Larchwood Care Homes (South) Limited

Mountwood

Inspection report

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Hampshire
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Date of inspection visit:
14 May 2018
15 May 2018
16 May 2018

Date of publication:
02 July 2018

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 site visit took place on 14, 15 and 16 May 2018 and was unannounced.

Mountwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mountwood accommodates 39 people in one adapted building. There were 29 people living at the home at the time of our inspection.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A condition of registration is for the service to have a registered manager. The service has not had a registered manager in post since November 2017 and therefore we have applied a ratings limiter to the Well Led section of this report.

We last inspected this service on 27 and 28 March 2017 and found the provider was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice in respect of the breach. Following our inspection the provider sent us an action plan on 30 June 2017 to tell us about the actions they were going to take to meet these regulations.

During this inspection, we found that sufficient action had been taken to meet the requirements of the regulation the service had breached at the inspection in March 2017 however we identified a further two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure they had deployed sufficient numbers of staff to ensure people were safe and their care needs met.

The provider had failed to ensure that staff had received supervision or appraisal as is necessary to enable them to carry out the duties they are employed to perform.

People received their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were stored safely.

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. Staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the

Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People had access to and were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks.

People were comfortable and relaxed in the company of the staff supporting them.

Staff treated people with dignity, respect and kindness.

People were supported to maintain relationships with their friends and relatives.

We have made two recommendations to the provider in the responsive section of this report. The service seek to ensure people are not at risk from social isolation and recognise the importance of ensuring activities promote social contact and companionship. People with a disability or sensory loss are given information in a way they can understand.

We identified two breaches 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 service was not always safe. The service had not been resourced with sufficient numbers of care staff to meet the minimum requirement set by the provider to support people to stay safe and meet their needs.

People received their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were stored safely.

People were protected against abuse because staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not received appropriate supervision and appraisal that would enable them to receive the guidance required to develop their skills and understand their role and responsibilities.

People's needs were not always assessed before admission to the home and some care plans did not always demonstrate the support required.

Where people were unable to express their views or make decisions about their care and treatment, staff had appropriately used to The Mental Capacity Act 2005 (MCA) to ensure their legal rights were protected.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although there was a weekly activities programme, there were insufficient resources in place to provide people with meaningful and stimulating activities that took into account their interests.

People's cultural and spiritual preferences at the end of their life

had not always been assessed and recorded.

The provider kept a complaints and compliments record. People and relatives told us they knew how and who to raise a concern or complaint with.

Is the service well-led?

Requires Improvement

The service was not always well led. The service does not have a registered manager in post.

Although improvements have been made to the governance and audit systems, it was too early for the provider to be able to demonstrate that the new processes were fully embedded and that these improvements could be sustained over time.

Staff told us morale was good and they felt supported by the management team.

The service worked closely with other health and social care professionals to achieve the best outcomes for the people they supported.

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 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 site visit took place on 14, 15 and 16 May 2018 and was unannounced. On the first day of our visit the inspection team consisted of two adult social care inspectors, one specialist advisor and two Experts 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 the second day the inspection team was one adult social care inspector, one specialist advisor and two Experts by Experience and on the third day one adult social care inspector

Before the inspection, we looked at information we held about the provider and home. This included their Provider Information Return (PIR) which was submitted on 4 April 2018. This is a form that asks the provider to give some key information about the service. Providers are required to send us a PIR at least once annually to give us some key information about the service, what the service does well and improvements that plan to make. We also contacted five health and social care professionals to obtain their views on the delivery of care. We only received one response.

During the inspection we spoke with the peripatetic manager [manager], regional manager, nine care staff, activities organiser and chef. We also spoke with 11 people living at the home and five visiting relatives.

Some people were not able to verbally communicate their views with us or answer our direct questions. 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 looked at the provider's records. These included five people's care records, eight staff files, training and supervision records, a sample of audits, satisfaction surveys, staff attendance rosters, and policies and procedures. We also pathway tracked five people. This is when we follow a person's experience through the service and get their views on the care they receive. This allows us to gather and evaluate detailed

information about the quality of care.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2017 the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that complete, accurate and contemporaneous records were maintained in respect of each person regarding the treatment provided. Following the inspection the provider submitted an action plan which stated they would meet the requirements of Regulation 17 by 30 June 2017. At this inspection, we found that sufficient improvements had been made regarding the completion of documentation relating to people's care.

Before our inspection the Care Quality Commission (CQC) had received a number of concerns related to the numbers of staff on duty at Mountwood and peoples care needs being compromised due to lack of staff. At this inspection we found there were not enough skilled staff deployed to support people and meet their needs.

The provider used a dependency tool to ensure that the levels of staff aligned with people's assessed level of need. At the inspection we were supplied with a review of staffing levels undertaken on 15 March 2018. The findings from that review stated that safe staffing levels were 7am-1pm, two nurses and six care assistants. 1pm – 7pm, two nurses and five care assistants and 7pm – 7am, one nurse and four care assistants. The findings also indicated that at that time 34 people lived at the home and 19 people were assessed as having high dependency needs which included for example, assistance with feeding, continence, mobility, washing and dressing. The assessment tool also indicated that for people with high dependency needs, 'Care hours required per patient per day were four hours'. During our inspection there were 16 people being cared for on the first floor of which 10 were cared for in bed and required two care staff to support them. Eight people also required assistance with eating.

The provider information return (PIR) dated 4 April 2018 states that for the 28 day period before the PIR was submitted (7 March 2018 – 4 April 2018), the service used 1338 hours of agency staff (nursing staff and care assistants) to support the service and where possible the same agency for continuity of care. The manager told us that recently (22 April 2018 – 6 May 2018) this had reduced to 726 hours. The PIR also states that as at 4 April 2018 the service had no staff vacancies.

Following our inspection the provider sent us a further two dependency tools dated April 2018 and 17 May 2018 which evidenced a reduction in required staffing levels to, 7am-1pm, two nurses and five care assistants. 1pm – 7pm, two nurses and four care assistants and 7pm – 7am, one nurse and four care assistants.

We examined staffing rosters and signing in sheets that recorded how many care staff had been on duty on each shift for the period 9 April 2018-16 May 2018. During this period the service had insufficient staff on duty to cover 20 daytime shifts on 38 days within this period as set by the provider to keep people safe. Staffing requirements between 7pm and 7am however were consistently within the prescribed levels. People living at the service and relatives felt the staff were not always available to provide support when they needed this.

For example, on the morning of the third day of our inspection only two nurses and four care assistants were on duty. This meant that people's personal morning care was compromised and some people did not receive personal care until the afternoon. We found that at times, people needed to wait for a period of time before they received the care and support they needed.

One person told us they did not feel there were enough staff and they were not always available when needed. The person added, "The permanent staff are very good but there are not enough of them. A lot of the agency staff don't seem to care and just go through the motions". Another person told us, "If you want anything you just push the buzzer and they come but they can take ages". A relative told us, "There's been time's the staff can't get to [persons relative] and they have to wait. It's not ideal for them". Another relative commented, "I don't feel there are enough staff, but they do their best. There have been times when staffing has been an issue but things seem to be improving". A health and social care professional told us, "We have an impression that there may be more bank staff (agency) employed than previously which may affect continuity-but this is an impression and we have no evidence for this".

Staff consistently told us that at times they had to do 'two peoples jobs' because staff had not turned up for work and they 'had to get the job done'. One member of staff said, "We do what we can and I have often stayed on after my shift has ended just to make sure we get people dressed. It's far from ideal and I know we could be a good service. If only we had the staff". Another member of staff told us, I don't always feel safe being on shift with only two other carers and a nurse. It doesn't happen all the time but it is a regular occurrence". A third member of staff told us, "The mornings are hectic. Worst part of the day". The service had not been resourced with sufficient numbers of care staff to meet the minimum requirement set by the provider to support people to stay safe and meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection the commission had received a number of concerns relating to the cleanliness of the home. At this inspection we found the home to be clean and tidy with no odours. Housekeeping staff worked each day and had a cleaning schedule in place to ensure all work was completed and areas were cleaned. Staff wore protective clothing (aprons and gloves) whist they worked. Disposable aprons and gloves plus hand sanitisers were available in the home for staff to use. The use of protective clothing is advised to prevent cross contamination and promote good hygiene. We toured the home which appeared to be clean although some of the lighter coloured bedroom carpets were stained. Housekeeping staff were evident during the visit and were constantly working. Bathrooms and toilets were clean and there were clean towels available around the home. People told us the home was kept clean. Comments included, "The cleaners do an excellent job", "The home is very clean", "It's clean; getting a bit 'tired' but it never smells and you always see them [housekeeping staff] on the go", "It's always clean, and there are usually two cleaners every day". However on the second day of our inspection a relative told us that they had made a verbal complaint to the regional manager regarding their relatives room being messy, with dirty carpets and table tops and smelling of urine'. The regional manager took immediate action to resolve the matter and conveyed this back to the relative via email later that day.

Safe recruitment processes were in place although the service was supported by agency staff on most days. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer

recruitment decisions. Checks to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff said they would feel confident raising any concerns with the registered manager. They also said they would feel comfortable raising concerns with outside agencies such as the Care Quality Commission (CQC), if they felt their concerns had been ignored. One member of staff told us, "Yes if I had cause to 'blow the whistle' I would do it without hesitation".

Care plans and risk assessments had been updated to reflect people's changing health needs. People's needs were assessed for areas of risk such as mobility, malnutrition, moving and handling and pressure area care. Records showed if people's health was deteriorating the person was referred to a health care professional such as the district nursing team, occupational therapist or GP.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored securely in a medicine cabinet that was secured to the wall. Only staff who had received the appropriate training for handling medicines were responsible for the safe administration and security of medicines. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily. Regular checks and audits had been carried out by management and senior staff to make sure that medicines were given and recorded correctly. Medication administration records were appropriately completed and staff had signed to show that people had been given their medicines.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. Up to date certificates were available for electric portable appliance testing, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists.

People had personal emergency evacuation plans (PEEPs) to help ensure effective evacuation of the home in case of an emergency. A signing in book was in place to record visitors to the home and to ensure an accurate record of people on the premises in case of an emergency such as fire.

Requires Improvement

Is the service effective?

Our findings

Staff had not received regular supervision or appraisals. Supervision and appraisals are important processes which help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The providers PIR states, 'Staff receive regular supervisions to discuss their current performance and future development'. However the supervision and appraisal records for all staff between March 2017 and January 2018 evidenced that only 15 supervisions had been undertaken in total by the previous managers during this time for approximately 25 members of staff. One member of staff told us, "Can't really remember when I had one last". Another member of staff said, "I have had one with the new manager and one with the old one last year, but that's it really". A further member of staff said, "I never had one with the previous managers but I have had one with [managers name] recently. The manager told us, "I have been in post for only six weeks and whilst I was supporting the previous manager before this I had put measures in place to address this. I have sent letters to all staff to arrange appointments for appraisals and have completed eight supervisions to date". The supervision and appraisal records we viewed confirmed that actions had been taken to address this. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Staff did not receive appropriate support or training to enable them to carry out the duties they were employed to do.

There was an on-going programme of development to make sure that all staff were up to date with required training subjects. The service had recently introduced a new on-line training and development programme that enable management to 'track' any shortfalls in training requirements. We looked at the training matrix for the service and found that staff had recently undertaken refresher training in, moving and handling, record keeping, safeguarding, dignity and respect. Further refresher training for nutrition and hydration, fire training, basic life support and person centred care had been arranged in the next three months. Specialist training had been provided to staff in dementia awareness and diabetes. This meant that staff had the training and specialist skills and knowledge that they needed to support people effectively.

Staff were supported in their role and had been through the provider's own induction programme. This involved attending training sessions and shadowing other staff. The induction programme embraced the 15 standards that are set out in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Care plans had previously been updated by the deputy manager who had recently left the service. One nurse told us, "I am slowly working through everyone's care plan to ensure it is up to date and we have captured all the information we need to care for people safely". There was evidence in these care plans of GP visits, physiotherapy sessions, chiropody, community dentist, eye tests, retinal screening and other external sources such as, Tissue Viability Nurse, (TVN), Community Mental Health Team (CMHT) and Speech and Language Therapist (SALT) referrals.

Care monitoring records were completed. For example, fluid balance charts, for recording people's input and output and charts for monitoring people's meals and snack. Repositioning charts were in place to ensure people's health and wellbeing which included twice daily checks on mattress settings for people

being cared for on pressure relieving mattresses. Blood sugar monitoring was recorded in care plans and injection sites for insulin were recorded on body maps. Rotating injection sites is important to ensure the effectiveness of insulin through proper absorption. It also reduces the risk of tissue damage caused by accumulation of extra fat at the site of many subcutaneous injections of insulin. Transdermal patches were also recorded on an application chart, when they were last given, which part of the body they were applied too and when the next would be due and where to place it.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of our inspection 20 people living at the home were subject to a DoLS which had been authorised by supervisory body (local authority).The home was complying with the conditions applied to the authorisation. The home had submitted further applications which had yet to be authorised by the local authority. The manager knew when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people were unable to express their views or make decisions about their care and treatment, staff had appropriately used to The Mental Capacity Act 2005 (MCA) to ensure their legal rights were protected. The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

People's mental capacity had been assessed and taken into consideration when planning their care needs. The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were knowledgeable about the requirements of the Act and told us they gained consent from people before they provided personal care. Staff were able to describe the principles of the Act and tell us the times when a best interest decision may be appropriate.

There was a rolling four week menu. The chef told us, "There is always a vegetarian dish on the menu and we provide pureed and soft meals as required". The kitchen staff were aware of which special diets people required. The assistant cook talked about people's preferences and choice. They told us, "Some people like finger food while others the set meal. They can always have something different if they want".

People we spoke with all said they have a choice of menu and if they did not like what is on offer an alternative is agreed and provided. People were encouraged and supported to eat and drink sufficient amounts to meet their needs. Some people took their meals in the dining room and this was encouraged to enable people to socialise. We received mixed feedback from people and relatives regarding the food at Mountwood. One person told us, "The food is very good". Another said, "Yes the food is very good indeed. I like it". One relative told us, "The food is very good. I am regularly invited to eat with my relative. It's very nice". However some people were not as complimentary. One person told us, "Food is awful, always

overcooked". A relative said, "There is too much stodge such as dumplings and potatoes and not enough fruit and veg".

The adaptations and design of the home met people's needs. People had enough space to move around the home with walking aids. We observed people using walking frames and wheelchairs and they were able to move around corridors at the home. The home was well lit and there was clear signage in place. This helped people with visual impairments or those living with dementia to orientate themselves within the home environment.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and compassionate. One person said, "I'm very happy here thank you. I've got them [staff] all under my thumb. It's quite a nice place this, all the helpers are very nice". Another person told us, "I like the view from my window, I can see the birds outside, we get a lot of blackbirds that I watch". A third person added, "I'm quite happy here" and "they [staff] come in here regularly to see if I'm okay". Their relative said, "They look after her very well". One relative told us, "Yes, they are very nice here. She [person] gets on well with them. There was one person who she didn't like but she's no longer working here". Asked if they felt welcome when visiting they said, "Yes, they [staff] call me by my first name now and make me a cup of tea". Another relative said, "The staff are marvellous, I could not wish for better". However one relative said, "There have been times when [relative] has still been in her night wear in the afternoon and still in bed. It happens when there are staffing issues which is fairly regular".

Staff cared for people in a relaxed, warm and friendly manner. We saw that non care staff who worked in the home such as kitchen and maintenance staff took time to sit with people and chat. Staff sat talking with people and engaged in lively conversations about their families, social events and sharing memories. There was a lot of laughter and we noted that staff took every opportunity to engage with as many people as possible. Staff interacted with people patiently and discreetly. For example, we observed a care worker checking that a person sat in the lounge had drunk her tea. The carer knelt down to be at eye level with the person and the person began to sing to the carer. They held hands and the person said to the carer, "You're lovely you are". Later one person who lived at the home was walking to the dining area with support from a care worker. They were arm in arm and laughed together as they walked.

Staff supported people to maintain their privacy and dignity. Staff knocked on people's doors before entering their rooms and asked people before they helped them with tasks such as dressing, moving or eating. One member of staff said, "We always seek consent before doing anything and ensure privacy and dignity is maintained when providing personal care by keeping people covered". People who could talk with us told us staff knew how they like things done. One person said, "They know how I like things done and support me very well". Another person told us, "Most of the staff know how I like things done". People told us staff treated them with dignity and respect. One person said, "They always close my door when they come into my room to support me". A relative told us, "They never ask me questions for my [relative] when I'm here they always ask her first and involve her in the discussion".

Staff supported people to maintain their independence. We asked staff how they did this. One staff member said, "When helping someone wash, we ask if they would like to do their own face and areas they can do for themselves. We help people to be as independent as they can through gentle encouragement, and we also encourage people to make their own choices of food and clothes". Everyone we spoke with told us they were supported to be as independent as possible. One person said, "I am able to do most things for myself and I am supported to do the little things I can't".

People's relatives had 'posted' positive comments on a national website in relation the care and support at Mountwood. Recent comments included for example, 'Very pleased with Mountwood Nursing Home

Andover, very caring and polite staff at all times. Taking great care of my father in law', 'My wife is very happy living there and is very much liked by the care staff and residents alike. I am able to talk to staff about her care' and 'Home clean, very pleasant. Staff are excellent mum was cared for and tended to with love, dignity, time and patience. Anything she needed was attended to'.

Requires Improvement

Is the service responsive?

Our findings

There was some evidence that the service had been trying to improve social engagement and facilities with people and encourage them to partake in activities. The home had set up one room as an old-fashioned tea room. A china tea set in a familiar pattern of a regency design was laid out on a table and there were reminiscence pictures on the walls. A sofa and chairs contained several dementia friendly cushions, on which were attached buttons, different textures and beads. We did not see any people being supported to use this room at any other time. The home also had a well maintained and secure garden but we did not see anyone being supported to access it.

During the morning of the first day of our inspection between 10am and 12.20pm there were seven people sat in the lounge on the ground floor. The only interaction they received was from members of staff whilst carrying out tasks such as offering drinks or providing personal care. On day two of our inspection we observed three people sitting in the lounge at 10am. They had their lunch in the same seats and were only supported to get up at 2pm when personal care was offered. Although staff did engage with them at various times the only stimulation / activity was modern music playing on the TV. The afternoon activity was cookie making. The activity co-ordinator helped three people sat at a table to roll out dough and encouraged them to choose different shaped cutters and decorations. The activities co-ordinator was very inclusive and spent time with each person. There was a very relaxed and happy atmosphere during this activity. People were fully engaged in this activity and one person told us told us they liked to feel the texture of the dough and enjoyed choosing the cutters and decorations. However one person we visited in their room told us they were not able to get out of bed without assistance and they were not offered any activities. They added, "I am able to walk with help and would love to go out in the garden". A relative told us, "Yes we go outside in the garden. I was going to take her out to-day but I think she's a bit tired".

Although there was a weekly activities programme, there were not enough resources in place to provide people with meaningful and stimulating activities that took into account their interests. There was one full time member of staff who was a dedicated activities coordinator responsible for devising and delivering activities and when care staff resources were limited they told us they would be required to provide care and support instead of activities.

We recommend the service seek to ensure people are not at risk from social isolation and recognise the importance of ensuring activities promote social contact and companionship.

Some people were unable to easily access written information due to their healthcare needs. The registered provider did not have a policy in place to provide staff with guidance on the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with this standard.

We recommend the provider implements guidance for staff to follow regarding the Accessible Information Standard and also incorporate this into relevant documents within the service.

Staff knew people well. People had been involved in planning their care with staff and told us they received the support they needed. Staff described to us what people were able to do for themselves and how they preferred their support provided, this was the same as people had described to us. Some care plans contained detailed information for staff about people's support needs and preferences, including what they were able to do for themselves. However, other people's care plans did not contain as much information. Staff delivered care in the way people preferred. For example, a member of staff visited a person in their bedroom to provide their support. Before the staff member left they checked with the person if they would like their bedroom door open or closed and their television on or off. Another person was quietly spoken and staff followed the guidance in the person's care plan to make sure they understood what the person was saying and responded appropriately. We observed staff spending time chatting to people, answering their questions and giving them the information they wanted.

Everyone living at Mountwood had a care plan in place, which covered their needs. Each resident had a blue folder which contained a document called the daily care record and weekly booklet. This was to enable staff to contemporaneously record food and fluids, repositioning, bowel activity and hygiene records. Care plans were regularly reviewed for any nursing care people needed such as the management of catheters. Staff had planned some areas of people's end of life care with them, including consideration of any advanced decisions, such as refusing treatment. However some people's cultural and spiritual preferences at the end of their life had not been assessed and recorded. Some people and their relatives had informed staff about some of the decisions they had made for the end of their life including funeral arrangements. People who had chosen to receive their end of life care at Mountwood had been supported to do so by staff and health care professionals. Staff made sure medicines were available to keep people comfortable and free from pain at the end of their life and these were administered promptly when people needed them. People's relatives and friends were able to spend as much time as they wished with their loved one at the end of their life.

Routines were flexible depending on people's daily choices. For example, people's care plans included information about people's usual routines, such as when they liked to get up and go to bed. People told us they got up and went to bed when they liked. One person told us they liked to get up early in the morning and night staff gave them their medicines as this was what they preferred. They told us they had recently changed their routine to get up about an hour later and staff now gave them their medicines later at their request. Some people told us they preferred to stay in their bedroom at times and join in activities in communal areas at other times. People told us they enjoyed spending time in the garden in the warm weather.

The provider kept a complaints and compliments record. People and relatives told us they knew how and who to raise a concern or complaint with. The complaints procedure gave people timescales for action and who in the organisation to contact. People told us that if they were unhappy they would not hesitate in speaking with the manager or staff. Complaints had been appropriately investigated and by the manager.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left the service in November 2017. The provider contacted us on the 16 February 2018 to advise us that the deputy manager would, after a six month probationary period be applying to become registered manager at the home. On the day of our inspection however we were told that the deputy manager had left the service on the 6 April 2018. The service has not had a registered manager in post since November. The service was being led by a manager with support from the regional manager from within the organisation.

Following the last inspection the registered provider created an action plan to address the areas of concern we raised. Improvements had been made to the governance and audit systems. However it was too early for the provider to be able to demonstrate that the new processes were fully embedded and that these improvements could be sustained over time. During our inspection the manager and regional manager interviewed a prospective candidate for the role of registered manager; however following our inspection the regional manager advised us that they would not be progressing the applicant and the service continues to not have a registered manager in post.

The manager was aware of their responsibilities and it was evident from this inspection visit that improvements had been made. We looked at the audits and checks which were being completed by the management team. Audits and checks were completed in areas such as medication, health and safety and care planning. The regional manager told us that an 'impact audit' had been undertaken by the provider's quality assurance team between 4 and 6 April 2018. This had highlighted a number of areas for improvement and action plans were in place to address these issues. During the inspection we evidenced that action was being taken in respect of improving the dining experience for people, the updating of care plans to include people's spiritual needs and end of life wishes, behavioural management plans and staff supervision. Quality Monitoring visits by the regional manager to improve the service were on-going and the visit report dated 26 April 2018 records for example, "A very positive atmosphere in the home".

During our inspection the manager and regional manager were a visible presence throughout the home. People, their relatives and staff spoke positively about the way the home was now managed and how approachable the current management were. People told us they felt the home was well managed and feedback regarding the current manager was positive. One person said, "The new manager is very approachable and very nice and although I don't have a lot to do with them about managing they seem to do very well. Not sure how long she will be here though. They seem to get through a lot of managers". Another person said, "I think the lady in charge [manager] is wonderful and they come and chat with me and bring me a cup of tea". Staff described the manager as friendly, approachable and responsive. One staff member said "[manager] encourages all staff; we all feel we can come and talk to her, [manager] has made a big difference". During the inspection we found the manager to be open, transparent and receptive of the

feedback we provided throughout the course of the inspection.

We looked at staff meeting records for February and May 2018. Topics included attendance rosters, training and sickness. The manager told us, "The staff meeting in February was poorly attended with only seven staff however our recent meeting was much better with 16 care staff coming along". One member of staff told us, "Morale hit an all-time low at the beginning of the year but it has improved and is continuing to improve". Another member of staff told us, "The manager at the moment is only filling in until we get a new one. If we could have a manager like her it would be fine. She supports staff and isn't afraid to get her hands dirty. You won't find her sat in the office". A third member of staff added, "Six months ago we were all stressed out. There was no stability and I hated working here. Things are now much better and I think we have turned the corner. We know we still have lots to do but at least now I enjoy coming to work". Staff told us they were happy and motivated. People told us that since the new manager had been in post staffing had improved and the staff were a lot happier.

Relatives told us there were now family meetings although the last one was on the Wednesday before Good Friday and was not well attended. Other meetings had been arranged every month throughout the year. The manager told us, "I really hope relatives buy into this". One relative told us, "The manager holds a surgery every week and relatives can book an appointment. This is a vast improvement on previous communication". One person told us, "The new manager is trying her best, but I know they will not be staying and don't know who will take over".

Providers are required by law to notify The Care Quality Commission (CQC) of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found the service had met the requirements of this regulation. The provider had notified the Care Quality Commission (CQC) of all events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding the home.

Ratings from the last inspection were displayed at the entrance to the home as well as being available on the registered provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

The service worked closely with other health and social care professionals to achieve the best outcomes for the people they supported. The registered manager told us since the last inspection the service had developed stronger links with specialist community based health and social care professionals and worked in partnership with them.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not been resourced with sufficient numbers of care staff to meet the minimum requirement set by the provider to support people to stay safe and meet their needs. Staff did not receive appropriate support or training to enable them to carry out the duties they were employed to do.