

***We are the regulator:*** Our job is to check whether hospitals, care homes and care services are meeting essential standards.

## Montrose

Montrose Care Home, 40 Prince of Wales Road,  
Dorchester, DT1 1PW

Tel: 01305262274

Date of Inspection: 02 October 2013

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November 2013

We inspected the following standards as part of a routine inspection. This is what we found:

<b>Care and welfare of people who use services</b>	✓	Met this standard
<b>Cleanliness and infection control</b>	✓	Met this standard
<b>Management of medicines</b>	✓	Met this standard
<b>Supporting workers</b>	✓	Met this standard
<b>Complaints</b>	✓	Met this standard

## Details about this location

Registered Provider	Maricare Limited
Registered Manager	Miss Jennifer Kate Harding
Overview of the service	Montrose Care Home is registered to provide accommodation and personal care for up to 21 older people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

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## Summary of this inspection

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### Why we carried out this inspection

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This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 2 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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### What people told us and what we found

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People told us that they were happy with the care and support they received and the way in which staff supported them. They told us that their views and experiences were taken into account and their decisions were respected. We observed staff speaking to people in a respectful manner.

People had detailed care plans which reflected their needs and choices. We saw that they had been reviewed regularly. People had access to medical support and specialist advice if required. We noted that one visit made by a visiting professional had not been recorded in the person's notes.

Records showed that staff had received the training to do their jobs. Staff we spoke to confirmed that they felt trained and supported to do their jobs.

We found that the home had a medication policy in place. During our visit one medication error was identified. The provider told us the measures that would be taken, which included supervised practice and assessment of competency .

People who used the service had access to a range of activities within the home. People who used the service were observed in a music session on the day of our visit.

Relatives we spoke to said that they were happy with the 'open door policy' and felt that they could approach staff if they had a concern or complaint. We saw that the home's complaint policy had been made accessible. It gave clear guidance on the people that could be contacted with a complaint, both within the organisation and externally.

You can see our judgements on the front page of this report.

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## **More information about the provider**

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Please see our website [www.cqc.org.uk](http://www.cqc.org.uk) for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

### Care and welfare of people who use services

✓ Met this standard

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

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### Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

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### Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

People we spoke to were happy with the care and support they had received. We observed staff interacted with people who used the service in a calm and respectful manner. The relatives we spoke to told us that they found the staff kind and helpful. People told us that they enjoyed the food, and that portion sizes were good. People told us that the Chef came round to them everyday to ask them what they would like. People said they could make choices but they appeared unclear as to what the choices were. The provider told us that a written menu had been planned.

Records showed that people had received an initial pre-assessment before they had moved into the home. We saw that the information had then been used to develop a care and support plan which included people's physical, social, psychological and spiritual needs and wishes. We saw that people's choices had been recorded. For example, "I will get up when I choose to" and "I may change my mind so please don't assume I will have what I had yesterday". Members of staff we spoke to told us that people who lived in the home could choose when to get up in the morning, when they wanted to go to bed and what they wanted to do with their time during the day.

We saw that people's records included an "all about me" section which gave members of staff a personal insight into people's life. They included details of the person's family life, hobbies and abilities. They also recorded the things people needed support with. For example, one person's included the time they liked to get up in the morning, go to bed and the activities they enjoyed doing.

People who lived in the home had been given a letter with information about the role of their care plan. The letter detailed the areas that would be included, such as mobility, medications and the level of assistance needed. The letter had also highlighted that it was

important for people to be included in both the development of their plan and its ongoing review. We saw that people had signed the document to say how involved they wanted to be in the planning of their care, and who else they wanted to be included. For example, one had been signed by a person who lived in the home, and had detailed who they wanted to be involved. This meant that permission had been obtained before sharing personal information with others.

People who lived in the home had been assigned a keyworker. We saw that an explanation of the role of the keyworker had been given to people in writing.

We spoke to three relatives who told us that they knew about the development and review of the care plans and the role of the keyworker.

We saw that people's ability to make specific decisions had been recorded. For example, financial decisions and day to day decisions. People were supported to make all the decisions they could themselves. Members of staff told us that they helped people to make choices and decisions. For example, they showed people different clothes to choose from, and described food if they did not recognise its name. We saw that Advocacy leaflets were available in the reception area.

We saw that people had access to medical and specialist support. For example, the GP and District Nurse. The provider told us that people could be directly referred to the Falls Team, the Occupational Therapy Team and the Community Mental Health Team. A record of professional visits were made in people's care plans. The provider might like to note that a visit made by the Community Mental Health Team to a person who had displayed challenging behaviour had not been recorded.

We spoke to a District Nurse who was visiting the home. They told us that they had seen an improvement within the home over the past year. They told us that the home responded to concerns raised and that communication had improved between the home and the District Nursing Team. They told us that they had supported the home with a person's end of life care recently. They said that the home had been proactive, and had provided good care.

We found that risks were identified within people's care plans. For example falls, pressure damage and nutritional. One person's plan had identified them as being at a medium risk of falls. We saw that the risk assessment had identified the contributory factors; deafness in one ear and poor eyesight. Measures that had been put in place had been recorded. We saw that risk assessments had been reviewed regularly.

The provider had put individual risk assessments in place to manage the evacuation of people who used the service in the event of a fire. One said that the person had sensory loss. It also stated how the person could be mobilised in an emergency.

We saw that people who used the service had access to a range of activities within the home. A notice board in reception showed the planned activities. Two outside entertainments were booked each week and staff provided activities on the other days. Activities included story telling and poetry sessions. A poster showed that The Tank Museum had planned to visit the home with 'Horse in War and Peacetime'. On the day of our visit we observed two staff playing music in the sitting room with a group of people who were playing hand held instruments. We observed that one person had wanted to change their instrument. A member of staff listened to them and offered them a choice of other

instruments. Members of staff told us that they knew people well. We were told that some people "enjoyed reminiscence sessions, chess and quizzes". One person said "I like the family life here" and another said they liked to watch the television. We saw that subtitles were on the television when we visited, and we saw that a large numbered digital clock had been placed prominently in the sitting room.

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

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**Our judgement**

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The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed, and people were cared for in a clean, hygienic environment.

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**Reasons for our judgement**

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There were effective systems in place to reduce the risk and spread of infection.

During the visit we toured the home. We looked at communal areas, a selection of bedrooms, the laundry and the kitchen. We found the home to be clean and odour free.

We spoke with three people who lived in the home, and with five relatives who were visiting. People told us that they were happy with the standard of cleanliness within the home. People told us that they could approach the manager if they had any concerns.

We found that the home had an infection control policy in place, which had been up-dated in January 2013. Records showed that staff had signed to declare that they had read and understood the policy.

Members of staff we spoke to told us that they had received training in infection control. Training records confirmed this.

We saw that members of staff had access to personal protective equipment. For example, gloves, aprons and antiseptic hand gel. Staff confirmed they understood when personal protective equipment should be used. One member of staff told us that aprons were colour coded. They told us that the colour used was dependent on the task being undertaken. For example, a red apron to be used if handling potentially infected material.

We saw that the laundry room was tidy. Clean clothes waiting to be returned to people who used the service had been stored in individually labelled baskets. Dirty clothes that were waiting to be washed had been stored in laundry baskets with lids on, to prevent the spread of infection.

The provider had in place a detailed cleaning schedule, which staff had signed once each task had been completed. The manager told us that they did regular spot checks of the home, and monitored the daily signing sheets to ensure that correct standards of cleanliness had been maintained.

Within the kitchen we saw that the worksurfaces and flooring were clean. We looked in the fridge. We found that plated food had been covered and dated, and opened packages had been dated. The provider told us that they monitored the standard of hygiene within the kitchen, and the working practices of members of staff who worked in the kitchen.

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

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## Our judgement

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The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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## Reasons for our judgement

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Medicines were handled appropriately.

We saw that the home had a medication management policy in place. Staff who administered medication had received training and records confirmed that the manager monitored their on-going competency. Records showed that members of staff had signed to confirm that they had read the medication management policy.

During our visit we checked inside the medication trolley. We saw that it was kept in an orderly manner. Individual named boxes were seen inside the medication trolley. They contained medication which had not been dispensed in blister pack form.

We saw that opened bottles and boxes stored within the trolley were labelled and contained opening dates. This allowed staff to monitor stock levels.

When PRN (as required) medication had been prescribed we saw that staff had recorded whether the medication had been given or not. Also the dosage which had been administered had been recorded.

Controlled drugs were stored within a locked cupboard. A separate controlled drugs book was in place. We saw that this had been audited on a regular basis.

We observed a member of staff whilst they conducted part of a medication round. We saw that they were wearing a red tabard. This showed that they were not to be disturbed. We saw that when they walked away from the trolley, they locked the trolley to ensure no-one had unauthorised access to its content.

We saw that the home had a general risk assessment in place which related to the administration of medication. This included guidance for members of staff. For example, to not leave medication unattended, to check for allergies and where to store delivered medication until assigned.

We checked fifty per cent of people's Medication Administration Record (MAR) charts. Six

had been completed appropriately. However, we saw that one person's morning medication had been omitted on one day. No reason had been recorded. The manager explained the home's policy on managing medication errors. They told us what measures would be taken to protect people who used the service from harm. We were told that an action plan would be put into place which would include supervised practice for the member of staff involved, competency assessments and further training as required. The provider had measures in place to identify medication errors. Records showed that the provider completed a weekly medication management audit, which included checking MAR charts for errors.

**Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

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## Our judgement

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The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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## Reasons for our judgement

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Staff received appropriate professional development, and staff were able, from time to time, to obtain further relevant qualifications.

We saw that staff had received an induction in line with the Skills for Care Induction Standards. We also saw that the manager had detailed training plans in place for the training that they provided.

We looked at the training matrix in place. We found that members of staff had received mandatory training which included Safeguarding Vulnerable Adults, Infection Control, Food Hygiene and Manual Handling. Records showed that additional training had been provided. Topics included dementia, continence, choice, diversity and dignity and end of life care. We looked at four member's of staff's records. Three had recently received mandatory training up-dates, and one person had been booked to attend training the following week. The member of staff confirmed this.

We found that members of staff had access to further professional development. Five members of staff had a National Vocational Qualification (NVQ) Level 3, and three members of staff had a NVQ Level 2.

We found that members of staff had individual supervision records. We looked at four staff records. We saw one person had been observed doing a medication round, and had been spot checked delivering personal care. Another member of staff had received an infection control observation. We saw that targets were set, and action plans put in place where appropriate. For example, one person's target had been to start their NVQ Level 3. We confirmed with the member of staff that they had started the training programme.

On the day of our visit we spoke to four members of care staff, in addition to the manager and deputy manager.

One member of staff said they "loved working at the home", and "the training is done really well; part theory and part practical which suits me well". They said the manager had an open door policy and could be asked anything. They said that there were regular staff meetings, where they could raise anything.

One member of staff said "we are managed and supported well". They confirmed that they had completed their mandatory training, and had received supervision. They also said that they had been regularly spot checked when delivering care, and when doing a medication round.

Another member of staff said "we are encouraged to sit and talk to people who live here" and "I know the residents well". They also told us that the "manager is supportive", and has an "open door policy".

**People should have their complaints listened to and acted on properly**

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**Our judgement**

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The provider was meeting this standard.

There was an effective complaints system available.

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**Reasons for our judgement**

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We asked for and received a summary of complaints people had made and the providers response.

In 2013 one written complaint had been received. It related to a bonfire which had been lit within the home's grounds. We saw that a written response had been provided by the Executive Director.

We saw that the provider had a copy of the home's complaints procedure within an information folder clearly visible in the main reception area. The complaints procedure gave details of who to contact if they had any concerns or complaints. In addition to whom to contact within the provider organisation it gave the contact details of the Care Quality Commission and the local Social Services department.

The main office had been moved next to the front door. The provider told us that they had an open door policy, which they said helped people who lived in the home, and their relatives, to voice any concerns and ask questions easily.

People we spoke to told us that they felt able to approach the manager if they had a complaint. One person who lived in the home said "I can just pop in and talk to the manager". Another person told us that they could tell the staff if they had anything they were not happy with.

One relative we spoke to told us that they knew that if they had a complaint they could speak to the home or they could contact the Care Quality Commission. Two other relatives said they would not hesitate to speak to the manager if they had a concern, and they felt they would be listened to.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

 **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

 **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

 **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

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**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

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**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

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We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

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### **(Registered) Provider**

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There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

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### **Regulations**

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We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

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### **Responsive inspection**

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This is carried out at any time in relation to identified concerns.

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### **Routine inspection**

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This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

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### **Themed inspection**

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This is targeted to look at specific standards, sectors or types of care.

## Contact us

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