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Montague House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 September.

Montague House is a privately owned care home providing long and short term residential care for up to 19 people. The service is in a residential area of Ramsgate and is a short distance from local amenities. On the day of the inspection there were 13 people living at the service, some of whom were living with dementia.

The service was run by a registered manager with the support of a deputy manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present on the day of the inspection.

At the last inspection in December 2015, the service was rated 'requires improvement', there were breaches of regulations and we asked the provider to take action to make improvements. The breaches of regulations related to the need to gain people's consent, staff supervision, involving people in their care, the lack of activities, involvement in the community and a lack of effective audit systems. The provider had taken action to involve people in the planning of their care. The registered manager had begun to meet with staff to hold one to one supervision meetings. However, action had not been taken to make sure that care was provided with people's consent. The provider had not supported people to be involved in the community and take part in meaningful activities. Audits had not been completed regularly and had not identified the shortfalls found at this inspection. These were continued breaches.

Some areas of the service were unclean and unhygienic. Risks to people were not consistently identified and assessed and guidance for staff was not always provided on how to minimise risks to people.

There were not enough staff to give people the care and support they needed. Staff were often too busy to spend time with people. There were long periods of time when people had no interaction from staff.

The registered manager and staff had not assessed people's capacity for either day to day or more complex decisions. Staff did not always act in accordance with the Mental Capacity Act 2005.

People were being deprived of their liberty without consulting with or referring to the relevant authority. No assessments had been completed to check if any restrictions in place were the least restrictive possible and in the person's best interest.

We observed some positive interactions between staff and people. However, staff did not consistently promote people's dignity and treat them with respect. When staff told people they would be back to support them, they did not always return to assist them.

Staff did not engage with people. Staff did not support people to be involved in the community as much or as little as they wished and to take part in meaningful activities. People told us they had nothing to do except sleep or watch the television.

There was a lack of regular and effective auditing and monitoring. Audits were not completed regularly or effectively. People, relatives, staff and health professionals were not asked their views about the quality of the service. Shortfalls identified during the inspection had not been identified by the registered manager or provider.

People told us that they felt safe living at Montague House. Staff knew how to recognise and respond to abuse and understood the processes and procedures in place to keep people safe. People received their medicines safely and on time. Medicines were stored safely.

The provider had recruitment and selection processes in place to make sure that staff employed were of good character. Staff completed training and had one to one supervision meetings.

People's health was monitored and staff worked with health and social care professionals to make sure people's health care needs were met. People had enough to eat and drink and had a choice of home cooked food. People told us they were happy living at Montague House. People told us staff respected people's privacy.

Each person had a descriptive care plan which had been written with them. People said that staff were generally responsive to their needs. There was a complaints system and people knew how to complain. People's relatives could visit when they wanted to and there were no restrictions on the time of day.

There was a lack of structured quality assurance systems and processes. Breaches of regulations had not been identified by the provider. The views of people were not being sought on a regular basis or being used to drive improvements at the home..

The provider had submitted notifications to CQC in a timely manner and in line with CQC guidelines.

We last inspected Montague House in December 2015 when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection further and continued breaches of regulation were identified. You can see what action we have asked the provider to take at the end of the full 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 safe.

Some areas of the service were unclean and unhygienic.

Risks to people were not consistently identified and assessed and guidance for staff was not always provided about how to reduce risks.

There was not enough staff to provide people's care and support, including engaging and spending time with people.

People told us that they felt safe living at the service. Staff knew how to recognise and respond to abuse and understood the processes and procedures in place to keep people safe. People received their medicines safely.

The provider had recruitment and selection processes in place to make sure that staff employed were of good character.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always act in accordance with the Mental Capacity Act 2005.

People were being deprived of their liberty without their consent and without consulting with or referring to the relevant authority.

Staff completed training and had one to one supervision meetings.

People's health was monitored and staff worked with health and social care professionals to make sure people's health care needs were met. People had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not consistently promote people's dignity and treat them with respect.

People told us they were happy living at Montague House.

Staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff did not always have time to spend with people. People were not supported to be involved in the community as much or as little as they wished and to take part in meaningful activities.

Each person had a care plan which included their likes and dislikes. People said that staff were generally responsive to their needs.

There was a complaints system and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well-led.

Audits were not completed regularly or effectively. Shortfalls identified during the inspection had not been identified by the registered manager or provider.

People, relatives, staff and health professionals were not asked their views on the quality of the service so it could be improved.

The provider had submitted notifications to CQC in a timely manner and in line with CQC guidelines.

Montague House

Detailed findings

Background to this inspection

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

The inspection took place on 6 September 2016 and was unannounced. This inspection was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury. We spoke with the Kent local authority.

We met and spoke with nine people living at the service. We spoke with the cook, care staff and the registered manager. During our inspection we observed how the staff spoke with and engaged with people.

We looked at how people were supported throughout the day with their daily routines and activities and assessed if people's needs were being met. People talked to us about their care and support. We reviewed care plans and associated assessments. We looked at a range of other records, including safety checks, staff files and records about how the quality of the service was managed.

We last inspected Montague House in December 2015 when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Montague House. People looked comfortable and relaxed in the company of each other and staff.

At the last inspection in December 2015 there was a strong smell of urine in part of the service. Some people's toilets and hand basins were not clean. There was no cleaning schedule in place to identify what should be cleaned each day / week / month.

At this inspection there was still no cleaning schedule in place to give staff guidance on what should be cleaned / deep cleaned. The service was not clean and hygienic in all areas. For example, in one en-suite toilet the flooring did not meet the skirting board and the gap in between was very soiled. The inside of the door was dirty. Paintwork was scuffed showing bare wood and could not be adequately cleaned. There was a frame over the toilet and the legs of this were heavily soiled. Another person's en-suite toilet had a similar issue with the flooring. There was a heavy stain around the toilet and bin, and the pedal bin did not work so people needed to use their hands to open it.

Staff wore personal protective equipment, such as, aprons and gloves when supporting people with their personal care. Toilets and bathrooms had hand towels and liquid soap for people and staff to use. Small bottles of alcohol gel were hung on the outside of each bedroom. Bins were lined so that they could be emptied easily. Outside clinical waste bins were stored safely and kept locked.

The provider failed to keep the service clean and hygienic to ensure the premises were safe. This is a breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Potential risks to people were not always recorded. For example, when people were at risk of developing pressure areas their care plan included guidance for staff on how to protect the person's skin with the use of prescribed creams and specialist equipment. However, when there had been involvement from community nurses to support people with their skin their recommendations had not been noted in the care plan.

Potential risks to people had not always been identified and assessed. The risk sections in some care plans that should have been completed had not been completed at all. When people had mental health needs there was some information about how this should be managed by staff. For example, one person's care plan noted 'If agitated when you try to reassure, walk with them to calm down, return when calmer'. There was no guidance for staff on what particular signs to look for or what the possible causes of agitation might be. There was no risk assessment in the person's care plan.

Some people were supported by staff with their personal care. On occasion people refused to be assisted and this had been recorded. There was no guidance for staff about how to manage this and when to seek advice. For example, one person was at risk of self-neglect. There was guidance for staff on how to support the person to wash and dress but the risk of the person neglecting themselves had not been assessed. The risk section of this person's care plan had not been completed. Daily notes for the person showed that in

the previous seven days they had refused to be supported with their personal care on four days. Staff had not involved health professionals or assessed the person's capacity to consent to the support.

The provider failed to ensure care and treatment was provided in a safe way. The provider failed to assess risks to people and do all that was practicable to mitigate any such risks. This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us staff were usually there when they needed them. People said, "There are very few restrictions, except you might have to wait if there is not enough staff. Usually there are enough", "Staff can only do so much but there are enough of them" and "When I am ready for bed I just ring the bell and they [staff] come to help". A member of staff commented, "We just need two staff on shift plus a senior or manager. There is always time to do what is needed. The day shift overlaps half an hour with the night shift from 07:30 because that is a really busy time. It works well and we also have a 15 minute handover between shifts". The duty rota showed that there were consistent numbers of staff working at the service. On the day of the inspection there were two staff, a cook and the registered manager on duty. The staff team was small and many had worked at the service for a long time. There was a handover between staff at the beginning of each shift and a communications book was used to keep staff up to date with changes in people's needs. Staff worked flexibly to cover shortfalls, such as annual leave and sickness.

During the inspection staff were not rushed and call bells were answered quickly. However, staff did not have sufficient time to spend with people and there was little interaction and engagement by staff. Some people needed the support of two staff to move from their wheelchair to armchair or to get out of bed. When staff were doing this, or if one staff was supporting people with their medicines, staff were not available to support people or act if someone fell or needed something quickly. During the inspection there were occasions when staff were supporting people in their rooms and there were no staff in the lounge where most people were sat.

The provider had failed to deploy sufficient numbers of staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people had difficulty moving around the service and used special equipment, such as a walking frame. There was guidance for staff on what people could do independently and what support they needed to help them stay as independent as possible. When staff supported people to move this was done is a safe way. Staff explained what they were going to do and reassured people when they used special equipment, such as a hoist.

People were protected from the risks of abuse. Staff knew about abuse and knew what to do if they suspected any incidents of abuse. Staff told us they had completed training on how to keep people safe and this was confirmed by the training records.

Staff understood how to keep people safe and their responsibilities for reporting accident and incidents. Staff reported accidents to the registered manager or deputy manager and they raised concerns with the relevant authorities in line with guidance. The registered manager monitored accidents / incidents to identify any trends. When a pattern was identified action was taken to refer people to other health professionals and minimise the risks of further incidents and keep people safe.

Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with people. Information had been requested about staff's employment history and any gaps in people's employment were discussed during interview. Written references were obtained and included the most

recent employer. Checks were carried out with the Disclosure and Barring Service (DBS) before employing any new member of staff to check they were of good character. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were trained in how to manage medicines safely. People told us staff supported them to make sure they received their medicines safely and on time. People said, "My medicines are always brought to me on time" and "The staff bring me my medicines three times a day. I know what they are all for".

Medicines were stored in a locked room. The medicines trolley was clean, tidy and secured when not in use. Some medicines had specific procedures with regards to their storage, recording and administration. These medicines were stored in a cupboard which met legal requirements and records of these were in order. Staff made sure people had taken their medicines before they signed the medicines record. People's medicines were reviewed by their doctor to make sure they were still suitable.

Staff knew how to respond and leave the building in the case of an emergency. Each person had a personal evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service. Fire exits were clearly marked and regular fire drills were completed and recorded. One person told us, "We have talked about fire precautions and procedures. There was a false alarm once- the staff knew what to do and did everything right".

Requires Improvement

Is the service effective?

Our findings

People said the staff were 'knowledgeable and efficient at their jobs'. People had confidence in the staff. People told us, "All the staff are skilled. They are very attentive to health matters" and "They have got good staff here. They know what they are doing".

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

At the last inspection in December 2015 the provider did not have processes in place to make sure that care was only provided with people's consent. Staff did not always act in accordance with the MCA. There were no assessments to establish whether people had capacity or not to make specific decisions, such as using bedrails. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to take action as there was a breach of the regulation relating to the need for consent. The provider noted on their action plan following the inspection, 'All care plans are being updated and consent forms are being put in place. Service users are being asked to sign the consent form to say that they are in agreement with care plans put in place and care received'.

At this inspection people's capacity to make day to day decisions had not been assessed. Some people had been diagnosed as living with dementia and were not able to give their valid consent to care and support. When people were not able to give consent to their care and support, staff did not act in their best interest and in accordance with the requirements of the MCA. For example, particular decisions, such as agreement to using bed rails or to consent to living in the service had not been assessed. People had not been given practical help to make a decision about and to consent to using bed rails. People's capacity to make day to day decisions had not been assessed. The registered manager told us that everyone living at Montague House had capacity to make decisions, but this had not been assessed to confirm this was the case.

A number of people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) agreement in place that had been completed by health professionals. They noted that, due to people's health conditions including dementia, they did not have the capacity to make such a decision. For example, one DNACPR had a summary from a GP and noted 'Severely frail person with dementia [and list of other medical conditions]. Does not have capacity to make an informed decision regarding CPR as they are unable to retain the information'. This was contrary to the registered manager's understanding.

The Care Quality Commission (CQC) contacted the registered manager in March 2016 on receipt of concerns raised to us about the lack of capacity assessments for people living at Montague House. In response to this the registered manager informed CQC, 'We are going to carry out mental capacity assessments on all clients to provide evidence of each person's capacity'. This had not been done.

Four staff had not completed training on the MCA and DoLS and eight staff last completed this training in 2012. They did not have a clear understanding of the key requirements of the MCA and how it impacted on the people they supported. The key requirements, including giving people practical help to make decisions and using the least restrictive options to keep people safe were not put into practice effectively to ensure people's human and legal rights were protected. During our inspection people were not offered choices about what they wanted to do or how they wanted to spend their time. The registered manager and staff told us people got up when they wanted to. One person said, "We get up when we like and do things at our own pace" and another person told us they got up at 06:00 which they had not done before moving to Montague House and commented, "But I don't mind. I come here [lounge] and sit and stay here until it is time to go back to bed".

Throughout the inspection people were supported with their personal care needs by staff. We asked staff if people had a choice of male or female staff. Staff commented, "I have never had it raised as an issue by anyone. I always give a choice the first time I work with a new person but I think people just see it as my job". There was no information in people's care plans that they were given a choice of the gender of staff supporting them.

The provider did not have processes in operation to make sure that care was only provided with the consent of the relevant person. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no-one living at Montague House was subject of an authorised DoLS even though some people were restricted. The registered manager did not have a good understanding of their responsibilities under the MCA to submit applications to the 'supervisory body' for a DoLS authorisation when needed. Some people were prevented from leaving and some people's movement was restricted. No assessments had been completed to check if the restraint or restriction was the least restrictive possible. No DoLS applications had been made to the supervisory body to ensure these restrictions were lawful. For example, one person living with dementia sat in the lounge for most of the day. Whilst sitting there staff moved their walking stick out of reach so they were unable to get up and walk around when they wanted to. Staff told us there had been an incident when they had hit another person with their walking stick. Staff commented, "Since the incident, when they are in the lounge we take their stick away. They are able to ask for it when they need it. I think deep down they know why we do that". There was no capacity assessment in place and no record that the person or their loved ones had been involved in making this decision.

Throughout the inspection one person appeared very unsettled. During the morning of the inspection they spent time talking and walking around the service, with their walking aid. They sat in an armchair in the dining room and, shortly afterwards, got up unaided and began to walk without their walking aid. Two staff were sat together in the 'snug' area of the dining room. One member of staff got up and went to the person and said "I don't really know what you want" and sat the person at the dining table. In the afternoon, this person still appeared unsettled and said to staff, "I want to go outside". A member of staff replied, "I know you do but you can't". There was no assessment of the person's capacity to check if they could make the decision to stay at Montague House. There was no signed record of the person agreeing to stay at the service. The registered manager had not contacted the local authority to discuss the restriction of not allowing the person to leave or held a meeting with the person, their loved ones and health professionals to

make sure they were acting in the person's best interest.

The provider failed to ensure people were not being deprived of their liberty for the purpose of receiving care without lawful authority. The risk of people being deprived of their liberty unlawfully had not been assessed and mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in December 2015 staff did not receive the appropriate support, professional development and supervision to enable them to carry out the duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to take action. The registered manager sent CQC an action plan following the inspection. This noted 'New supervision documents are being put in place and staff supervision to take place monthly as well as yearly appraisals and regular staff meetings. Support and development needed will be recorded'.

At this inspection staff had received one to one supervision from the registered manager and the deputy manager. Staff had the opportunity to discuss their role and they were supported to develop their skills, knowledge and experience. For example, some staff were being supported to complete level 2 vocational qualifications in social care. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve a vocation qualification, candidates must prove that they have the ability (competence) to carry out the job to the required standard. Staff told us what training they had undertaken and this matched the information on the training schedule completed by the registered manager. Training included topics such as moving and handling, first aid and fire safety. During the inspection we observed staff supporting people to move around the service safely.

People were provided with a choice of healthy food that they liked. People said, "The meals are good", "I like the meals" and "The supplied meals are very good. They know I don't like liver. The cook is an asset – they are a good cook".

People chose where they wanted to eat their meals. Most people ate together in the dining area. Staff respected people's choice when they wanted to eat their meal in their room. The cook told us, "The job involves seeing all the residents every day about their meal choices, so I learn about individual likes and dislikes". The cook was aware of any food allergies and said that there was no-one on a special diet. The lunchtime meal looked appetising and people ate well, saying that they had enjoyed it. Staff told us that snacks, such as biscuits, fruit and yoghurts were available for people throughout the day.

Some people were at risk of malnutrition or dehydration. When people were not eating their meals because their health was deteriorating, or they were unwell, staff monitored people's weight. Specialist health professionals, such as speech and language therapists and dieticians, were contacted for advice. Each person had a nutrition plan which provided staff with guidance on promoting choices of food, portion sizes and what level of support people needed with meals. Some plans noted amounts people should drink to remain healthy. For example, one person's care plan noted 'Needs to drink 1.5 litres of water a day. Does need to be prompted to do this'. However, there was no fluid chart in place to record how much fluid the person had drunk. We checked the daily records for this person and their food intake was described, however, there was no mention of any fluid intake. There was a risk people may not be drinking sufficient to maintain good health. We discussed this with the registered manager and they arranged for a fluid chart to be implemented.

People were supported to maintain good health. People's care records showed relevant health and social care professionals were involved with their care. Care plans were in place and reviewed regularly to reflect

any changes in people's health needs. One person told us they had been short of breath and staff had arranged for a doctor to see them. They said staff had explained how to use an inhaler and that they were well supported with their health needs. Another person told us staff had supported them with hospital visits and having their hearing aid repaired.

Requires Improvement

Is the service caring?

Our findings

People said they were happy living at Montague House and appeared relaxed in the company of each other and staff. People told us about the care and support they received. People's comments included, "I like the care and attention they give when they help me with getting dressed and washed"; "We are never made to feel we are a burden. We haven't been involved with the paperwork, but I know that they know what we need" and "There have been no staff I've objected to. Some have been not so good, but they don't last."

During the inspection we observed some positive interactions between staff and people living at Montague House. However, staff did not consistently treat people with care, compassion, dignity and respect. Staff were busy with their daily duties and did not always show concern for people's well-being. For example, during the inspection one person was taken in their wheelchair into the lounge at 10:40am. They were placed facing their armchair and they were unable to see the television or the garden through the window. The member of staff told them they would return with another member of staff to support them into their armchair. Half an hour later the person was still sitting in the wheelchair waiting for staff to support them. Staff had not paid any attention to the person despite going into the lounge to other people. At 11:40am a member of staff commented to the person "You didn't drink your tea" to which the person responded "I didn't know it was there". Staff said "Have some juice" and placed a glass of squash in the person's hand. They walked away with no further interaction and no mention of helping the person into a comfortable chair. At 12:05pm a member of staff walked into the lounge and said, "Its dinner time everybody" and pulled the person in their wheelchair backwards into the dining room. There was no explanation of what they were about to do. Two staff then supported the person to sit comfortably on a dining room chair. We recommend the provider reviews staff practice to ensure people are always treated with dignity and respect.

People said they were happy with the care they received. One person pointed to the cook and commented, "They are good in the garden too. They are very kind to everyone". The cook said, "I have a duty to provide good care. It's natural, they see me in the kitchen and I see them around the home and if they need help at that time I want to see them treated how I'd like my mother to be treated".

Some people and their relatives had been involved in the planning of their care and support and had signed their care plan to confirm this. People had support they needed to wash and dress. Good attention had been given to people's appearance and their personal hygiene needs had been supported. One person said that they had to wear special stockings which they found uncomfortable but that staff had explained the importance of wearing them which reassured them. Another person told us how they tried to keep their independence and said, "I have a fridge in my room to keep food and drinks I particularly like. It makes me feel a bit more independent". Some people had signed notes on their bedroom doors expressing their wish that they were not checked at night. One person commented, "I told the manager I didn't want to be checked at night, because I can ring the bell if necessary." Staff knew people well and understood their likes and dislikes. For example, while the cook was taking people cups of tea they chatted with them about their favourite biscuits and sweets.

People's confidentiality was respected, conversations about people's care were held privately and care records were kept securely. Care plans were located promptly when we asked to see them.

Staff respected people's privacy. One person commented, "As far as respect is concerned, they are very good". Staff knocked on bedroom doors and waited for signs that they were welcome before entering people's rooms. They explained why they were there and made sure people understood before they continued with any support.

People moved freely around the service and could choose where they wanted to spend time. Staff knew when people wanted their own space and respected this. One person told us, "I like to be left to myself, and they know that". The cook told us that it was particularly important for one person to have the company of others as they lived with depression. However, this person had been left in their wheelchair facing their armchair and had little interaction from staff and was unable to see other people in the room.

Staff supported people to develop and maintain friendships and relationships. One person told us they preferred to be in the lounge and see people around them. They said they had forged a friendship with another person and they sat together to have their meals and chat. However, during the inspection staff had seated these two people opposite each other with a television between them so they were not able to talk to each other. Staff always sat people in the same chairs. Staff did not suggest people moved so they could chat to each other when they wanted to.

Although there were no visitors during our inspection people and staff told us there were no restrictions in place and relatives visited whenever they wanted to. Entries in the visitors' book confirmed families and friends regularly visited their loved ones at different times.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed and that staff were responsive to their needs. People said, "I get what I need and I am quite content", "Staff help me when I need them to" and "I am comfortable. I have a lovely room". However, people told us there was little for them to do. One person commented, "People just get used to inactivity – then there is no need to provide anything because people don't ask for entertainment".

At the last inspection in December 2015 the provider had not supported people to be involved in the community as much or as little as they wished and to take part in meaningful activities. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to take action. The registered manager sent the Care Quality Commission (CQC) an action plan. This noted, 'More activities to be provided for service users. This is not just group activity; it will be one to one also. All service users will be asked to join in and the outcome recorded. Service users will be given the choice of activities they wish to be involved in'.

In May 2016 the registered manager updated CQC on their progress against their action plan following the last inspection. They noted, 'We are carrying out more activities with our service users. After talking to them about activities it was clear that a majority of our service users prefer to take part in one to one activities rather than group activities. Staff have been allocated more time during the day to provide this and are spending time playing cards, selection of board games, manicures, planting flowers and plants for service users to have outside their rooms. We also have a person come in who sees individual service users and their activities include quizzes, music therapy and reminiscence activities. They have also spoken to service users regarding animal therapy and they have had a lot of interest in this and they hope to commence with this very soon'. The registered manager told us, "A person comes in to do activities once and sometimes twice a week". A member of staff commented, "A while ago we had someone who came in just to do activities but it stopped and now it's down to us. Recently staff have been playing draughts with people and we do bingo and stuff like that. I've seen less and less happen over time and it will fizzle out if they aren't able. We do get to spend a lot of time chatting". During the inspection we did not observe staff chatting and engaging with people. People were not aware of any arrangements regarding activities.

During the inspection two people went out to a day centre. One of them commented, "It's the high point of the week. There's nothing to do here except watch TV or sleep". Most people were seated in the lounge. The television was on continuously. People told us, "I don't take any notice of it really [the television]. I'm not one for TV or radio" and "Nobody seems to watch it. I'm not interested". One person said they liked the television on as a background while they were resting and that they watched 'little bits'. Another person said, "I don't go in there [lounge] because the television is always on, but people aren't asked if they want it on". Staff did not ask anyone if they wanted the television on or if there was something they would like to watch.

One person had a box of drawing paper and crayons by their chair which they said they used. Other people had personal books and magazines near their chairs. During the inspection staff did not offer to support

people to access and use these.

One person, who preferred to stay in their room, told us they read and watched television and had no interest in going out or in organised activities and trips. They said they enjoyed it when staff spent time chatting with them and that staff knew them well. Some people told us they enjoyed spending time in the garden when the weather was warm. People said, "I sit outside if the weather allows. I know that if I wanted, the staff would take me out. They used to. They have always been very good to me", "The garden is a good facility" and "I'm content. I don't want to go any further than the garden". People were supported to go out by their relatives.

The provider had not ensured people's care and treatment was designed to reflect their preferences and ensure their hobbies and interests were supported. This was a breach of Regulation 9(1)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in December 2015 people were not involved in the assessment, planning and reviewing of their care to make sure it was provided in the way they preferred. People's life histories had not been recorded to help staff get to know people and what was important to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to take action. The registered manager sent CQC an action plan and noted 'We are working with Social Services and head of nursing team for older persons to improve on person centred care planning, making sure that service users and families have much more input on the care plans of individuals'.

At this inspection staff had worked with health professionals and implemented new care plans. A 'care plan agreement form' was in each person's file. Some of these had been signed by people to say they had been involved in writing their care plan and others had not. People were assigned a keyworker – this was a member of staff who was allocated to take the lead in co-ordinating someone's care. A record in each care plan set out the keyworker's involvement in the review process and noted, 'Monthly reviews take place through group meetings and discussions, all of which you will be involved in'. Care plans had been reviewed with people each month by the keyworker or the deputy manager.

An assessment process was in place when people were considering moving to Montague House. This was done so the provider could check whether they could meet people's needs or not. However, there had been no new admissions to the service for over 18 months. Care plans provided staff with guidance on what people could do independently and what support they needed. A separate night care plan had been written and gave staff information on continence, personal hygiene needs and oral care. Staff were talking with people and their relatives to obtain further detail about people's past to develop the information they had on people's life histories.

The provider had a policy in place which gave guidance on how to handle complaints and copies of this were displayed in the service. When complaints had been made they had been investigated and responded to appropriately. People and relatives told us they would raise any concerns with the registered manager or staff and felt that they would be listened to and their complaint properly addressed. One person said, "I complained once about a member of staff, I didn't like their manner of speaking to me. The manager dealt with it and the member of staff apologised to me. I just wanted them to learn from their mistake which they did". Another person commented, "I haven't had cause to complain but there would be no problem in doing so. The manager and deputy are very good".

Inadequate

Is the service well-led?

Our findings

At the last inspection in December 2015 the provider did not have robust quality assurance systems in place. There were no reports following audits to detail any actions needed, to prioritise timelines for any work to be completed and to name who was responsible for taking any action. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to take action. The registered manager sent us an action plan and noted 'For management and senior staff to carry out effective auditing, identifying any shortfalls in our service and recording actions taken to improve the service we provide'.

At this inspection the provider failed to take appropriate and timely action following the last inspection and we found continued breaches of Regulation 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We also found new breaches. Some audits had been carried out. For example, regular medicines audits had been completed. An environmental audit had been completed; the most recent environmental audit was dated July 2016. This comprised of a tick list. Some actions had been noted, for example, '21/7/16 stair carpet cleaned'. There were no action plans with timescales for improvements to be made and who would be making the improvement. Other audits were not completed regularly. The shortfalls identified during our inspection relating to the poor cleanliness of some areas had not been identified by the registered manager.

The registered manager had not audited care plans to check they included the relevant information staff needed to guide them in proving safe and effective care, such as checking people's risk assessments.

The Kent local authority told us they had spoken with the registered manager in March 2016 about people's mental capacity and about whether people should have deprivation of liberty safeguards (DoLS) applications made. At this inspection the registered manager had still not acted to assess people's capacity and had not applied for any DoLS authorisations even though people were being prevented from leaving.

The registered manager or the provider was not checking that staff were providing good care through competency checks or observations of staff. The registered manager did not ensure that staff understood and promoted people's involvement, compassion and dignity or review the day to day culture in the service. There had been incidents when staff practice was not acceptable and the registered manager had not picked this up. For example, during the inspection, we observed people being told by staff that they would return and they did not, leaving the person unable to see other people or the television. We also observed the two staff on duty took their break at the same time which left no staff with people. We discussed this with the registered manager who told us that "Staff know they shouldn't take their breaks together". Later, one staff member took their hot drink and sat in an armchair in the lounge with people, however, they did not chat with people.

People knew the registered manager and staff by name. People said they did not know who owned the service and did not remember seeing the provider. There had not been a resident's meeting since July 2016 so people had not had the chance to get together and discuss the service since then. A member of staff told

us they had 'never been aware' of a resident's meeting and so was not aware of any outcome. People told us they would speak to staff if they had any concerns.

People were not involved in the day to day running of the service and did not have the opportunity to have a say about the service. Decisions were made that affected people without people being involved in these decisions. For example, one person told us, "In the last few days they've changed the seating in the dining room. It was small tables for two people to sit at, now it's a big block. I have asked people if they know why that was done but they don't know. It shows we need meetings to discuss things like that, but we don't have them".

People, relatives, staff and health professionals were not asked for their views about the service. In May 2016 the registered manager updated CQC on their progress against their action plan following the last report. They noted, 'We have recently sent out some questionnaires for both service users and visitors'. During the inspection we asked to see the results of the latest quality assurance survey. We were shown the results of a survey conducted in April 2015, before the last inspection. There was no record of further feedback from people, relatives or health professionals. People told us they had not been asked their views on their satisfaction with the service.

There was a risk that people may not receive safe care and support because the provider had not identified the shortfalls, by way of effective audits and checks. The provider failed to monitor, assess and improve the quality of the services provided, including the experience of the people living at Montague House, relatives, staff and health professionals. This was a continued breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their responsibilities in recording and notifying incidents to the Kent local authority and the Care Quality Commission (CQC). All services that provide health and social care to people are required to inform CQC of events that happen in the service so CQC can check appropriate action was taken to prevent people from harm. The registered manager notified CQC in line with guidance.

The registered manager and deputy manager worked at the service each day. The registered manager told us they held regular meetings with the staff. The last recorded meeting had been in July 2016. A member of staff said, "We used to have them regularly, but now it is on a needs basis, so I expect we will have one after the inspection report". This member of staff said they were not aware of the outcome of the previous CQC inspection. The provider had a range of policies and procedures which were being updated. Staff knew where to access the information should they need it. Records were stored securely to protect people's confidentiality.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care and treatment was designed to reflect their preferences and ensure their hobbies and interests were supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have processes in operation to make sure that care was only provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to keep the service clean and hygienic to ensure the premises were safe. The provider failed to ensure care and treatment was provided in a safe way. The provider failed to assess risks to people and do all that was practicable to mitigate any such risks. The provider failed to ensure people were not being deprived of their liberty for the purpose of receiving care without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance There was a risk that people may not receive safe care and support because the provider had not identified the shortfalls, by way of effective audits and checks. The provider failed to monitor, assess and improve the quality of the services provided, including the experience of the people living at Montague House, relatives, staff and health professionals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to meet people's needs.