Larchwood Care Homes (South) Limited

Mountwood

Inspection report

11 Millway Road
Andover
Hampshire
SP10 3EU

Tel: 01264333800

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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

This inspection was unannounced and took place on the 25, 26 and 28 October 2016. At the last inspection on 23, 24 and 26 June 2015 we found that the provider had breached three regulations associated with the Health and Social Care Act (Regulated Activities) Regulations 2014 (HSCA 2014). These related to: the provider not managing risks in relation to people's food allergies appropriately; not ensuring that complete, accurate and contemporaneous records were maintained relating to people's care; and staff not receiving appropriate training to enable them to carry out the duties they were employed to perform.

We told the provider they needed to take action and we received a report setting out the actions they would take to meet the regulations. At this inspection we reviewed whether or not these actions had been taken and the provider was now meeting the requirements of the HSCA 2014. We found improvements had been made regarding two of the breaches identified concerning staff training and food allergies. However we found one continuing breach regarding the complete, accurate and contemporaneous completion of documentation and a new breach with regards to meeting the requirements of the Mental Capacity Act 2015 (MCA). We have also made two recommendations regarding the design of the environment and activities provided for those people living with dementia.

Mountwood is a home which provides nursing and residential care for up to 39 people who have a range of needs, including those living with dementia, epilepsy and the detrimental effects on people's physical health following a stroke. At the time of our inspection 33 people were living in the home.

Mountwood is a two storey building with its own secure garden situated on the outskirts of the town of Andover. The home comprises of 40 single rooms, 36 of which have en-suite facilities. Access to the first floor is by a passenger lift and main staircases are accessible via user operated keypads. On the ground floor is a communal lounge with a separate activities room/lounge area, the home's kitchen and a dining room as well as laundry facilities and a nurse's station. On the first floor there is a joint lounge and dining area with tea making facilities available in a small kitchenette and a further nurses station. To the front of the property is a newly secured garden area with raised flower beds, seating and bird tables to provide interest for people living in and visiting the home.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home. 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.

People were assisted to receive their medicines as prescribed. However people's records in relation to these medicines were not accurately and fully completed which meant it could not be identified if people were receiving the care they required in order to keep them safe and manage their pain.

People were not always supported by sufficient numbers of staff. The provider was regularly using agency

staff to support staff working at the home and had taken action to increase the number of staff employed. People were receiving the care they required however would sometimes have to wait to receive care. Records regarding the care people received were also not completed fully as a result of these staffing shortfalls.

People were supported by staff to make their own decisions regarding the day to day care they received. However documentation did not always show that people's decisions regarding their care had been appropriately assessed and documented prior to care being delivered in accordance with the requirements of the MCA We could not always see that assessments and appropriate decision specific best interests meetings had been held before a course of care was delivered.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted. However these had not always been accompanied with the required appropriate MCA assessment and best interest decision documentation.

People's care plans and documentation were not always subject to regular monthly review. Whilst appropriate risk assessments were in place for most people we could not always see that staff had been provided with the most up to date information regarding people's care. Agency staff responsible for administering medicines did not always have the most accurate information available allowing them to support them in their role. People were at risk of not receiving the care they required to meet their needs and wants.

The registered manager was supported by a clinical lead who was responsible for overseeing the completion of documents and records specifically relating to peoples care. We could not always see the registered manager had been supported by the provider and the clinical lead to ensure that records were effectively and accurately completed for people living in the home. Quality assurance processes were also not always completed effectively. Processes did not always identify where information relating to people's care was inaccurate or missing allowing appropriate action to be taken to ensure people received the care they required to meet their specific needs.

Staff provided care to those living with dementia, however, the environment did not always support people to move around the home safely and to remain independent. Corridors were well lit however flooring was not always appropriate to support those with limited eyesight. Continual changes in type and colour of flooring would not assist those with limited vision as a result of their condition to be able to move effectively around the home. Appropriate signage in communal areas was not always in place allowing people to orientate themselves independently around the home.

We have made a recommendation about having an appropriate environmental design to support those living with dementia to mobilise independently.

The provider sought to engage people in activities however we could not see that all the activities provided supported those living with dementia to fully participate in familiar and recognisable tasks.

We have made a recommendation about having additional activities to enable people living with dementia to participate fully.

Relatives of people living at the home told us they felt their family members were cared for safely. Staff understood and followed the provider's guidance to enable them to recognise and address any

safeguarding concerns about people.

People were supported by staff who had been through a thorough recruitment procedure to ensure they were suitable to deliver care. Staff had received an effective induction into care delivery. All new care staff were required to complete initial induction training and accompany experienced members of staff whilst they completed their role to see what was required of them. Regular supervisions were not always being completed in line with the provider's guidance. However staff told us they were able to express concerns at any time with the registered manager and their colleagues and felt supported as a result.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such as a loss of accommodation as a result of fire or flooding.

People received sufficient food and drink to maintain their health and wellbeing. Snacks and drinks were encouraged between meals to ensure people remained hydrated. People assessed as requiring a specialised diet, for example a pureed or diabetic diet, received these and the food was pleasantly presented.

The staff and registered manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The registered manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People told us they knew how to complain and all said they would speak with the registered manager and senior staff if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during participations in the completion of annual survey questionnaires and providing feedback to an independent survey company.

The provider's mission statement regarding the quality of the care people were to receive whilst living at Mountwood were openly displayed within the home but were not immediately known by staff. However staff were able to describe how the registered manager wanted them to treat residents and they demonstrated they knew these standards of providing care which was respectful of people's dignity. We could see these standards were evidenced in the way care was delivered.

The registered manager and staff promoted a culture which focused on providing care in the way that staff would wish to receive care themselves. The registered manager had fulfilled the requirements of their role as they had informed the CQC of notifiable incidents which occurred at the home allowing the CQC to monitor that appropriate action was taken to keep people safe.

We found a continuing breach and a new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Medicines were administered safely by nurses. However records did not always show that people were receiving their topical medicines as prescribed.

People were not always supported by sufficient numbers of staff to ensure their needs were always met promptly. People said they would sometimes have to wait to receive care.

There was a thorough recruitment process in place to ensure the suitability of staff for their role.

Risks to people had been identified and recorded; detailed guidance was provided for staff on how to manage these safely for people.

Is the service effective?

Requires Improvement

The home was not always effective.

We could not always see that the legal requirements of the Mental Capacity Act (MCA) 2005 were met for people who lacked the capacity to make detailed decisions about their care. People were at risk of receiving care which had not always been provided in their best interests.

People were supported by staff who received an effective induction and training support to enable them to complete their role confidently.

People were able to eat and drink enough to maintain their nutritional and hydration needs. People who required a specialised diet received the food in an appropriate way to meet their health needs.

People were supported by staff who sought healthcare advice and support for them as required.

Is the service caring?

Good

The home was caring.

People told us that staff were caring. Staff had developed friendly and relaxed relationships with people.

Staff took the time to know people, their individual lives and care preferences to enable them to give care in a way which was kind and compassionate.

People received care which was respectful of their right to privacy whilst maintaining their safety.

Is the service responsive?

Requires Improvement

The home was not always responsive.

People were encouraged to participate in activities which were available daily however we could not always see that the activities available were designed for those living with dementia.

People's needs had been appropriately assessed before care delivery began however we could not see that people's care plans were subject to monthly review. This was required to ensure the information remained current for staff to have the most up to date information available to meet people's needs.

There were processes in place to enable people to raise any issues or concerns they had about the home. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Requires Improvement

The home was not always well led.

Quality assurance processes were not always used effectively to identify when people's care documentation was lacking the information required by staff to provide care which met people's needs.

The registered manager promoted a culture which placed the emphasis on people receiving quality care from staff in a homely environment.

Staff were aware of their role, felt supported and told us the registered manager provided positive leadership. The registered manager was aware of the requirements of their role and had formed the Care Quality Commission about important and

significant events that occurred at the location.

Mountwood

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 function. This inspection checked whether the provider was 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 home under the Care Act 2014.

This inspection took place on the 25, 26 and 28 October 2016 and was unannounced. The inspection was conducted by an adult social care inspector 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; on this occasion they had experience of family who had received residential care. The Expert by Experience spoke with people living at the home, staff, their relatives, observed mealtime sittings and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the home is required to send us by law. The provider also completed as Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with seven people, one relative, one nurse, the chef, two activities staff, six care staff, one member of housekeeping, the home's clinical lead who was also a nurse, the registered manager and a visiting social health care professional. We reviewed a range of records about people's care which included care plans in relation to eight people, including their daily care notes detailing the care provided and their Medicine Administration Records (MARS). We viewed seven staff recruitment files which included supervision and training records. We also looked at a number of documents involved in managing the home; these included the provider's policies, procedures, quality assurance processes and resulting action plan, complaints and compliments. We also looked at staff rotas for the dates 1 September to 25 October 2016. During the inspection we spent time observing staff interactions with people, including during two lunch time sittings.

Following the inspection we spoke with an additional three relatives.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the home in June 2015 we found the provider was not fully meeting the legal requirements relating to a number of Regulations of the HSCA 2014. The provider had not ensured that people were protected from the risk of harm as action had not always been taken to manage risks when it was identified people had allergies or intolerances to certain food. This was a breach of Regulation 12 (Safe care and treatment). The provider had also not ensured that complete, accurate and contemporaneous records were maintained in respect of each person regarding the treatment provided. This was a breach of Regulation 17 (Good governance) of the HSCA 2014. The provider sent us an action plan following the June 2015 inspection detailing the steps they would take to ensure the home was meeting the requirements of the regulations. This also included the timescales for completion of these actions.

At this inspection we could see that some action had been taken in regards to Regulation 12. The provider had taken the action to ensure that people's allergies and intolerances to food items were clearly documented for the chef and kitchen staff. This information was readily available, provided to us during the inspection and known by the catering staff. The provider was now meeting the requirement of this regulation.

Observations showed people were receiving their medicines safely; however records did not always confirm this. Nurses were responsible for administering medicines and staff were responsible for the application of prescribed creams known as 'Topical' medicines. These included barrier creams and emollients which protect people's skin from the risk of pressure ulcers. We could not see that records always correctly and clearly documented for staff when people required their topical medicines. Staff were aware of the frequency these medicines should be applied however the appropriate guidance was not always made clear to agency staff. Due to a lack of clear documented guidance the provider could not be assured that any agency staff unfamiliar with people's needs and reliant on this guidance would always administer topical medicines as prescribed. Daily care records also did not always accurately show whether people had been provided with their topical medicines. Staff identified that due to a lack of staff they were not always able to complete records effectively. It could not be demonstrated through the TMARs or people's daily care records that medicines had been provided in order to protect people's skin. There was a risk that people may not have received their topical medicines as prescribed.

For people who received 'as required' medicines, commonly known as PRN, we could not see that guidance had always been provided to nurses on all occasions as to when their use was appropriate, including the maximum dosage of a medicine people could receive in a 24 hour period.. Nurses knew when people required their PRN medicine, however, as this was not always documented, it may not have been clear for agency nurses, unfamiliar with people's care and reliant on this guidance, who were responsible for managing people's medicines safely. The provider was regularly using agency nurses to support their current staff numbers.

The provider had not ensured that accurate, complete and contemporaneous care records were kept in relation to service users. This was a continuing breach of Regulation 17 (Good governance) of the HSCA

2014.

Medicine administration records (MARS) were correctly completed by the nurses to identify people received their medicines as prescribed. Nurses were not subject to annual competency assessments to ensure medicines were managed and administered safely. However nurses were supported to remain their professional registration and we did not see any medicine errors during the inspection. New documentation was in place at the time of the inspection to ensure these would be completed annually assessing nurses' competence and confidence to manage medicines safely. There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance. Two medicine rounds were observed during which the nurses appropriately supported people to take their medicines as prescribed. Medicines were stored, administered and disposed of correctly which included those which require refrigeration to remain safe. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited by the clinical lead to check that records and stock levels were correct.

People were not always supported by sufficient numbers of staff to meet their needs in a timely manner. The registered manager identified the required staffing levels required across the home. These consisted of two nurses and seven care staff working in the morning and afternoon with one nurse and four care staff working during the night.

Where shortfalls in the current staffing levels were identified the provider used agency staff and nurses to try and meet the minimum levels of staffing identified as a requirement. However due to staff sickness staffing levels often fell below this minimum level. Between1 September and 25 October 2016 there were 29 shifts which were staffed with levels below the provider's minimum. This was often as a result of staff being unable to work their shifts at the last minute due to illness. The provider did not have a contingency plan in place to address this risk. This meant people were at risk of not always receiving care in line with their assessed needs at the time they needed it due to a staff shortage.

Staff told us they were delivering care people needed however there would often be a delay before they could meet all people's needs. People confirmed they would sometimes have to wait to receive care. One person told us, "I do feel safe because there are always people around, but you have to wait sometimes for them to be free to help". Another person said, "I can just call out if I need help, sometimes it is quicker than others".

Staff told us, and we saw, that people's daily care records and care plans were not updated regularly with full details of the care provided due to a lack of time available for staff to complete. The provider and registered manager had acknowledged that the lack of permanent staff was having an impact on the completion of paperwork and placing additional stress on existing staff. As a result steps had already been taken before the inspection to improve the current levels of staffing and reduce reliance on agency staff as additional support. A Chartered Recruitment Consultant had been employed by the provider and was present on the second day of the inspection. Their role was to review recruitment and retention processes to identify where the provider would be able to recruit permanent nurses and staff. This would enable people to receive care from easily recognised and remembered staff and for paperwork completion to be undertaken.

There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood. This was known as the Emergency Contingency Plan. In the event of an evacuation the provider would utilise other Nursing Homes in the nearby facility or a local church hall.

These plans allowed for people to continue receiving the care they required at the time it was needed.

Personal Emergency Evacuation Plans (PEEPs) had not been completed for people living at the home. These provide an easy to follow guide for staff and emergency services personnel about the support people required in the event of an emergency. The provider's recently completed quality assurance audit in August 2016 had identified that PEEPS had not been created for people living at the home. This had been included in the homes development plan and was to be completed by the clinical lead to the home by the end of November 2016. This would allow staff and emergency services personnel to have the most up to date information regarding people's moving and handling needs and immediate healthcare requirements in the event of an emergency.

People, relatives and the social care professional we spoke with, told us that people living at Mountwood were safe. One person told us, "I do feel safe, there's nothing particular, but people are always around if I need help". A relative said, "110% - I feel that he (family member) is safe there".

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe the physical and emotional symptoms people suffering from abuse who could not verbally communicate could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns within the home and where to report externally to the appropriate authorities. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, those associated with people's personal care and physical wellbeing and risks associated with acquiring a pressure ulcer. They also included, where required, risk assessments regarding people's behaviour which could challenge. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people had restricted mobility due to their physical health needs. In these people's care plans there was guidance for staff about how to support them to mobilise safely around and outside the home. We saw this guidance was followed by staff throughout the inspection. Additional risk assessments were completed when required to manage new risks to people's safety. This included risk assessments associated with people's nutritional risks. A visiting specialist nutritional nurse spoke positively of the specific nutritional risk assessments which had been created and the action taken by staff to manage these risks appropriately. Records did not always show that people's care plans and risk assessments had been reviewed monthly. However staff knew people's individual risks and were able to demonstrate that they knew how to support people safely.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Requires Improvement

Is the service effective?

Our findings

At out last inspection in June 2015 we found the provider had not ensured that people were supported by staff who had received appropriate training to enable them to manage people's needs effectively and safely. This was a breach of Regulation 18 (Staffing) of the HSCA 2014.

The provider sent us an action plan following this inspection detailing the steps they would take to ensure the home was meeting the requirements of the regulations and the timescales for completion. At this inspection we found that the provider had taken the required action to meet the requirements of the regulation. There was documentation in place which identified clearly when staff required an update of their training. The home had also employed an administration assistant who's role included monitoring staff training to ensure that when updates to training were required these were arranged.

People were supported by new staff who received a thorough and effective induction into their role based on the Care Certificate. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. New members of staff told us they had been in receipt of training such as manual handling and dementia awareness prior to delivering care. They had also been supported by other care staff by shadowing them during care delivery to ensure they understood the requirements of their roles. Staff told us they were confident in their ability to deliver care and we could see this evidenced throughout the inspection.

The Mental Capacity Act (MCA) 2005 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. Staff were not always readily able to discuss the principles of the MCA however all clearly identified they knew how to offer support to people enabling them to make their own choices during their everyday interactions.

It was not always evident that the provider had always complied with the requirements of the MCA when people had been assessed as lacking capacity to make specific decisions about their care. Some records showed that decision specific best interest meetings had been discussed with people, family members and social care professionals when people were unable to consent to receiving medical treatments. The action taken as a result of the best interest decisions had resulted in significant positive health improvements for people. However, this had not been consistent and the home had not documented that all decisions taken as occurring in people's best interests. The provider, registered manager and clinical lead had not ensured that appropriate processes were documented to ensure that any actions taken on people's behalf had been within the principles of the MCA. For example, one person was in receipt of covert medicines. Whilst discussions had been held with the relevant persons no MCA assessment or best interests documentation had been completed to see if administering medicines covertly was in the person's best interests. People were at risk of receiving care which had not always been identified as being provided in their best interests.

People's freedom cannot be restricted without the appropriate authorisation being sought. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager showed an understanding of the DoLS which was evidenced through conversations and submitted applications. However we could not see that appropriate MCA assessments had been completed with correctly held best interest meetings prior to the submission of the appropriate application forms. The provider operated a locked door policy which meant that people, other than one resident, were unable to leave the home without the support of staff. This meant that their liberty was being deprived as they were unable to leave without continual supervision. People were at risk of having their freedom deprived unlawfully without the appropriate MCA assessment and resulting best interest meeting stating this was required. These would identify that the person was no longer able to recognise the risk associated with leaving the home and therefore a DoLS would be appropriate.

The home had not always demonstrated they had assessed people's capacity to make specific decisions regarding managing their medicines or risk associated with leaving the home. Best interest decisions had not always been completed to ensure that the home was demonstrably operating in people's best interests and those relatives and significant persons in people's care had been involved in those decisions. This process had not allowed people the opportunity to maintain their independent living skills regarding their medicines and ability to leave the home unsupported.

There was not always evidence that, where MCA assessments and best interest decisions were required, the service had acted in accordance with the principles of the MCA. This was a breach of Regulation 11 (Need for consent) of the HSCA 2014.

People, their relatives and the social care professional we spoke with were positive about the ability of staff to meet people's care needs. Relatives said that they felt staff had sufficient knowledge and skills to deliver care. One relative we spoke with told us, "Staff have good skills and they do a jolly good job, they treat all the residents the same".

Despite providing care to those living with dementia we could not see that the environment had been adapted to support people to live as independently as possible. The home was an older building which had not been specifically designed or decorated to meet the needs of those living with dementia. The corridors in places were not very wide and where not naturally lit, although there had been the provision of lighting which helped the brightness of these areas. This is necessary to support those with limited eyesight associated with old age and those living with dementia. There were contrasting coloured handrails to support those who were able to mobilise independently in a majority of the areas of the home. The incompleteness of the handrails had been identified during a provider audit in August 2016 and steps were being taken to assess if the width of the corridors in certain areas allowed for these to be installed. Toilets, bathroom doors and doors leading to communal areas such as the lounge and dining room did not always have pictorial signage to make identification easier for people. This had also been identified during the provider's audit in August 2016 and the registered manager had visited another home to see the systems in place there and had ordered appropriate signs. The carpet and flooring throughout the home was not always appropriate for those living with limited eyesight as it was dark in places with multiple, repeated small patterns. Changing colours and patterns of flooring can be disorientating for those who have limited visual capacity as a result of their dementia.

We recommend that the provider seeks advice and guidance from a reputable source about developing a dementia friendly living environment.

People were assisted by care staff who received support in their role. There were processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. However staff told us and records confirmed these supervisions were not happening in accordance with the provider's frequency guidelines of at least every eight weeks. The registered manager acknowledged that supervisions and appraisals had not been occurring as frequently as per the provider's guidelines. However the registered manager expressed that they had an 'open door' policy to staff, relatives and visitors and could be spoken to at any time. Despite not receiving regular supervisions staff told us they felt supported and could seek additional guidance at any time. One member of staff told us, "It's very easy to speak to (registered manager) I can speak to her about anything, same with the nurses I would say I can feel I can talk to anybody". Another member of staff told us, "I can't say I don't feel supported (the registered manager) is very supportive". Staff told us they were able to speak to their colleagues and the registered manager at any time if they required additional support. Processes were in place so that staff received the support required to enable them to conduct their role effectively.

People and relatives were mainly complimentary about the food provided and staff ensured people were supported to maintain their nutrition and hydration needs. One person told us about the food, "I enjoy the food, it's the sort of thing I would choose, and we always get choice when they come round with the menu", another person said, "It is quite good". A relative told us about the food provided, "If a resident doesn't want the meal choice the carers will offer other options until something takes their fancy".

People were supported to enjoy their meals however observations showed people would sometimes wait to be assisted owing to the staffing numbers available. Staff were aware of the importance for people to eat and drink sufficiently to maintain their hydration and nutritional needs. When people stated that they did not wish to continue or had not eaten much of their meal staff sought alternatives to try to encourage these people to eat. Staff often came down to eye level to help the interaction with people to offer support whilst assisting them to eat. Squashes and water were available in people's rooms with snacks available and biscuits and tea on frequent offer.

The chef was aware of people who had specific dietary needs such as diabetic or those who required a pureed or soft diet. They also identified when a person's changing health needs meant temporary changes were required to their diet. For example one person was living with a mouth ulcer which made it uncomfortable to eat normally. We could see that this person's meals had been altered to puree to minimise the discomfort they would experience whilst eating. We could see that care had been taken when presenting pureed food so that it retained an appetising visual appeal and was separated on the plates to allow people to identify what they were eating. The chef had found out people's likes and dislikes to ensure that meals could be prepared to meet their specific needs and preferences.

People were supported to maintain good health and could access health care services when needed. People living with specific health conditions which required additional support had guidance provided to staff on how to manage effectively. There was evidence of referral to and collaborative working with other external healthcare professionals. Specific and clear guidance was provided to support staff on how to manage people living with certain illness or injury for example those with pressure ulcers. We could also see that people had moved to the home suffering from significant pressure ulcers. Care plans provided detailed guidance for staff and showed healthcare professional input had been obtained to ensure that these situations were managed effectively. We could see and records showed that those suffering with pre-existing

areas of injury had been healed as a result of the positive actions taken.

Good

Is the service caring?

Our findings

All the people, relatives and a social care professional we spoke with told us that support was delivered by caring staff. One person told us, "You never get treated badly here, they look after us very well - they are very caring and always helpful". A relative said, "I think the caring is absolutely outstanding - the interaction of the carers with residents is so positive and cheerful".

Relaxed, friendly and caring relationships with people had been developed by staff. Not all people's care plans viewed information about what was important to them such as where they had lived, worked, their family relationships and hobbies and interests for example. This information allows care staff to know the people they are supporting allowing them to engage with familiar and comfortable topics. However care staff had actively sought to find out this information from the people they supported. This allowed them to engage in meaningful and personal conversations during care delivery. We saw that all care staff displayed a detailed knowledge of people's interests, preferences and family relationships and spoke fondly of those they assisted. People were supported by care staff who were caring in their approach and had taken time to get to know them as an individual.

Where appropriate physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people to engage with them. When communicating with people most staff would lower themselves to eye level to ensure that people were engaged in conversation. Staff would also often gently place a hand on people's arms to communicate that they were to be engaged in conversation. We saw that people were comfortable and actively supported this physical contact with staff.

People were supported by staff who took positive steps to minimise their distress and guidance was provided for staff to manage appropriately. For example one person required regular repositioning in their care plan due to their risk of acquiring pressure ulcers. This frequency of repositioning had proved distressing to the person involved so staff had appropriately assessed that they would increase the length of time between repositioning them. This enabled the person to receive safe care but in a way that minimised their discomfort and distress.

All staff said that despite being busy they would all find the time to spend with any people who were upset to ensure their emotional wellbeing needs were met. Residents confirmed that staff would treat people kindly in periods of anxiety and took action when necessary. One relative told us, "If a resident is confused the staff treat them very kindly and personally spending time with them to try and find what has triggered their confusion and if it can be put right". Another relative said, "I came in the other day and (family member) appeared to be much more agitated than usual. I mentioned this to a carer who then discussed with the staff nurse…within 10 minutes (a nurse) came to investigate if anything specific was causing the agitation, and whether there was anything that could be done to alleviate this". We observed staff taking the appropriate action to support people when distressed.
During the inspection one person receiving personal care became distressed and began crying and shouting out, staff continually reassured this person they were there to help them feel better. Staff remained calm, kind and reassuring in their interactions with this person until they calmed and care delivery had been

completed. People were supported by staff who knew how to respond appropriately to people's emotional needs.

People were supported to express their views and where possible were involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear, eat and drink and where they would like to spend their time.

People and their relatives told us they were treated with respect and had their privacy maintained at all times. One person told us, "The carers are careful to respect my privacy and they always treat us kindly with dignity and respect". A relative said "The staff always respect privacy, sometimes when I arrive I find a sign on the door indicating they are helping with personal care, and residents are always treated with dignity and respect, all of them, not just (family member)". Signs identifying that care was being delivered were displayed on people's doors and communal bathroom areas. This informed any potential visitors that the person was not in a position to be disturbed and they should wait to be invited into the room. Staff were also able to provide examples of how they respected people's dignity during care delivery and treated people with compassion.

Requires Improvement

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided.

People's care needs had been assessed and documented by the nursing staff before they started receiving care. These assessments identified people's support needs and were used to develop care plans outlining how these needs were to be met. This included obtaining information on people's medical histories and diagnosis, personal care needs and whether people required any assistance with their eating and drinking or mobility. Care plans were then created from these preadmission assessments to ensure care delivered met these needs.

Staff had not always been provided with the most up to date guidance to support people and their changing needs. Records identified that people's individual needs, care plans and risk assessments should be reviewed monthly to ensure care plans provided the most current information for staff to follow. However, we could not always see all records were being updated when required. A month before the inspection the new provider had requested all staff complete new documentation which included creating new care plans and risk assessments. Some of this work had been completed by the time of the inspection however only three of the new care plans were in place. Staff were still delivering care using guidance in the previous provider's documentation. Whilst regular staff were aware of people's changing needs and could demonstrate how to manage these any agency staff, unfamiliar with these people and therefor reliant on the care plans for guidance, may not know what appropriate care to deliver. For example one person had suffered a stroke which had resulted in this person having an inability to communicate their needs clearly with staff. This information had not been updated in this persons care plan so any new agency staff may not have been aware there had been a change in this person's needs. Another person had experienced a change in their mental health however guidance provided by a health care professional had not been appropriately documented in the correct part of their care plan and made clear for staff. When agency staff were working, permanent members of staff were also deployed which meant there were always staff at the home who knew the specific care people required. However there was a risk that people would not be receiving care in line with their needs because their changes in needs had not been appropriately documented.

The provider had not ensured that accurate, complete and contemporaneous care records were kept in relation to service users. This was a continuing breach of Regulation 17 (Good governance) of the HSCA 2014.

For some other people when it had been identified there had been a change in people's health care needs this was recorded and actioned appropriately. Records showed that when one person was continually losing weight the appropriate action had been taken. The person was appropriately referred to and assessed by the GP for their weight loss. Guidance was then provided for staff in this person's care plan advising them of the action to take to ensure this weight loss did not continue. This included offering larger portions of food and to assist with supporting them with their meal routine if required. A nutrition nurse

visited the service and recommended that a nourishing evening drink with fortified milk and a high calorie snack in the evening was offered at 8pm. We could see that a 'Nite Bites' drink and sandwich round had been implemented at 8pm each night to encourage people to enjoy snacks and drinks to enable them to regain and retain a healthy weight.

Handover between all staff were held at the change of shift twice a day. These were held between the nurses and the senior care staff. Senior care staff then passed this information to other care staff. The handover contained specific information in relation to people's needs such as their moving and handling needs, their medical diagnosis and any special instruction regarding people's diets such as puree or thickened fluids being required. This was to ensure all staff deployed had the most up to date information on people's needs required to deliver the most appropriate care. However these did not include all the specific information required regarding people's individual needs. Agency staff would also have to refer to care documentation kept in people's rooms which were not always complete and up to date. People were supported by regular staff who knew their health needs however it could not be ensured that agency members of staff responsible for people's care were always provided with the most accurate and up to date information relating to people's needs.

The provider sought to engage people in meaningful activities. People we spoke with talked positively of the activities that were available for their participation. One person told us, "I enjoy things here" another person said, "I like the exercises we do when sitting in the chair, it's good to be able to keep mobile". Relatives confirmed that staff sought opportunities for people to participate in activities and encouraged them to participate. One relative told us, "The carers have tried really hard to encourage him, but dad doesn't want to join in the activities he just wants to stay in his room".

The home employed two activity coordinators who ensured two activities were offered for each day of the week which included weekends. Some people's care plans contained a social interests, hobbies, religious and cultural assessment. This detailed people's individual abilities, needs, preferences, personal wishes and specific risks associated with these activities. For example one person's care plan had been updated to record that they had changed the level of interaction they required from being involved in most activities to being a more private person. We could see that this person was encouraged to participate in activities but chose not to and this was respected .

A typical weeks activities programme was reviewed which had defined activities each day. These included discussion groups, pampering, bingo, arts and crafts and exercise. The home supported those living with dementia but we could not see that all activities offered were of the type which would meet their particular needs. This can include home style activities such as gathering laundry, dusting and setting tablets which can help provide purpose and links to people's lives before they moved into the home. However the home did offer people the chance to reminisce which is an important activity for those living with dementia. Reminiscence tasks can include looking at photographs and creating memory boxes. These types of activities can help a person living with dementia feel connected to their life before receiving care and can maximise their choice and control. Some activities such as those involving reminisce can also help people seek an emotional connection with others. We could see that some people living in the home had been supported to create memory boxes. These are highly personalised boxes situated outside people's individual rooms which contain pictures, images and items of personal significance. These allow people to orientate themselves within the home to identify their room but also provide opportunities for people to help retain memories of important people and places to support their emotional wellbeing.

We could not see external organised activities were not regularly included in the activities programme. However the home also held fetes and invited people, family, friends and the local community to the home

to participate in events.

We recommend that the provider seeks guidance from a reputable source on how to actively promote activities identified as appropriate for those living with dementia. This is to ensure that all people are offered the opportunity to participate in meaningful activities.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. When concerns had been identified prior to an official complaint being made action was taken to immediately rectify situations. One relative told us, "I did raise a concern which involved another resident who was wandering….when I raised this with the management they immediately purchased the stair gate to prevent other residents just wandering in and it was resolved very satisfactorily." One person said "I've never had to complain, I haven't needed to, but I know staff and management are approachable and I would be happy to raise a concern or make a complaint knowing that staff would listen and respond."

The provider's complaints policy was openly displayed and accessible to people, their visitors and relatives in the public foyer. This provided information regarding how people could complain and the actions that would be taken in response to a complaint being received. The provider's complaints policy included information on how to raise concerns with external agencies such as the Local Government Ombudsmen if a complainant remained dissatisfied with the outcome of their complaint.

There had been one complaint received since the last inspection. Records showed that the complaint regarding a staff member's attitude during care delivery had been investigated by the registered manager and steps taken to address the causes of the complaint. The complainant was then responded to appropriately in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

We could not always see that documentation relating to people's care always accurately reflected their individual needs. The provider for the home had changed in 2016. This had caused some uncertainly with the resulting changes in processes, policies and procedures which required action by the registered manager and clinical lead. However, we could not always see that the registered manager was supported by the provider and clinical team in their role to ensure documentation relating to health related issues was completed and updated monthly as required by the provider. The registered manager did not have a clinical background which would enable them to complete specific health related documentation such as TMARS, MARS and health specific care plans such as for those living with diabetes. This role was the responsibility of the clinical lead to complete as an experienced registered nurse. However, we could not see that this role was always being completed fully. Nursing staff had responsibility for ensuring MCA and best interest decisions were being appropriately completed, however, this had not always been happening. The clinical lead acknowledged that care plans and peoples care records had not been updated monthly as required and identified this as being due to a lack of permanent nurses available.

We could not see that regular effective auditing processes were in place to monitor the quality of the service provided. Audits were required to be completed of people's care plan documentation on a monthly basis by the home's clinical team, who were responsible for overseeing the quality of the nursing care provided, the registered manager and the regional manager. These audits gathered evidence of compliance with the regulations from a range of sources which included care plans, infection control audits, medication management and quality monitoring reports. During our inspection we noted that it had not been identified that people's TMARs had not been accurately completed and were missing relevant information required by staff to provide the most appropriate care. They had noted that care plans were not always updated however did not identify that people's MARS did not always contain clear and concise guidance required by agency nurses and staff on how to manage people's health needs appropriately. This lack of documentation meant it was not always clear that people were receiving the most appropriate care their required to maintain their health and wellbeing. This had led to the continuing breach of Regulation 17 of the HSCA 2014.

However where audits were used effectively and areas identified areas for improvement actions were recorded on a development plan and monitored for completion to ensure that the home was meeting the identified standards. A providers audit was completed twice yearly by the regional manager. The last provider audit completed in August 2016 highlighted a number of the issues identified during this inspection. This included that the home's signage was not always available and appropriately used for those living with dementia. As a result the registered manager had visited another of the provider's home which specialised in providing dementia care viewing the signage in place to support people. This audit also identified that people's care plans and daily records were not always completed fully and there was no evidence that care plans were evaluated and reviewed on a monthly basis. The new provider had supplied new documentation relating to care plans and people's records a month prior to the inspection. However as an immediate response the registered manager had introduced a 'Resident of the Day' system a matter of weeks before the inspection. This involved each resident having a full review of their care plan on a specific

date of the month to ensure it met their needs. Nurses were responsible for completing these reviews however the use of agency nursing staff meant these were not always completed effectively.

During the inspection it was identified that one person's care plan was very unclear with the guidance provided to staff regarding how to manage their diabetes care. An agency nurse was requested to rewrite this persons specific care plan making it clear their needs and the care required. However despite this being rewritten we saw this continued to lack the information and guidance provided for agency staff on how to manage this person's needs effectively. This meant this person was at continued risk of receiving care which did not meet their needs. The registered manager was aware of the need for regular care plan reviews and the clinical lead, who had responsibility for ensuring these were completed, was given a deadline to complete all by 31 March 2017. However this meant there would be a period of time where people were at risk of not receiving the care they required to meet their needs as people's documentation did not always contain the most accurate and up to date information required. The provider and registered manager had audits in place that when used effectively identified areas where improvements could be made of the quality of the service provided.

The registered manager wanted to promote a happy, person centred and homely culture at Mountwood and actively sought feedback from people living at the home, their friends and family. Most people we spoke with were confident in the registered manager's ability to manage the home and address concerns. People and relatives told us they were happy with the quality of the service provided. One relative told us, "I feel like I am going into his (family members) own house, they (staff) treat us all like family All the care is centred around her (family member)". Another relative said, "The home is a calm place, and the staff always seen calm. They are kind and caring and do all they possibly can with the residents to make them comfy".

The registered manager wanted each individual to be able to feel that Mountwood was their own home. This aim was underpinned by providing a comfortable homely environment where staff treated people as individuals ensuring they were happy. The person centred culture was understood by staff and observed in the care delivered. This was evidenced in the positive comments received from people and relatives of those living in the home. One person told us, "The staff here are super, everything is really good". One relative told us, "The staff genuinely seem to care about the residents. Nothing is too much trouble and they make me feel as welcome as much as (family member)". Another relative said, "My son visits occasionally and he has said (family member) has never looked better and is always very happy".

The provider had a 'Mission Statement' which was openly displayed in the home. This included information regarding the type of care people should experience whilst living at the home. The provider sought to promote the value that a professional team of staff would focus on developing standards of excellence in the home ensuring the delivery of quality services. Staff were not always able to identify the providers values in the mission statement as these were new to the home. However, all were able to say that the registered manager's values were to provide quality care, treating people as individuals, providing care which respected their dignity and respect. One member of staff told us "(the registered manager) said (treat everyone) as if it was mum. How you would treat your mum…everything that you do and everything that you say, would you accept that for your mum". Another member of staff said regarding the registered manager's values that staff should, "(treat people) as they want their parents to be treated". This caring culture was reinforced with staff through staff supervision meetings and discussions and observations conducted daily by the registered manager around the home.

The registered manager was a visible presence to people, relatives, visitors and staff. Relatives and a social care professional we spoke with were confident that the registered manager was approachable and able to be spoken with at any time. One relative told us, "The (registered) manager is seen most times I visit, and she

is very approachable", another relative said, "The manager is seen on the floor and always asks if everything is okay when she sees you". Staff and the social care professional we spoke with were positive about both the registered manager and the support they received to do their jobs. They told us that the registered manager was open to their concerns and needs. One member of staff told us, "She's (registered manager) always there for us" and another member of staff said, "She's (registered manager) a very good manager, she's very supportive and I have approached her with few suggestions for example and she took them on board". People and their family were able to communicate freely with staff and the registered manager creating an open and honest environment to share feedback and concerns.

The registered manager was able to evidence that they knew what was required of their role. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the home. We use this information to monitor the home to ensure they respond appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance.

The quality of the service people experienced was monitored through the use of residents and relatives surveys as well the completion of an online national and independent care home survey. The home's surveys were conducted annually and the results reviewed by the provider to see where improvements could be made. The results from the last completed September 2016 survey were viewed. People were asked to rate the home in areas including, if the general appearance of the home and grounds were welcoming and inviting, if staff appeared to be available when people needed them and if the home responded appropriately when the needs of people changed. The 2016 survey identified that all the people who responded had done so positively in most aspects. However one person out of the five who had completed stated they did not feel that staff were always available and did not always feel they were kept up to date with the progress people were making in the home. These results had only been made available to the registered manager a short time before the inspection. We could see that they were due to discuss the results with the provider immediately following our inspection to see where improvements could be made.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home thanking them for the quality of the care provided. One relative spoke very highly of the care provided to their family member whilst at Mountwood saying that thanks to the quality of the care provided "He's just a changed person since he's been in here." People had also included their comments on an independent website which allows people to share their experiences of the care they received. We saw people had written positively of their care experience. One relative commented, "My mother has been at Mountwood…her care is excellent, her mental health is treated with care, humanity and understanding by everyone". Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the registered manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always ensured that people's capacity to make decisions regarding their care had been appropriately assessed to ensure that actions taken were in people's best interests. Regulation 11 (1)