they like to book it in advance”. Staff planned baths on a rota. One person spent the day in their pyjamas because it was their ‘bath day’ although they had refused a bath. Another person was brought to sit in the lounge in short nightwear because they were “Due for a bath today”.

People who were able to communicate their choices told us, “They give you a certain time to go to bed, about nine. I’m happy with this. I get up at about 08:30. That’s fine”. Another person said, “I often go to bed about 21:30. I prefer this. I get up at 06 30. They don’t mind at all”. Night staff told us that most people were assisted to bed before they came on duty at 20:00.

People were not offered choices in ways they could understand. People who were not able to move around by themselves were not offered choices about what they would like to do or where they would like to spend their time. We observed staff bringing people to the lounges and

Is the service responsive?

assisting them to sit in chairs without discussion about where they would like to sit or offering them anything to look at or interact with such as magazines, books or objects that might interest them. People who were anxious and walking around were told to sit down rather than engaged in conversation or activities.

Staff told us they were not always able to provide the support people needed and there were times when they were not able to respond when people asked for help. People told us about times they had asked for support with their personal care but had to wait because staff were busy helping other people.

Some people required help to move their position at regular intervals because they were at risk of developing pressure wounds. There were charts to record each time staff helped them to move. The staff had not completed these charts so no one could tell if these people had the care they needed. The deputy manager told us no one had a pressure ulcer. However, these people had been assessed as needing this care due to the risk of lying or sitting in the same position for too long and staff could not show this care had been given to them.

Staff did not have time to spend with two people whose behaviours were causing distress and disturbance to themselves and other people. People who were quiet did not receive any attention other than when staff were helping them with their personal care needs or serving drinks and meals.

People were brought to the dining table up to 40 minutes before the meal was served. One person who was asked to sit at the table 20 minutes beforehand left the table three times before they received their meal. This person had been taken to sit in a position where they had to push past

other people in order to leave the dining table. On each occasion staff took them back to sit at the table again rather than allow the person to do what they wanted to until the meal was ready.

People were not provided with any activities on 19 January 2015. People who were able to discuss activities told us, "There's not really anything to do"; "There's not much to do"; "I haven't seen any activities"; "No, nothing to do" and "Not a lot to do".

There were no individual activity programmes to ensure people living with dementia had meaningful activities to promote their wellbeing. An activities coordinator was employed for two afternoons each week. People had no personalised activities programme, which took account of their interests or abilities to enable staff to provide meaningful activities. Whilst there were a variety of items which could be used for activities, such as games, puzzles, books and arts and crafts equipment in one of the houses, these were not offered to anyone. The television was on in one of the lounges but most people were not in a position to be able to see it. The activities coordinator did support a small number of people to take part in an activity for a short time on one afternoon. Most people were not supported to engage in any activity and staff did not have time to support people to engage in activities that were meaningful to them.

The examples above mean the provider had failed to plan and deliver care which met people's individual needs or ensured their welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Is the service well-led?

Our findings

We received differing opinions from people and relatives about the service. One person said they “Recommend it all, it’s smashing. The guy who owns it is the best bloke in the place and his family as well”. Relatives who complained to us about the service did not feel they were listened to and that their views were not taken into account. One relative said, “I think they have meetings but I don’t go” Other relatives told us they had not been made aware of any meetings, or questionnaires. One relative praised the leadership describing, “A high level of compassion here. It comes from the top”. None of the relatives were able to think of any feedback that had changed anything, but most felt they were listened to.

The provider’s representative told us that the registered manager was no longer working at the service and they were recruiting a new manager. The registered manager had stopped working at the service shortly before our inspection. The deputy manager and the provider’s representative were overseeing the day to day management of the service. They knew each resident by name and people knew them and were comfortable with them.

The Mont Calm Mission Statement was on display near the front of one house. This stated, ‘Our Mission is to Provide an optimum level of health, dignity and Independence for the residents in our care. We intend to be the best in our class’. There were brief sentences showing how this would be done, and a reference to ‘the residents’ charter’, which was not displayed. Our finding during the inspection showed that these aims were not being communicated clearly to the staff or put into practice. The provider’s approach to managing the service was reactive rather than proactive in developing and improving the service people received.

The provider did not have an effective system in place to regularly assess and monitor the quality of the services provided. The provider’s representative had not carried out any audits on behalf of the company to ensure that people were receiving a good service. The provider’s representative relied on the competency of senior staff to carry out checks. These checks had not been completed and the provider had not been informed or taken steps to find out

about failings in the care or the service. Where any shortfalls had been identified by staff, the local authority or other professionals action had not been taken to make the improvements to the care or the service that were required.

There was no effective system in place to manage risks to people’s safety and welfare. The management team at Mont Calm who had been delegated responsibility to assess and manage risks, had not been provided with the training they needed to carry out their roles. There was no system to make sure the staff received the training they needed. Training was not effective to make sure staff had the knowledge and skills to care for people, whose behaviours were a risk to themselves and other people.

There was no system to assess how many staff with the right skills were required at all times to provide people with safe, effective, caring and responsive care. Staff told us morale was low and there were not enough staff to meet people’s needs. There was no system to make sure staff received the supervision and appraisals they required to allow them to discuss their role, their training needs and their work standards.

We attended a meeting on 1 December 2015 with the local authority who had a number of concerns about people’s safety and welfare. This meeting was attended by the provider’s representative and the management team. Staffing levels at the service were discussed at this meeting and the Provider was sent an action plan following the meeting. This included a request to update the ‘dependency analysis tool’ to ensure there were enough staff to meet people’s needs and keep them safe. This action had not been completed. There had been no analysis of people’s individual needs. The number of staff employed at the service did not take account of the level of support each person needed.

Relatives, a whistle-blower and health and social care professionals, including the Community Psychiatric Nurse (CPN) and the Local Authority Safeguarding Coordinator shared concerns with us about people’s safety and welfare. There were no effective systems in place to ensure that advice from visiting health professionals such as GP’s or visiting nurses was passed on to the staff and management team to make sure people received the safe care they needed.

There were no effective systems to ensure the views of people, their representatives and staff were taken into

Is the service well-led?

account in the way that the service was run. People and their representatives were not kept up to date with changes in the service, or provided with opportunities to provide feedback about the quality of the service they received. Where concerns and complaints had been raised these had not been managed effectively.

The examples above show that people are not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication was ineffective between staff, the managers and the providers. As well as with health and social care professionals, which meant that significant information about people was not passed on or reported to relevant authorities. This included information about safeguarding incidents. These incidents had not been recorded or communicated to others which meant that opportunities for learning from these incidents were missed so no actions were taken to prevent them happening again.

Advice given by health professionals had not been communicated between staff. Plans of care had not been updated to reflect advice, treatment or care when people's needs changed. This meant action had not been taken to make sure people received appropriate and safe care.

Records relating to people's care and treatment were not well organised or adequately maintained. A number of records we looked at were not accurate or kept up to date, including care plans, records of people's weights, repositioning charts and records relating to wound care. This meant that staff and others did not have access to consistent information and people were not receiving planned care that met their needs.

People were not protected against unsafe or inappropriate care because accurate and up to date records were not maintained regarding their care and treatment. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

People were not protected against the risks malnutrition or dehydration.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The provider had not made suitable arrangements to ensure people's dignity was upheld.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The provider had not made suitable arrangements for obtaining people's consent to restrictions on their freedom.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

People's complaints were not always fully investigated and, so far as reasonably practicable, resolved to their satisfaction.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against risks of inappropriate or unsafe care and treatment the registered person had not ensured that there was an accurate record in respect of each person which included appropriate information and documents in relation to the care and treatment provided. Other records were not available or not up to date in relation to the management of the regulated activity. Regulation 17 (2d)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person did not have suitable arrangements to ensure that staff were appropriately supported by providing appropriate training.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not protected against risks of inappropriate or unsafe care and treatment, because the assessment of needs and planning and delivery of care did not ensure their welfare and safety. The planning and delivery of care did not reflect published research evidence and guidance in relation to people with dementia and other conditions. Regulation 9 (1) (a) (b) (i) (ii) & (2)

The enforcement action we took:

We served a warning notice which required the provider to meet this regulation by 6 March 2015.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

People were not protected against risks of inappropriate or unsafe care and treatment, because systems designed to regularly assess and monitor the quality of the services provided to identify, assess and manage risks relating to people's health, welfare and safety were not effective. They did not take account of people's complaints and comments made, and views including the descriptions of their experiences of care and treatment. Regulation 10 (1) & (3) (d)

The enforcement action we took:

We served a warning notice which required the provider to meet this regulation by 6 March 2015.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

People who use services were not protected against the risks of neglect and acts of omission that cause harm or place at risk of harm. Regulation 11 (1) & (2) (b) (l)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:

We served a warning notice which required the provider to meet this regulation by 6 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to safeguard people's health, safety and welfare.</p>

The enforcement action we took:

We served a warning notice which required the provider to meet this regulation by 6 March 2015.