MGL Healthcare Limited

Mont Calm Residential Home

Inspection report

72-74 Bower Mount Road
Maidstone, Kent
ME16 8AT
Tel: 01622 752117
Website:

Date of inspection visit: 27 and 28 April 2015
Date of publication: 16/07/2015

Ratings

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

Overall summary

This inspection was carried out on 27 and 28 April 2015. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received.

Mont Calm Residential Home provides accommodation and personal care for up to 39 older people. There were 25 people living at the service during our inspection. People had a variety of complex needs including people with mental health and physical health needs and people living with dementia. Accommodation was provided in two adjacent houses. There was a passenger lift between floors in each house.

The service did not have a registered manager. The previous registered manager had ceased working at the service in December 2014. The provider told us that a new manager was due to start working in the service during the week of our inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated Regulations about how the service is run.

Summary of findings

At our previous inspection on 19 and 20 January 2015 we found breaches of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. We took enforcement action and required the provider to make improvements. We issued four warning notices in relation to care and welfare; safeguarding people from abuse; quality assurance and having enough staff. We found six further breaches of regulations. We asked the provider to take action in relation to nutrition, privacy and dignity, obtaining consent; handling complaints; staff training and record keeping.

The provider gave us an action plan on 6 February 2015 but did not provide timescales by which the regulations would be met. The provider did not send us the updates we requested in relation to progress they had made.

At this inspection we found that some improvements had been made but the provider had not completed all the actions they told us they would take. In particular they had not met the requirements of the warning notices we issued at out last inspection. As a result, they were breaching regulations relating to fundamental standards of care.

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

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. The provider was not aware of some incidents of abuse and had therefore not notified these to the relevant authorities to make sure people were protected from the risk of abuse.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. The provider had not arranged for a fire safety risk assessment to be carried out by a suitably qualified person to make sure people were protected from the risk of fire.

People were not always provided with enough to eat and drink. One person had experienced significant weight loss. Action had not been taken in a timely manner to ensure they were protected them from malnutrition. People were not offered choice at mealtimes in ways they could understand.

Some people had not received their medicines as prescribed. Suitable arrangements were in place for managing medicines, but the recording of some medicines did not follow guidance issued by the National Institute for Health and Clinical Excellence.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had not submitted Deprivation of Liberty Safeguards (DoLS) applications for most people, although they were aware of the requirement to do so. People's mental capacity had not been assessed before decisions were made on their behalf.

The provider did not have an effective system to assess how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times. We observed that there were not enough staff deployed to care for people effectively.

Staff had not received training in managing people's behaviours that had a negative effect on themselves or others. Staff had not been trained in privacy and dignity or how to meet some people's specific needs.

The complaints procedure was out of date and did not provide information about external authorities people could talk to if they were unhappy about the service. People told us they would speak to staff or the provider. We have made a recommendation about this.

People were not always involved in planning their care and their spiritual needs were not taken into account. We have made a recommendation about this.

People were not always provided with personalised care. They were not provided with sufficient, meaningful activities to promote their wellbeing.

Staff were cheerful and patient in their approach and had a good rapport with people. The atmosphere in the home was generally calm and relaxed and there were lots of smiles and laughter.

Summary of findings

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and were complimentary about the care their relatives received. People were consulted through resident's and relative's meetings and their views taken into account in the way the service was run.

Most staff had received the essential training and updates required, such as food hygiene and fire safety training, to meet people's needs.

People were generally complimentary about the food and drinks were readily available throughout the day.

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

Ensure that providers found to be providing inadequate care significantly improve

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

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

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe

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

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

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

People did not consistently receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not always effective

One person was not always getting enough to eat and drink to maintain their health. Choices of food and meals were not offered in ways people living with dementia could understand.

There were no clear procedures in place in relation to the Mental Capacity Act 2005. The provider understood how to implement Deprivation of Liberty Safeguards.

Training in people's specific needs had not been completed. Most staff had the essential training and updates required. Some staff had not received the supervision and support they needed to carry out their roles effectively.

People were supported effectively with their health care needs.

Is the service caring?

Requires improvement

The service was not consistently caring

People or their representatives were not always involved in planning their care.

People's privacy and dignity was protected.

Staff were kind, caring and patient in their approach or supported people in a calm and relaxed manner.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The complaints procedure was out of date. Complaints were managed effectively to make sure they were responded to appropriately.

People were not always provided with personalised care.

Summary of findings

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

Is the service well-led?

Inadequate

The service was not well led.

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

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

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

Mont Calm Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 April 2015 and was unannounced. This was a focussed inspection to look at actions the provider had taken to make the improvements required following our inspection on 19 and 20 January 2015.

The inspection team included three inspectors one of whom was a pharmacist inspector. The team also included an expert-by-experience who had personal experience of caring for older family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including the provider's action plan, information from the local authority and our last report.

During our inspection we observed care in communal areas; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We examined records including staff rotas; management records and care records for four people. We looked around the premises and spoke with 11 people, 10 relatives, three care staff, the cook, the deputy manager, the general manager and the provider. We also spoke with a GP and the local authority safeguarding coordinator.

Inadequate

Is the service safe?

Our findings

At our last inspection on 19 January 2015, we identified breaches of Regulations 11 & 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 13 & 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff to keep people safe. People were not protected from abuse or from other risks to their safety and welfare. We issued warning notices and required the provider to make improvements by 6 March 2015. We also asked the provider to take action to make improvements to their recruitment procedures and the administration of medicines. The provider sent us an action plan but did not provide timescales by which the regulations would be met. They did not send us the updates we asked for to show their progress.

At this inspection we found that some improvements had been made. However, there were not enough staff deployed to ensure that people were protected from the risk of abuse or harm.

People told us they felt safe. People said, "I do feel safe"; "I do feel safe, everything feels all right"; "Yes, I do feel safe, and I actually am safe" and "People will always moan and groan and find fault but we are all safe". Relatives told us that there were not always sufficient numbers of staff on duty. A relative said that their family member was safe at the home, they went on to say, "We never question (the family member's) safety". Another relative told us "I know (the family member's) is safe and will never be abused".

We looked at records to make sure that incidents were recorded and reported to the local authority safeguarding team in accordance with the Local Authority procedures for safeguarding adults. In the four care plans we looked at we found two incident reports when abuse between people had taken place. The general manager told us that they had not been informed about these incidents so they had not been reported to the appropriate authorities. The safeguarding policy was not up to date and showed incorrect contact details for outside agencies. A copy of the 'Local Authority Safeguarding Adults Procedures' was not available to staff at the service. Although most of the staff had training in safeguarding, they did not have access to all the information they needed about how to report abuse, including contact details for the Local Authority safeguarding team.

One person opened the fire door in one of the lounges to walk into the garden several times during our inspection. People who sat close to the door were exposed to cold air from outside when the fire door was left open. Although staff quickly closed the door when they noticed, they had not taken action to encourage the person to use an alternative route into the garden which did not disrupt other people. We observed that this person often encroached on people's personal space, touching them and moving their drinks or food. There were a number of occasions when there were no staff in the lounge to supervise or make sure people were safe and not subject to unwanted attention.

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

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

Relatives had differing views about whether there were enough staff on duty. They said, "They could always do with more staff. It is always adequate and they are very aware and conscious of how many there are of them around"; "There is not enough staff on, but they do their best"; "I do sometimes feel there are not a lot of staff here. I know it's not their fault, but the staffing is not good enough for some of them, who can be disruptive. They are under pressure getting them ready for bed before the night staff come on. It only leaves a couple of staff out on the floor when someone needs two. I just think they need more help"; "I understand

Is the service safe?

they have some male carers due soon, they are being checked. This should help enormously"; "I do think there's enough" and "There are always four or five staff when I'm here".

There were not enough staff deployed in communal areas to make sure that people were protected from harm or received the individual care they needed. The number of staff employed was not based on an analysis of how much time was needed to provide appropriate levels of care and activities for people. There were periods of time of up to ten minutes when there were people in the lounges without any staff present. At one point in the morning people were calling out repeatedly in one of the lounges when there were no staff around to help them. One person was upset and crying, another person tried to comfort her.

There were not enough staff to keep people safe. The examples above were a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicines were stored safely and good systems were in place to ensure medicines were ordered in time for continuity of treatment. Staff checked orders and supplies, and the printed Medicine administration record (MAR) charts to ensure they were correct and to ensure the smooth running at the start of each 28 day cycle.

Although systems used were good, one person's supply of a medicine was not received. A fax had been sent to the GP to chase this medicine but there was no further evidence that action was taken to ensure this person received it. Records showed that the person did not get this medicine for seven days which was a risk to their health.

We looked at controlled drugs (CD). There were several aspects that were not managed following best practice guidance. There were two cupboards to store CD. One of these cupboards was not compliant with the requirements of the Misuse of drugs (Safe Custody) Regulations 1973. Both CD cupboards were used to store other valuable items. We found a discrepancy between the record of the stock within the cupboard and the stocks seen in the cupboard. The provider was not following the latest guidance to manage medicines safely.

Where there were shared care arrangements with the GP surgery and district nurses, the service failed to monitor that treatment was delivered. We saw two examples where an injection due every three months was not administered. For one person this injection was last administered in May 2014 and was not administered when the next two doses were due although the medicines had been dispensed and were available. Care staff had not followed up these missed doses with the surgery. During our inspection the general manager contacted the GP surgery about the missed doses. They told us that the GP had confirmed that this injection was being reviewed because the people concerned were refusing the injections.

Two people were prescribed a thickening agent to help aid swallowing and to prevent choking. There were no written instructions for staff to follow on how to mix this and what consistency was needed for the people concerned.

Records completed by care staff showed that some people were prescribed creams to be applied twice a day to protect their skin. Records completed by care staff who had applied the creams showed that they only had one application each day. These people's medication administrations records (MAR) were initialled by the team leader twice each day to show that two applications had been administered, The deputy manager told us that the team leader initialled the MAR chart after asking care staff if they had applied the creams but the records staff completed had not been audited.

The examples above showed the provider was not managing people's medicines safely. This was a breach of Regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "They give me my pills every day without fail. Every day, it's there". In most cases people were given their medicines as prescribed and intended by their doctor. Some people were prescribed medicines, including sedatives or pain relief medicines 'to be taken as required'. There was individual guidance in place for staff to follow to make sure a consistent approach was taken in deciding when to offer the medicines.

We recommended following our inspection in January 2015 that a fire risk assessment of the premises should be carried out by a suitably qualified person. This had not been done. During our inspection the provider showed us evidence that this had been booked. Safety checks were carried out at regular intervals on all equipment and installations. There were systems in place to make sure people were protected in the event of a fire, instructions

Inadequate

Is the service safe?

were displayed throughout the home concerning what actions staff should take in case of a fire. There was equipment in place in case of fire such as extinguishers. Fire exits were clearly marked and accessible.

Inadequate

Is the service effective?

Our findings

At our last inspection on 19 January 2015, we identified breaches of Regulations 14, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 14, 11 & 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's health and nutritional needs were not met. Restriction to people's freedom had been put in place without their consent or consultation with others involved in their care. Staff were not suitably trained to meet people's needs. We asked the provider to take action to make improvements. The provider sent us an action plan but did not provide timescales by which the regulations would be met. They did not send us the updates we asked for to show their progress.

During this inspection we found that some improvements had been made. People had positive things to say about staff such as, "They are all lovely" and "They are very good". Relatives said the staff were, "Friendly and knowledgeable, and they do a fantastic job"; "The Handyman is really good, you've only got to ask him and he gets it done" and "From what I've seen, they are good at their job".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At our last inspection we found that the provider had not acted in accordance with the Mental Capacity Act 2005 (MCA). They had not made applications for Deprivation of Liberty Safeguards (DoLS) to the local authority in relation to all the people who lacked capacity to consent to remain at the service. During this inspection we found that improvements had been made. People's freedom to move around the ground floor was not restricted by a locked door. The provider told us that DoLS applications had been submitted for two people which the local authority had authorised. The general manager told us that they would be making further DoLS applications. We observed staff asking people for their consent before they carried out any care tasks with them.

However, were no clear procedures in place or guidance in relation to the Mental Capacity Act 2005 (MCA). Decisions about care and treatment were made on behalf of people. There were no mental capacity assessments to establish that people lacked the capacity to make those decisions themselves. These included decisions about diet and administering medicines.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us about recent MCA 2005 and DoLS training they had attended. They told us how this had helped them to understand their responsibilities in supporting people to make decisions. They understood when 'best interest' meetings should be held and gave examples of issues that had been discussed with health professionals and relatives such as a person with diabetes eating chocolate whenever they wanted to.

At our last inspection we found that staff were not monitoring people's weights regularly or providing the diets they needed. During this inspection we saw that one person's food and fluid chart showed that they were not receiving adequate nutrition. This person, who was identified as at risk of malnutrition had lost six kilograms since our last inspection. Staff had recorded the weight loss but appropriate action had not been taken to ensure the person received the nutrition they needed. Although the deputy manager told us they provided fortified milkshakes and other fortified foods for people who were at risk, this person's records showed that only one milkshake had been given in a seven day period. Other entries on the record showed they were asleep at mealtimes and sometimes they had refused their meal. There was no record that any food or fortified drinks had been offered at night when the person was awake. The GP was aware of the risk to this person and had prescribed food supplements but staff told us the person often refused these. This meant that this person was not protected against the risk of malnutrition. We reported this to the local authority safeguarding team.

People were offered a choice verbally of the lunch time meal. People who had difficulty understanding were not shown the two meals on offer to be able to indicate their choice. People did not have any control over the content of the meal or portion size. The meal was plated up out of sight of where most people were sitting. An up to date menu was not displayed and there was no information in individual care plans about people's likes and dislikes to help staff offer people the foods and drinks they preferred.

The example above showed that people were not protected against the risk of malnutrition or dehydration. People were not offered choices of food in ways they could understand. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Improvements had been made in nutrition for most people and weights were being monitored and recorded. The cook said that she did her best to, "Let them have what they all want. If I've got it, they can have it". She knew who liked a salad every day and those who preferred a baked potato, and confirmed that other choices were offered. The cook came out from the kitchen to see if people were enjoying the food and offered seconds. A member of staff helped one person to eat their lunch who required full support to eat and drink. They gave the person their full attention and chatted with them. A pleasant relaxed atmosphere was created by the member of staff which meant this person ate well.

Most people were receiving the nutrition they needed to maintain a healthy weight for them. Staff were able to describe how to fortify and enrich foods and drinks to boost the calorific value. They showed us a jug of fortified milkshake they were offering to people. They also showed us how they added grated cheese to the mashed potato at lunch time for people who needed extra calories to maintain their weight. People made positive comments about the food such as, "It's very good"; "I am still happy with the food. I have my fresh salads, but they try their best with all of them"; "It's all right, the food. They find something I like and sometimes I've eaten bread and butter, but I'm fussy, I know"; "The food is nice, but I'm fussy. I usually find something to eat" and "The food is okay". Relatives told us they were happy with the food. They told us that they could have lunch with their family member and their family member liked it. Relatives also told us "(The family member) is a fussy eater, but they are happy with the food" and "(The family member) had sandwiches and ice cream today, because they did not want the lunch so we are quite happy with that".

At our last inspection we found that staff had not received training in managing people's behaviours that had a negative effect on themselves or others. Training in privacy and dignity and training in the specific needs of people such as Parkinson's disease, mental health needs and sensory loss had not been provided. The training manager showed us training materials they had sourced ready to deliver some of this training to the staff. They told us they were looking for additional sources of training to make sure staff were trained to provide care for people with specific needs.

The provider had not ensured that staff were trained to meet people's needs. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that, although most staff had some dementia awareness training they did not demonstrate an understanding of how to communicate with people in a way which allayed anxiety and met their needs. We found that improvements had been made in that staff were engaging with people in a positive way when they needed support or reassurance.

Staff told us they felt supported and that morale had improved among the staff team. The provider and staff confirmed that some staff supervisions had been undertaken by the general manager in the absence of a registered manager. There was no system to make sure staff received regular supervision and annual appraisals they required to allow them to discuss their role, their training needs and their work standards. The provider told us they saw it as a priority for the new manager to reinstate regular supervision for all the staff.

A GP who was visiting the home spoke positively about the service people received, comparing it favourably with other services they visited. Relatives told us people's health care needs were being well met. They gave examples of prompt responses to illness. One relative told us, "They phoned me immediately they found blisters. (The family member) has seen the doctor, the district nurse and the chiropodist". Other relatives said, "They are very very good at getting a doctor here. If (the family member) is a bit wheezy, they say they'll get the doctor and get back to us when he's been, and they do"; "They are reassuring when they phone, once (the family member) has seen the doctor, and they always let us know about any test results"; "They speak to us if (the family member) is unwell and get a doctor. They always inform and discuss things with the family" and "I know (the family member) falls, but they are getting the falls team in".

Since our last inspection improvements had been made in that most people who had wounds such as ulcers had short term care plans in place to make sure that staff knew how to provide care in accordance with advice from district nurses. People were usually referred to health professionals when they needed medical attention or advice. People had seen G.P's, district nurses, community psychiatric nurses

Inadequate

Is the service effective?

(CPN) and dieticians for support with their healthcare needs. People who had falls were referred to the falls clinic for advice about causes and how to minimise the risk of falling.

Requires improvement

Is the service caring?

Our findings

At our last inspection on 19 January 2015, we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not involved planning their care and their privacy and dignity was not respected. The provider sent us an action plan but did not provide timescales by which the regulations would be met. They did not send us the updates we asked for to show their progress.

During this inspection we found that the provider had taken steps to improve the service. People told us they were treated with dignity and respect. Although one person was in the lounge in their night wear staff explained that this was because they had refused to get dressed. They were later persuaded to dress. People confirmed that staff made sure doors were closed when they helped them with personal care. People were mainly positive in their comments about the care staff. People told us, "Staff are helpful and caring, to a point, if they've got the time"; "They are all very nice, helpful people here. I have a good laugh with them all. People are friendly here"; "I think they look after me. They are very helpful here" and "They've been awfully good to me here. They have always looked after me".

Relatives told us that they felt welcome at the home at any time. They told us, "We are all very welcome"; "They make us feel welcome and offer plenty of hot drinks. Last night, they offered us food. The owner has quite often offered us dinner" and "We are all welcome, an open door here and we come at all times". Relatives described the care as positive They said, "The care is good. The girls [staff] genuinely care about the people, you can see by the way they touch them, so gently"; "The carers are very patient, they show so much patience and understanding"; "I find them all caring"; "We've always been happy with (the family member's) care. They are respectful of (the family member's) routines"; "As far as I'm concerned, there is excellent care" and "I'm perfectly happy with it all. They get to know her. All the day staff are laughing and joking and they are all polite all the time".

Staff were discreet in their conversations with one another and with people who were in shared areas of the home. Staff were kind, caring and patient in their approach with people and supported people in a calm manner. We observed people smiling and laughing during interactions between staff and people.

Some care plans had been reviewed and updated. There was no evidence that people had been involved in these reviews. The general manager told us that invitations to reviews of each person were being sent out to all families where appropriate asking for their involvement to make sure people's needs were understood and met. People's care plans did not include a record of any discussions with them or signed agreements relating to any changes in their care to show their or their representatives involvement or agreement.

At our last inspection two people talked to us about their faith and which to have connection with a place of worship. The section of people's care plans which was intended to provide guidance about how to meet their spiritual needs only had information about family relationships. Although care plans had not been updated to reflect people's spiritual needs the deputy manager had contacted a number of churches to ask for their support for people who wished to attend services or have visits and was awaiting responses.

We have made a recommendation that the provider takes account of published research evidence and guidance about involving people who are living with dementia in planning their care and meeting their spiritual needs.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on 19 January 2015, we identified breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care was not planned or delivered in a personalised or timely way. People were not provided with meaningful activities. We issued a warning notice and required the provider to make improvements by 6 March 2015. We also asked the provider to take action to make improvements in the way they handled complaints. The provider sent us an action plan but did not provide timescales by which the regulations would be met. They did not send us the updates we asked for to show their progress.

During this visit we found that some improvements had been made. People told us they were satisfied with the service and had no complaints. They said, "I don't have anything to complain about"; "I can talk to anyone really" and "I've never had to go to anyone". A relative described how a complaint they had made had been managed and that they were satisfied with the outcome. One relative said, "There's no negative atmosphere here at all now".

People knew who to talk to at the service if they wished to complain. They did not know how they could make a complaint or who to speak to outside the service if they were not satisfied. There was a complaints procedure on display but this was out of date with incorrect contact details for external authorities. Complaints records showed that complaints were recorded and acknowledged promptly. A record was kept of the investigation and feedback to the complainant.

We have recommended that an up to date complaints procedure is made available to people and visitors to the service.

At our last inspection we found that people moved into the service without a full assessment of their needs, behaviours or the resources available to manage their care. No new people had moved in since our last visit so we were unable make a judgement about any improvement about this aspect of the service.

People's preferred routines were not included in their care plans, such as what time they wanted to get up or go to bed or when they would like a bath or shower. Staff planned people's baths on a rota system. There was a note on the rota stating, 'do not change'. People told us they were satisfied with the routines commenting, "I'm happy to go to bed early", and "They come and get me for a bath its fine with me". People were offered choices in ways they could understand. Staff offered people choices about where they would like to sit and what drinks they would like.

Some people required help to move their position at regular intervals because they were at risk of developing pressure injuries. There were charts to record each time staff helped them to move to make sure that people were not left in the same position for too long. No one had a pressure injury. Staff knew who had been assessed as needing this care due to the risk of lying or sitting in the same position for too long. Records showed they had been repositioned regularly.

Some people were offered activities during our visit; colouring books and puzzles were brought to them. One person was reading the paper and another had a magazine. Other people had nothing to do. There were no objects close to them that they could look at or touch. People who were able to discuss activities told us, "The activities are more or less the same. It's very difficult to motivate them with jigsaws etc. We had an entertainer last Friday. We need more of that, really"; "There's not much to do and I never join in anyway" and "There's not really anything to do". The 'Summer Programme' of activities on display listed eight events from April to August, including 'music', a picnic in Mote Park, a garden party, and visits to a garden centre and a Priory. A member of staff told us that people had started to use the garden more as the weather improved. The garden was level and well maintained.

Most people had a 'My Plan' document in their individual care files which had been completed by relatives. This included information about people's interests and social histories. Information from this document was not used to plan meaningful activities which took account of people's individual interests and abilities.

There were no individual activity programmes to ensure people living with dementia had meaningful activities to promote their wellbeing. An activities coordinator was employed for two afternoons each week. People had no personalised activities programme, which took account of their interests or abilities to enable staff to provide meaningful activities. Whilst there were a variety of items

Requires improvement

Is the service responsive?

which could be used for activities, such as games, puzzles, books and arts and crafts equipment, these were not offered to most people. The television was on in one of the lounges on a music channel for most of the time. When care staff put familiar classical music on during the afternoon in one of the lounges people responded positively by singing along. Most people were not supported to engage in any activity and staff did not have time to support people to engage in activities that were meaningful to them.

The examples above mean the provider was not planning or delivering care which met people's individual needs or ensured their welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 19 January 2015, we identified breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People are not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems We issued a warning notice and required the provider to make improvements by 6 March 2015. We also asked the provider to take action to make improvements in record keeping. The provider sent us an action plan but did not provide timescales by which the regulations would be met. They did not send us the updates we asked for to show their progress.

Following our inspection we met with the provider and a senior member of staff who provided an action plan. The provider told us that the senior member of staff, who had a proven track record of management at another service, would be overseeing Mont Calm to make sure improvements were made. The provider had agreed to provide timescales for improvement and send us regular updates of their action plan to show their progress but had not done so.

At this inspection we found that some improvements had been made. People spoke positively about the service. Those who were able to respond to our questions told us they were happy with the service. Some relatives told us they had been upset by the recent press report following CQC publishing the January 2015 inspection report because, “It did not paint a true picture” and “The report upset the staff”. They said, “It might not be the most modern and up to date but it’s very homely and they do care for their residents. I have recommended it”. Another relative said, “They do a lot with (name of family member) so they are in the best care home for them” and “We have no problems at all with the home, never have had”.

There was no registered manager at the service. The provider told us that a registered manager had been recruited but had been unable to take up the post. Another manager had since been recruited who was due to start managing the service during the week of our inspection. The provider’s approach to managing the service was reactive rather than proactive in developing and improving the service people received.

The senior member of staff who managed another of the provider’s services had been appointed general manager to oversee both services. They told us they had been unable to spend much time at Mont Calm because of their responsibilities at the other service. The deputy manager had been tasked with making improvements to the service but had not received the support they needed to enable them to carry this out effectively.

The provider did not have an effective system in place to regularly assess and monitor the quality of the services provided. An audit had been carried out by the general manager in March 2015 which had highlighted areas which required improvement. This audit had not been followed up to make sure all the actions had been completed. This meant that not all the required improvements had been made to ensure that people were safe and the service was responsive and effective.

The provider relied on the competency of senior staff to carry out checks. These checks had not been completed accurately and the provider had not been informed of, or taken steps to find out about failings, such as failings in the care provided and the failure to report incidents of abuse. Where we identified shortfalls at our previous inspection, actions to improve the service had not been completed.

At our last inspection we found that systems to manage risks to people’s safety and welfare were not effective. The deputy manager had not been provided with the training they needed to carry out this role. The local authority had a number of concerns about people’s safety and welfare which included staffing levels at the service. They requested an action plan which asked for a ‘dependency analysis tool’ to ensure there were enough staff to meet people’s needs and keep them safe. This action had not been completed. By this inspection there had been no analysis of people’s individual needs. The number of staff employed at the service did not take account of the level of support each person needed.

People were not protected against unsafe or inappropriate care because accurate and up to date records were not maintained regarding their care and treatment. Records relating to people’s care and treatment were not well

Inadequate

Is the service well-led?

organised or adequately maintained. A number of records we looked at were not accurate or kept up to date, including care plans, night checks, food and fluid charts and medicines records. This meant that staff and others did not have access to consistent information and people were not receiving planned care that met their needs.

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

Improvements had been made in communication in the service to make sure that advice from visiting health professionals such as GP's or visiting nurses was passed on to the staff and management team to make sure people received the safe care they needed. Relative's meetings had been held to keep people and their relatives up to date with changes in the service and provide opportunities to for people and their relatives to give feedback about the quality of the service they received. The management of complaints had improved to make sure the service took prompt and appropriate action when people or their relatives raised any concerns.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs One person was not protected against the risks malnutrition or dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against risks of inappropriate or unsafe care and treatment the registered person had not ensured that there was an accurate record in respect of each person which included appropriate information and documents in relation to the care and treatment provided. Other records were not available or not up to date in relation to the management of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements to ensure that staff were appropriately supported by providing appropriate training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risk of unsafe care and treatment through the safe administration of medicines

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People 's consent to care and treatment was not always obtained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against risks of inappropriate or unsafe care and treatment, because the assessment of needs and planning and delivery of care did not ensure their welfare and safety. The planning and delivery of care did not reflect published research evidence and guidance in relation to people with dementia and other conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not have suitable arrangements to ensure that people were protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff deployed to safeguard people's health, safety and welfare.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were safeguarded from abuse or improper treatment.