Downlands Care Limited

Mountside Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Mountside Residential Care Home is registered to provide accommodation and care, without nursing, for up to 52 adults. Mountside Residential Care Home is a large Victorian property in a residential area of Hastings, within walking distance of the town centre. The house has been extended a number of times and in 2014 a new wing, Valley View, was added. Valley View provides single bedrooms with ensuite facilities and a large lounge/dining room with a small kitchen attached. Valley View lounge opens on to an extensive terrace that overlooks the gardens and the valley beyond.

This comprehensive inspection took place on 6 and 7 October 2016 and was unannounced. There were 49 people living at the home when we visited.

This home requires a registered manager as a condition of its registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 home is run. At the time of this inspection there was a registered manager who had been in post for a number of years.

People were happy to be living at Mountside Residential Care Home and they had positive, warm and friendly relationships with the staff. Staff enjoyed working at the home and were supported by the registered manager and deputy manager.

Staff had undergone training and knew how to recognise and report any incidents of harm. However, incidents were not always reported in line with local protocols. Potential risks to people had been assessed. Medicines were not always managed well, which meant there was a risk that people might not receive their prescribed medicines safely.

There were sufficient staff on duty to make sure that people's needs were met in a timely manner. Staff had received a thorough induction and had undertaken training in some topics relevant to their role. Staff recognised that they needed further training, which had not yet been provided, so that they were equipped to do their job as well as possible. Staff had been recruited in a way that made sure that only staff suitable to work in this care home were employed.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had not always been fully assessed and some staff had a limited understanding of the principles of the MCA and DoLS. For those people who had been fully assessed, appropriate applications had been made to the relevant authorities. This ensured that these people's rights were protected where they lacked mental capacity to make decisions for themselves.

People's healthcare needs were monitored and staff involved a range of healthcare professionals to make sure that people were supported to maintain good health and well-being. People were given sufficient amounts of food and drink and people's dietary needs were met.

Staff showed that they cared about the people they were supporting. Staff treated people with kindness, respect and compassion and made sure that people's privacy and dignity were upheld at all times. People were encouraged and supported to be as independent as possible. People's personal information was kept securely so that their confidentiality and privacy were maintained.

Pre-admission assessments had been carried out. People and their relatives had been involved in planning the person's care and support. People's care plans gave staff some information about the ways in which each person wanted their care and support delivered. However, this was not always in sufficient detail to ensure that each person received personalised, consistent care.

A range of activities and entertainment was planned and delivered and some people had been encouraged and supported to pursue their individual hobbies and interests. People and their relatives knew that any complaints would be listened to and addressed.

The managers were very approachable and supportive. People, relatives and staff were given a range of opportunities to share their views about the service and put forward ideas for improvements. Staffs' views relating to training had not always been acted on. Audits of a number of aspects of the service provided were carried out. However, these had not been robust enough to identify the issues we found. Records were maintained as required.

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.

Medicines were not always managed well, so that there was a risk that people might not receive their prescribed medicines safely.

There were sufficient staff to ensure people's needs were met in a timely manner. Staff recruitment meant that only staff suitable to work at this home had been employed.

Potential risks to each person had been assessed but guidelines had not always been put in place to ensure that any risks were minimised. Staff had undertaken training in safeguarding and were aware of the procedures if they suspected anyone was at risk of being harmed. However, local safeguarding protocols to refer incidents to the local authority were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and were supported by management. Staff had undertaken training in some topics but required additional training to make sure they were knowledgeable and skilled to carry out their role.

Arrangements in place to ensure that people's rights were protected if they did not have the mental capacity to make decisions for themselves were not as robust as they should have been.

People were provided with sufficient food and drink to meet their nutritional needs. Healthcare professionals were involved to make sure that people's health was monitored and maintained.

Is the service caring?

Good

The service was caring.

People were supported by kind, compassionate and caring staff

who treated them with respect.

People were supported to maintain and improve their independence and were given opportunities to make choices about all aspects of their daily lives.

Visitors to the home were welcomed at all times. Advocacy services were available if a person needed an independent person to act on their behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person-centred and gave staff some information about the ways in which each person wanted their care and support delivered. Care plans did not always include sufficient guidance for staff to ensure that people received consistent care and support from the staff team.

A range of activities, outings and entertainments were planned and delivered.

People and their relatives were confident that any complaints would be listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance checks on various aspects of the home were carried out but these had not been robust enough to identify the issues we found.

The management team provided good leadership and the managers were approachable. People, their relatives and the staff had a number of opportunities to give their views about the service provided.

Records were maintained as required.

Mountside Residential Care Home

Detailed findings

Background to this inspection

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

This inspection included two visits to the home on 6 and 7 October 2016 and was unannounced. On the first day there were two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The visits were completed on the second day by one inspector.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

In June 2016 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assist with planning the inspection.

During our visit on 6 October 2016 we observed how the staff interacted with people who lived at Mountside Residential Care Home. We spoke with eleven people who lived there and four members of staff (three care workers and a housekeeper). We also spoke with the registered manager and the deputy manager. We looked at five people's care records as well as other records relating to the management of the home. These included safeguarding records and records of complaints. As part of the inspection we contacted some healthcare professionals who had regular contact with the home. On 7 October 2016 we returned to give

further feedback to the provider's representative.

Requires Improvement

Our findings

We looked at the way people's medicines were managed and found there were a number of issues. We looked at whether the amounts of medicines remaining in their packets tallied with the records of the amount of the medicine that had been given. We checked five medicines and found that the numbers tallied for two of them, but not for the other three. For example, one person had received 100 tablets of a pain killer prescribed to be taken when required. Records showed that none had been given but there were only 64 left in the packet. Staff were not able to explain this discrepancy.

Medicine administration record (MAR) charts had been signed to show when people had been given their medicines. However, there were some other issues with the way staff had completed the MAR charts. For example, hand-written entries on the MAR charts had not been signed to show who had made the entry; some entries on the MAR charts had been over-written, leaving the entry illegible; the code O (which needed an explanation as to what it meant) had been used but with no explanation of whether the medicine had been given and if not, why not.

We checked one senior care worker's knowledge about how they gave some medicines, which had special administration instructions. The member of staff confirmed that one was given correctly. However, they were not aware that the other medicine was more effective if taken some time before meals and before other medicines. We agreed that it was also the responsibility of the prescriber and the dispensing pharmacist to make staff aware of special administration instructions. Staff agreed that for people prescribed this medicine, they would check with the person's GP and follow the GP's advice.

Storage of medicines, including those medicines requiring special storage arrangements, was satisfactory. However, the room in which medicines were stored and dealt with did not have a supply of running water. This meant that staff were not able to wash their hands immediately prior to dealing with medicines. We saw that a bowl of water was used to wash the pots that had been used to give each person their medicines. We were directed to the sluice next door to wash our hands where we found there was no soap and a communal hand towel. Although we recognised that this room had been used to store and handle medicines for a long time, the environment did not meet current good infection control and medicine handling practice. Following the inspection the provider wrote and told us that they have had a water supply installed, with a sink with mixer taps and further storage.

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

People told us they felt safe living at Mountside Residential Care Home. Their comments included, "I'm treated very well" and "Staff are pleasant and treat me okay." One relative was sure that their family member was safe. They told us, "[Name's] safe, totally. No-one will ever hurt [them]." Another relative told us that their family member would "stick up for [themselves] and tell another member of staff [if anything was wrong]." This relative told us that on one occasion their family member had said that a member of staff from an external agency had not treated them well. This relative had been very impressed by the action that was taken by the home's staff and by the local authority safeguarding team.

In the PIR, the provider wrote, 'Our staff have relevant policies and procedures to guide them to undertake safe working practices…. We continue to hold regular safeguarding awareness training'. Staff demonstrated that they understood that safeguarding meant keeping people safe from harm or abuse. They showed that they would recognise and report anything that concerned them. Staff told us they had undertaken safeguarding training and one member of staff said, "I know how to check for things like bruises and where people may not be themselves…I would report any concerns to my senior or manager, CQC or the CAB (Citizens Advice Bureau)." Another member of staff told us, "I have had safeguarding training. I know to contact social services, CQC or social workers about safeguarding issues. I know they are there to help."

A relative told us they had been very impressed with the way the home's staff and the local authority safeguarding team had handled an incident involving their family member. They said the issue was "dealt with promptly" and they had been kept informed throughout the process. We checked records of three incidents and found that one incident of possible harm had been appropriately referred to the local authority safeguarding team. With regard to the other two incidents, the registered manager and deputy manager told us they had decided not to refer them. This was not in line with local safeguarding protocols and in discussion with us the managers agreed that they should have raised an alert relating to both incidents.

The provider had a system in place to assess and minimise any potential risks to people. Following a previous serious incident, the local authority had recommended that the home completed more detailed falls risk assessments. The registered manager told us that care plans were in the process of being updated with these more detailed assessments. In the care plans we looked at we saw that for people at risk of falling, risk assessments relating to falls had been carried out. Where needed, falls prevention equipment had been put in place and appropriate referrals made to the falls team or the person's GP.

Guidance was in place for staff so that they were clear about the actions needed to minimise the risk of a person falling. Staff were able to tell us about the guidance for individuals, which included using a sensor mat, ensuring the person's walking frame was in reach and calling the GP. A member of staff told us that as the result of a fall, changes had been made to the environment. Hand rails had been added to the slope leading into the lounge area so that people felt better supported and the risks of falling were reduced.

We also saw that assessments of other potential risks, for example relating to pressure areas; nutrition and hydration; and moving and handling had been carried out. However, we noted that care records for one person showed that although they had been assessed at 'very high risk' of developing pressure ulcers there was no care plan in place to guide staff on how to minimise the risk. For another person whose care records stated they were living with dementia, there was no assessment of the risks that this person might face relating to this condition. There was no care plan in place to give staff guidance on how to provide consistent care to minimise the risks.

We checked whether there were enough staff on duty to meet people's needs. We found that on the whole there were enough staff to meet people's care needs, but staff had little time to spend socialising with

people. The registered manager told us the number of staff was based on the number of people in residence, their needs, the geography of the building and the call bell audit (which showed how promptly people's calls for assistance were responded to). There were six care staff and one senior on duty in the morning and four care staff and one senior from 2pm to 8pm. The registered manager explained that a number of agency staff worked at the home to supplement the number of permanent staff. They said that recruitment was on-going and that additional kitchen staff had recently been recruited, which meant that there was more time for care staff to spend with people. A Head of Care had also been appointed but at the time of the inspection they had yet to start working at the home.

The registered manager told us they had recently worked a night shift. Their experience had confirmed that another member of staff was needed at night. They said that staff were being recruited to fill this gap. People did not express any strong views about staffing numbers, however we noted that one person waited 10 minutes after telling a member of staff they needed some assistance. They said, "Ten minutes is a long time when you need the [bathroom]." A relative said, "There aren't always enough staff but it can't be helped if someone [staff] doesn't come in." Staff had mixed views about whether or not there were enough staff. One member of staff said, "Staffing levels are good; sometimes we need to cover for staff sickness." Another member of staff told us, "There are safe staffing levels now…. Seniors discussed this need with management." A third member of staff felt that more permanent staff were still needed as working with agency staff was sometimes "quite hard". They added that the agency staff on duty on the day of the inspection had all worked at the home on previous occasions, which was "quite handy".

The provider had a recruitment process in place to ensure that only staff suitable to work in this care home were employed. Staff told us that all pre-employment checks, such as references, proof of identity and a criminal record check had been undertaken before they started work. One member of staff said, "They said I'd have to wait for it [criminal record check] to come before I could start." Another member of staff confirmed that they had been subject to the same process. They had not started work until all the pre-employment checks had been completed and were satisfactory.

The provider had policies and procedures in place to ensure that people were kept safe if there was an emergency. Some people's care records showed that personal emergency evacuation plans were in place. This was so that staff, and external agencies such as the fire service, would know what assistance that person would need in the event of an emergency such as fire or flood. The registered manager said that all staff attended fire safety awareness training twice a year. One new member of staff told us that, although they had not yet received formal fire safety training, they had been shown all the fire safety measures at the home and taught how to respond in an emergency. They demonstrated they would know what to do if there was a fire.

Requires Improvement

Our findings

We looked at whether staff had the knowledge and skills to do their job properly. Staff told us they had been given an induction when they started working at Mountside Residential Care Home. The induction included training and working alongside experienced members of staff. One member of staff said that they had had "three days shadowing [an experienced care worker]."

Staff told us that following induction they had undertaken training that the provider described as 'mandatory' and that regular refresher courses in these topics were arranged. This included moving and handling, first aid, fire safety and medication. The registered manager told us that all of the care staff employed at the home had either gained or were working towards a level three Diploma in Health and Social Care (a nationally recognised qualification). A relative said, "Staff seem to know what they're doing."

One member of staff told us, "The training is very good. I have recently had first aid training. This was a practical session and has completed my knowledge. Training is always updated here." Another member of staff said, "I am happy with training. I have NVQ3 (a nationally recognised qualification)." However, we found that training in additional topics relevant to staffs' role was not offered as a matter of course. This included training relating to conditions that people in the home might have, such as Parkinson's disease, diabetes and dementia. Staff told us they could ask for any training they needed. One member of staff said they had asked for training in diabetes, end of life care and dementia care. Another member of staff told us, "I have not had dementia training. I have asked for this." They said they had not been advised when this training would be arranged. This meant that staff did not always have the knowledge and skills required to be able to do their job as well as they could have done.

Some staff told us they had received formal supervision every three months and had an annual appraisal. Other staff had not been offered a supervision session for some time: one member of staff said they thought their last supervision was at the end of last year. Nevertheless, they said that they could "speak to management at any time" and overall staff felt well supported. The registered manager told us that "there were also focused supervisions carried out for staff who needed further sessions than others."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care records included an assessment document to record whether a person had the capacity to make a particular decision. We found that these had not been completed consistently and did not give the required information. For example, for one person the form did not make it clear what the specific decision was that the person needed to make. This meant there was a risk that people's rights were not being properly protected in this area. However, the managers told us they had recognised that the assessments "had only been half done" and were working on improving them.

For those people who had been fully assessed, and whose safety depended on their freedom being restricted, appropriate applications for DoLS authorisations had been made to the relevant authorities. Staff were upholding any conditions of the authorisations. This ensured that these people's rights were protected where they lacked mental capacity to make decisions for themselves

Staff told us they had undertaken training relating to the MCA and DoLS. However, we found that their understanding of the MCA and DoLS was limited and they were not confident that they had sufficient knowledge regarding the MCA and people's capacity. One member of staff said they knew they would benefit from more training. This member of staff was more confident in their understanding of DoLS, knew who had a DoLS authorisation in place and was able to give us a good example of why someone was being deprived of their liberty.

People were supported to have enough to eat and drink. Each person's nutritional and hydration needs had been recorded in their care records. When the assessment showed that they were at risk, their intake of food and fluid was recorded and their weight monitored. Staff were clear about when to refer the person to the GP. Staff were also clear about those people who needed a special diet. They explained that care staff shared people's food requirements with the chef and ensured that people were provided with the correct meals.

As part of our inspection, two members of the inspection team ate lunch with people who were eating in the main dining room. People had mixed views about the quality of the food that was provided. One person said it was "a bit samey" and another commented, "It's difficult to cook for 50 plus people…. It's not a hotel so you can't expect hotel standard." Nevertheless, on the day of the inspection we saw that most people enjoyed the food they were given.

Care records showed that people were supported to maintain their health by staff involving a range of healthcare professionals, such as the GP, community nurses, falls prevention team and dietician. Staff told us, for example, that they had referred someone, who was at risk of developing pressure ulcers, to the community nurse. In the PIR the provider wrote that the staff had recently 'worked in partnership with a palliative nurse'. They said this had 'enabled us to give good end of life care and a positive outcome in assisting a resident and staff in dealing and coping with end of life care.' The provider stated that they would be continuing to build these links so that they could 'maintain residents' wishes to remain in their own home.'

A local GP visited the home every week and the deputy manager said the GP would "come out at the drop of a hat" if anyone needed to see them. One person said, "If I need to see a doctor or dentist I mention it to the

staff." A relative expressed that they were confident that staff responded well to their family member's medical needs. They told us about a time when their family member needed to go to hospital. They said, "It was all very well organised." Senior care staff told us that the community nurses had taught them how to assist someone to use equipment to monitor and treat their medical condition.

Good

Our findings

People and their relatives were very complimentary about the staff. People told us that they liked the staff and we saw that people had good relationships with them. People used words such as "kind", "caring", "pleasant", "compassionate" and "helpful" to describe the staff. One relative said, "Staff are very good, my [family member] is always singing their praises. [Staff are] very caring, always ready to help." Another relative told us that their family member had "developed good relationships with the staff." They said, "Staff are absolutely brilliant. I have full confidence in them. I wouldn't want [name] anywhere else."

In the PIR the provider wrote, 'We always train the staff in treating residents in how they would wish to be treated, or a member of their family.' A person who was having their second period of respite care at the home told us how touched they were by the staffs' reaction when they arrived this time. They said, "When I came back [name of staff] and [name of staff] came and put their arms round me and said how lovely it was to see me again." This showed that staff made people they mattered to them.

One person had written a letter, which had been printed in the local paper. It was titled 'Well done to caring staff'. The person had written, 'I have been a resident at Mountside Residential Care Home for just over two years and these days we only seem to hear bad news regarding care homes…. The staff at the home always work so very hard to give enjoyment to all at these special times [the queen's 90th birthday celebrations] and throughout the year. Congratulations Mountside and praise to all the hard working care staff.'

The home had received numerous thank you cards and letters, particularly from people's relatives, which showed how much they appreciated the care given to their family members. Comments included, 'We as a family should like to express our gratitude for the professional care and attention given to our [family member] over the past [X] years'; 'Just to say a very big thank you for all the wonderful care you gave [name]…I know she was very happy'; 'To all the lovely staff. Thank you so much for looking after [name] so well'; and 'We would like to thank each and every one of you for all the care you showed my [family member] in his time at Mountside and especially in his last few weeks.'

During our visits we saw that people were comfortable with the staff and there were some warm and caring interactions between staff and the people who lived at the home. Some of the staff showed they genuinely cared about the person they were looking after. A relative said, "My [family member's] health took a downturn. Some of the staff got really concerned – that's what I really like."

Staff respected people's privacy and dignity and we saw that personal care was offered discreetly. A

member of staff described ways in which they maintained privacy and dignity, including making sure that curtains were closed and doors shut when providing personal care. One person told us, "I feel very well respected by the staff." Another person said, "They always knock on my room door and wait for an answer before entering."

At lunchtime we saw that staff took the time to encourage people to do as much as they could for themselves, only offering assistance if the person really needed it. This was so that people would maintain their independence. We noted that care records reminded staff that people wanted to do what they could for themselves. For example, one person's care plan stated, 'I am managing my personal care, prompt me with a change of clothes.' Staff gave us another example where they had been involved in making sure that people maintained as much independence as possible: they had asked the provider to supply a stand-aid. This piece of equipment meant that the person was assisted to stand, rather than being fully hoisted. However, at lunchtime we saw that staff removed people's walking frames from the dining room. This meant that people who used a frame could not leave independently: they had to ask for their frame to be returned.

Staff demonstrated that they knew people's likes and dislikes. For example, one member of staff was very clear about who needed soft, pureed or a diabetic meal. A relative told us, "On the whole they know [name's] needs and likes…..they're very very good." Another relative said, "They understand what my [family member's] needs are. [Name] likes a strict routine." People's likes, dislikes and preferences for the way they received their care were recorded in the care plans.

Staff told us that people were given choices in their daily lives. One member of staff said they always asked each person what they wanted, even when they knew the person would always choose the same thing. For example, people could choose where they wanted to eat their meal, when they wanted to get up or go to bed and what they wanted to wear. People told us they were given a choice of food and drinks. They said there were always two choices for the main meal and the alternative of a jacket potato with cheese if they did not want either of the choices. One person said, "If you don't like something they change it." A member of staff, when telling us about one person said, "[Name] likes to have breakfast and a cup of tea in their room. Night staff ensure they have a tray with a pot of tea each morning."

Visitors were always welcomed at Mountside Residential Care Home and there were no restrictions on visiting. We saw lots of visitors coming and going throughout the day. They were made to feel welcome and were given drinks and meals. One person told us, "Friends and family can turn up as they want to." A relative told us the staff "always make me feel welcome. I get on well with them." Another relative said, "When [name] first came, they [staff] said we could come and visit any time we liked. We feel welcomed."

We did not see any information about advocacy services that people could contact if they needed an independent person to act on their behalf. However, the registered manager told us that there were advocacy services available. They confirmed that they had contacted an independent advocate to be involved with one person to support them with a particularly distressing matter.

People's care records were kept securely and care plans included the person's consent to staff sharing information about them with relevant professionals only. This meant that people's confidentiality was maintained.

Following the inspection, the Directors of the company wrote to us. They wrote, "[Name of one of the Directors] was pleased when visiting Mountside to attend a coffee morning and entertainment to find three relatives enjoying themselves in helping giving out coffees and talking and laughing with the residents. I found out that some of these 'helpers' had sadly lost their own relatives that had been resident in Mountside

and their comments were 'we love Mountside it is so homely and the staff are angels – I really love coming and helping'."

Requires Improvement

Our findings

Care records included an assessment of the person's needs that had been carried out before the person was offered a place at the home. The registered manager told us that people were encouraged to visit the home before they agreed to move in. In the PIR the provider wrote, 'We base all of our assessments on a holistic approach which assists in giving person centred care.' Care plans were developed from the assessment. We saw that care plans were written in the first person, to show that people, and or their relatives, had been involved in the assessment and the care planning.

Some care plans gave staff guidance on the care the person needed and how they preferred their care to be delivered. However, we noted that in a number of instances there was information in the records, but no care plan to guide staff as to the care the person required in that area. For example, one person had a diagnosis of dementia but there was no care plan to inform staff how this condition affected this person or what actions they should take to support the person. Another person had been assessed as being very anxious but there was no care plan for staff to follow to help the person manage their anxiety and mental health needs. A third person's care plan relating to their diabetes did not give staff any information about how they would recognise if the person's blood sugar levels were too high or too low, or what staff should do in this instance. This meant that people might not always have received they care they needed or wanted, and that the care might not have been delivered consistently by the staff.

In the PIR the provider wrote that assessments 'continued to be updated' and that they continued to look at people's needs and changing needs. We saw that care plans were reviewed monthly. The reviews referred to the person's involvement in the review, but we did not see that the person's views or comments had been recorded. People were unsure about their care plans. One person told us, "I don't know if I have a care plan" and another said, "I don't know if I'm involved in my care planning." However, we saw that care plans had been updated when the person's needs had changed and a relative confirmed this always happened. They said, "Staff are very hot on updating the care plan." Relatives knew about their family member's care plan and told us they had been involved in compiling it. They knew they could look at the care plan if they wanted to (and with their family member's consent), but did not see a reason as they were satisfied with the care.

We saw that care records included a document with the title 'How I choose to live'. This gave very personalised information, for example about the person's preferences, likes and dislikes, hobbies and interests and their past lives. This helped staff to get to know each person.

The provider employed an activity planner and a range of activities and entertainments were arranged. Each month each person was given a plan of the month's activities and people were encouraged and supported to join in if they wanted to. During the afternoon of the first day of our inspection a large group of people congregated in Valley View lounge to watch a film. People and staff told us about some of the activities that took place. The provider had purchased a mini-bus, which was used once a fortnight to take people out for lunch. We saw lots of photographs on the wall, including from the party held to celebrate the queen's 90th birthday. In the newspaper article the person living at the home had written, '…the home put on a celebratory tea with Union flags at each table, also red-white-and-blue tablecloths, serviettes and plates. We enjoyed a buffet-style tea with a large cake made and decorated by one of the cooks.' We were told that other occasions such as Halloween, fireworks night and Valentine's Day were always celebrated. The deputy manager told us that a party had been held in the summer to celebrate their 25 years working at the home.

People's hobbies and interests were recorded in their care plans and we saw one person doing some knitting and another person doing jig-saw puzzles. Another person told us that staff were very interested in their needlework, but did not often have time to assist them with it.

The provider had a complaints policy and procedure in place. This was on display in the shared areas of the home and was in the written information given to each person when they first arrived to live at the home. We saw that any complaints had been recorded and responded to within the provider's timescales. For example, one person had complained that they had had to wait 15 minutes for their call bell to be answered. The registered manager investigated the complaint and found that it was substantiated. They updated the call bell policy and discussed the matter with all staff in handovers. The registered manager was continuing to monitor the call bells to ensure that staff answered these in a timely manner. They had written to the person and their relatives to tell them the action they had taken. People and their relatives told us they would be comfortable speaking with staff or the managers if they had any concerns. One person said, "I don't have any problems with the care home." Another person told us they had raised a minor complaint with the manager "and he sorted it out." A relative told us, "I don't think I've ever complained. [Name of registered manager] and [name of deputy manager] would be my first port of call."

Requires Improvement

Our findings

The provider had a system in place to monitor the quality of the service being delivered to people by the staff. The managers told us they carried out audits of various aspects of the service, and spent a lot of time on the floor doing spot checks on the way staff were working. However, these audits and checks were not robust enough as they had not always identified the issues we found during the inspection. For example, audits of medicines had not identified the failure to manage medicines safely. Monitoring of care plans had not identified that care plans did not contain sufficient information and guidance for staff to ensure that people's current needs were met in the way they preferred.

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

Staff were given opportunities to express their views. However, staff views were not always acted on to drive improvements in the service. Staff told us that they were aware they needed further training in various topics relating to their work. Although they had requested this training, this had not been actioned.

People told us they were happy living at Mountside Residential Care Home and their interactions showed that they were comfortable with the staff. One person said, "It's [the home is] very nice. Everyone's friendly and helpful." People were happy with their rooms and one person described Valley View as "quiet and lovely". A relative told us, "[Name's] very happy. It's been brilliant for her. She really enjoys it here."

People's relatives told us they would recommend the home. One relative said, "If I knew of someone looking…I'd thoroughly recommend here. Our family have been really happy with everything for the last [number of] years. [Name] has everything she needs. A relative had written to the registered manager: they said, 'We would like to thank you so much for all the kind care and attention you and all your staff gave to [name of family member] over the [number of] years she spent at Mountside. We would have no hesitation in recommending your care home to anyone, you certainly have outstanding care, catering and activities etc.'

Staff were happy to be working at Mountside Residential Care Home. One new member of staff said, "I like it [the home]. I'm pleased, very pleased [to be working here]. Staff have made me feel part of the team – they're all very nice." The deputy manager told us, "They're a good team." Staff received regular supervision and staff meetings were held. Minutes from the staff meetings were made available for all staff to read.

People's relatives felt the home was managed well. Their comments included, "The management is perfect. They've always got time to speak to me"; "I get on very well with [names of registered and deputy managers]. They're very approachable"; "They've done really really well. [Name of deputy manager] has been an absolute diamond"; and "[Name of deputy manager] has been absolutely brilliant and my [family member] really trusts her." Relatives told us that the management notified everyone if there were any changes to what was going on in the home, such as staff recruitment and staff promotions.

The home carried out an annual survey to make sure that people and their relatives were satisfied with the service being delivered by the staff. One relative told us this had happened recently and they had assisted their family member to complete the questionnaire. Relatives also told us that a "residents' and relatives' meeting" was held every three months. This gave them an opportunity to put their views about the service and any ideas for improvements to the managers. Staff told us that a recent improvement had been the purchase of a reading lamp for people who wanted to do jig-saw puzzles in Valley View lounge. People were less sure about the opportunities for them to be involved in the home, making comments such as, "No-one has asked me if I'm happy here" and "I haven't been here long enough to be involved."

The provider's representative visited and walked around the home every week. They had a meeting with the managers, at which they all discussed various aspects of the service. As a result they were in the process of introducing a new staff handbook.

We found that records were maintained as required and kept securely when necessary. Records we held about the home confirmed that notifications had been sent to CQC as required by the regulations.

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 Medicines were not managed properly and safely. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes to monitor and improve the quality and safety of the service provided were not effective. Regulation17 (1) (2)(a)