Review of compliance

Maricare Limited Montrose	
Region:	South West
Location address:	Montrose Care Home 40 Prince of Wales Road Dorchester Dorset DT1 1PW
Type of service:	Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	Montrose Care Home is registered to provide accommodation and personal care to a maximum of 21 elderly people. At the time of the inspection visit on 2 and 9 February 2012 there were 16 people living in the home.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Montrose was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with one person who said the carers "are very good, they look after me well".

Care staff told us it was quicker to use a wheelchair rather than offer to support a person to walk.

Two people we spoke with told us that there were not enough carers at Montrose.

A relative we spoke with told us of their concerns regarding the lack of stimulation and activities provided at the home.

One person told us they had put on weight since living at Montrose because the food is so appetising. Another said "the cooks are wonderful, can't fault the food".

Four people we spoke with knew who to speak with if they had a concern.

One person told us that drops had been prescribed to be put on a wound and that a carer had put them into their eyes.

What we found about the standards we reviewed and how well Montrose was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People are not always involved in planning their care and treatment. Staff did not always deliver care in a dignified, person-centred way to promote independence.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People do not consistently experience effective and appropriate care, treatment and support that meets their needs.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

People are given a choice of what to eat and drink to meet their needs.

Overall Montrose Care Home was meeting this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People are protected against the risk of harm or neglect at Montrose Care Home and safeguarding concerns are responded to appropriately. The safeguarding policy does not reflect local and national guidance. Not all staff had an understanding of safeguarding adults inspite of having received training .

Overall Montrose Care Home was not meeting this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People live in an environment which is unclean, particularly the bathrooms and kitchen. They are also exposed to the risk of cross infection because infection control and prevention procedures are not effective. Food hygiene and storage procedures are also not effective.

Overall Montrose Care Home is not meeting this essential standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People who use these services are not protected against the risks associated with the unsafe use and management of medicines. Montrose care home does not have safe, effective arrangements in place for recording, handling and dispensing of medication.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks

and assure the health, welfare and safety of people who receive care

The system in place to regularly assess and monitor the quality of service that people receive is ineffective. There was no evidence of identified learning from the quality assurance process to improve practice.

Overall Montrose Care Home was not meeting this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with one person who said the carers "are very good, they look after me well". Another person told us that the carers do not have time to explain anything.

One person we spoke with looked well cared for with clean colour coordinated clothes and hair neat and with manicured nails. We spoke with five women who had excessive facial hair which appeared undignified.

We observed carer workers interacting with people speaking caringly and respectfully. For example two carer workers were transferring a person in a hoist and throughout the procedure they spoke with the person providing reassurance and telling them what they were doing.

A person we spoke with told us they were involved in the initial care planning process for their relative.

Other evidence
We reviewed four care records and found evidence of only one of these people being involved in the assessment and planning of the care and support required.

We spoke with three carer workers and they told us they understood about involving people in making decisions about their care and support. However they told us that often they were not able to accommodate people's requests or promote their independence because they were too rushed. For example they told us it was quicker to use a wheelchair rather than offer to support a person to walk.

Our judgement
People are not always involved in planning their care and treatment. Staff did not always deliver care in a dignified, person-centred way to promote independence.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Two people we spoke with told us that in their opinion there were not enough carer workers at Montrose. They told us that the carer workers had to give lots of time to people who were more demanding, like those that need to be moved using a hoist. One person told us that often meal and medication routines were late because carer workers were assisting certain people who needed more care. Two members of staff that we spoke with confirmed these comments from people.

One person told us they feel lonely and spent much time in their room and carer workers did not take them out. Two other people told us that they were bored as there was nothing to do.

We observed five people sitting in the lounge. They were looking around or sleeping in their chairs with no conversation or stimulation provided by staff.

A relative we spoke with told us of their concerns regarding the lack of stimulation and activities provided at the home.

During our inspection visit we saw a person had bed rails and bumpers on their bed. The person told us they felt safer with bed rails as they had fallen out of bed twice.

A person we spoke with told us they had not had a bath for weeks and did not know when they were going to get one. Another person said they felt that personal care was provided by the staff only as a favour.

During the inspection we noted that several rooms were cold. The people in these rooms told us they felt cold. Whilst in other rooms we noted were extremely warm. The staff we spoke with were not aware of a problem with the heating.

Other evidence
We reviewed four care records at random. Each care record we reviewed had a long term needs assessment which included the person's life story and future wishes which were written in the first person.

Risk assessments were not completed consistently. A nutritional risk assessment in one person's file showed that body weight was monitored monthly and a significant weight loss had occurred. A referral had been made to a dietician and advice given. However, a falls risk assessment for one person was reviewed monthly and had a high risk score. There was no evidence on the care record what measures were put in place to support and prevent this person from falling. Neither was there evidence that professional advice had been sought.

We saw daily allocation sheets which gave a summary of people's care and welfare needs. These sheets were used by carer workers for making notes throughout a shift. We were told by the registered manager this information was then used to handover to carer workers on the following shift and the person who delivered the care was responsible for updating the daily notes.

The care plans we reviewed were not updated regularly to reflect current care needs. We did not see that changes that had been highlighted were fed back into the plan of care. For example a person whose daily notes stated that they had been experiencing frequent headaches for which advice had been sought from a health professional; the care plan had not been updated to include and monitor this problem.

We noted that when needs assessments and care plans had been reviewed the comments were generic. For example the comment 'no change' was regularly documented when a care plan had been reviewed.

The registered manager told us that the senior staff updated the care plans on a regular basis and a new care planning process was currently being implemented.

We did not see any activities provided for people. We saw an activities programme on the notice board for the week commencing 19 December 2011. We also saw an activities sheet dated 31 October 2011 with no further subsequent recordings. The registered manager told us that due to budget restrictions there was no longer an activities coordinator employed at the home. The deputy manager we saw had set up an activities table in the lounge with jigsaw puzzles, coloured crayons and books for people to help themselves to.

The care staff we spoke with told us there were insufficient staff rostered to provide appropriate care and that staff were working excessive hours to meet people's needs.

Our judgement
People do not consistently experience effective and appropriate care, treatment and support that meets their needs.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We spoke with four people about the food at Montrose. One person told us they had put on weight since living at Montrose because the food is so appetising. Another said 'the cooks are wonderful, can't fault the food'. We were told by one person that the 'food is ok, only a moderate chef, not enough meat' and another said 'the food is good, would like a steak, but they don't do it here'.

We observed nine people taking a lunch time meal in the dining room. The food they were offered was hot and presented in an appetising manner. People were given a choice of food.

In the morning the chef was seen going around the home speaking to all the people telling them the two main course choices and asking them if they wanted anything different. At lunch time in the dining room, food was served individually and people were able to select what vegetables they wanted and how much. One person was offered support when eating; this was done in a discrete, dignified way.

Other evidence

Our judgement
People are given a choice of what to eat and drink to meet their needs.

Overall Montrose Care Home was meeting this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
One person told us that they always felt safe at Montrose. Four people we spoke with knew who to speak with if they had a concern.

Other evidence
We received four safeguarding notifications from the local authority in the last 12 months which were investigated and subsequently managed appropriately by the home. Three of the allegations were unsubstantiated. One safeguarding allegation was substantiated and as a result of an investigation a member of staff was dismissed and referred to the Independent Safeguarding Authority (ISA).

The registered manager told us that no Deprivation of Liberty Safeguarding (DoLS) were in place or applied for in the last 12 months.

We spoke with two members of staff who told us they had received safeguarding adult training. However, they did not understand and recognise the signs of abuse, the Mental Capacity Act or DoLS. Another member of staff we spoke with was able to discuss adult safeguarding confidently, including the signs of abuse and how to respond and raise concerns appropriately.

The registered manager showed us the staff mandatory training matrix. The training matrix demonstrated that all staff were required to have safeguarding adult training each year. All but two staff were up to date with safeguarding adult training.

The safeguarding policy we saw did not cross reference or include the local authority safeguarding guidance. Neither did the policy include the Mental Capacity Act or DoLS. A separate policy for whistle blowing was in place.

Our judgement
People are protected against the risk of harm or neglect at Montrose Care Home and safeguarding concerns are responded to appropriately. The safeguarding policy does not reflect local and national guidance. Not all staff had an understanding of safeguarding adults inspite of having received training .

Overall Montrose Care Home was not meeting this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not ask people about their experience in this regard.

The carpets in the lounge and two rooms were noted to be heavily stained in places. In one person's room the carpet was malodorous.

During our inspection we saw six toilets that were dirty with dried faeces around the bowl. We saw sinks in people's rooms that were dirty. The waste bin for dressings in the sluice room was over-flowing. The floor and surfaces in the sluice room were not clean. We saw a cleaning schedule which indicated that there had not been a cleaner in the home for two days. We saw past cleaning schedules which showed that not all areas of the home were cleaned regularly. For example some bathrooms were only cleaned once a week and that some weekends no cleaning took place.

Other evidence
The fridges in the kitchen were found to contain food which was uncovered and undated. The fridge also contained food which was passed its use by date and some which had mould on. At the end of the inspection after the chef had left the premises we saw that the kitchen was left in a dirty state with dirty crockery, pots and pans spread around, the cooker was dirty as was the floor.

We found that food and drink was not prepared and stored in line with the requirements of the Food Safety Act 1990. For example we saw boiled rice in the saucepan it had been cooked in that morning, stored uncovered and undated in the fridge.

There was no lead for infection control in the home. We were told that the new deputy

manager was going to be trained to undertake this role at some time in the future.

We were shown a training matrix which indicated that 53% of staff were due to have infection control training in February 2012.

The registered manager showed us the infection control policy dated January 2012 which referenced the Health and Social Care Act 2008 Code of Practice for Prevention and Control of Infections and Related Guidance. From the evidence we have found the home was not following its own policy and was not complying with criterion 1,2, and 9 of the code of practice.

Our judgement
People live in an environment which is unclean, particularly the bathrooms and kitchen. They are also exposed to the risk of cross infection because infection control and prevention procedures are not effective. Food hygiene and storage procedures are also not effective.

Overall Montrose Care Home is not meeting this essential standard.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
One person told us that drops had been prescribed to be put on a wound and that a care worker had put them into her eyes. We did not see that an incident form or medication error form had been completed. This was discussed with the registered manager and it was not clear that any action had been taken as a result of this error.

During the inspection visit we observed medication given to people with no explanation given by the carer of what the tablets were for or ensuring that the person took the tablets. In one person's room we saw several medicine pots from previous medication rounds. We also saw one person with antibiotics in a medicine pot on their table.

Other evidence
We reviewed 10 medicine administration records (MAR) charts. There were discrepancies in the documentation on these records. For example we noted that antibiotics on at least two occasions had not been signed for. We also noted that a person was prescribed a drug to be given when required, however it was noted it was given routinely four times a day every day.

A protocol for the administration of 'when required' medication was not available. We did not see evidence of regular audit of medications or MAR charts.

We saw a person self-medicating with a spray under the tongue which was kept in their room. This person told us that staff were not alerted when the spray was used. The

MAR chart was reviewed for this person and it was found that this medication spray was not prescribed on the MAR chart.

On one MAR chart it was noted that a prescription for antibiotics was hand-written, not dated or signed.

The training matrix did not identify that staff had received training in medication administration. However we saw in two staff files that they had attended medication awareness training.

Our judgement
People who use these services are not protected against the risks associated with the unsafe use and management of medicines. Montrose care home does not have safe, effective arrangements in place for recording, handling and dispensing of medication.

Overall Montrose Care Home was not meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People who live in the home and visitors we spoke with told us that they would approach the registered manager if they had any concerns.

Other evidence
The registered manager showed us the quality assurance programme which was in place. This included monthly audits of care plans, accidents/incidents and infection control. Audit reports were produced but there was no evidence of identified learning points or how learning as a result of the audits was shared with staff to improve practice.

We were told that monthly quality assurance questionnaires were given to residents and reported on. We did not see that this information about quality and safety was acted upon and fedback to people in the home

We were told that no meetings had been held with relatives of people living at Montrose in the last 12 months but one was planned for the end of March 2012. We saw a poster on the notice board in the hall with the dates for residents meeting in 2011.

The registered manager showed us minutes of a resident's meeting held in January 2012. Eight residents attended this meeting and discussed their views on staffing, activities and mealtimes. The meeting minutes recorded that five people expressed the view that more staff were needed to meet everyone's needs.

We reviewed the complaints folder which showed that complaints were not monitored and analysed. There was no evidence that any learning takes place as a result of a complaints investigation.

During the inspection visit we were unable to see any documentation relating to the operational management of the kitchen as all records had been taken off site. We did not have any evidence with regard to the monitoring of fridge temperatures, food serving temperatures or kitchen cleaning rotas.

Our judgement
The system in place to regularly assess and monitor the quality of service that people receive is ineffective. There was no evidence of identified learning from the quality assurance process to improve practice.

Overall Montrose Care Home was not meeting this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People are not always involved in planning their care and treatment. Staff did not always deliver care in a dignified, person-centred way to promote independence.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People do not experience effective and appropriate care, treatment and support that meets their needs.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The safeguarding policy does not reflect local and national guidance. Not all staff had an understanding of safeguarding adults inspite of having received training.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated	Outcome 08: Cleanliness and infection control

	Activities) Regulations 2010	
	How the regulation is not being met: People live in an environment which is unclean, particularly the bathrooms and kitchen. They are also exposed to the risk of cross infection because infection control procedures are not effective.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: There are not safe, effective arrangements in place for recording, handling and dispensing of medication.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The system in place to regularly assess and monitor the quality of service that people receive is ineffective. There was no evidence of identified learning from the quality assurance process to improve practice.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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