Martha Trust

Mary House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The Inspection took place on 4th and 5th August 2016 and was unannounced.

Mary house is a purpose built care home registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for a maximum of 13 people with profound learning and physical disabilities. At the time of our visit there were 11 people living in the home. At the time of our inspection there was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Audits to monitor the quality of service were effective. They identified actions to improve the service where needed and these were carried out.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. People told us that staff asked their permission before they provided care. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. The provider also had systems in place to reduce the risk of people experiencing abuse. When concerns were raised, the provider had investigated these thoroughly and action had been taken to protect people when necessary.

Medicines were managed safely and people had access to their medicines when they needed them. However, medicines were not clearly audited when counting stock from one month to the next. We have made a recommendation about the procedure for stock checking all medicines.

Staff were trained and there were enough staff with the right skills and knowledge to provide people with the care and assistance they needed. They knew the people they cared for well and treated them with kindness, compassion, dignity and respect. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met.

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection, such as staff sitting and talking with people as equals. People could have visitors from family and friends whenever they wanted.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People led full and varied lives and were supported with a variety of activities often with one to one support.

Support plans ensured people received the support they needed in the way they wanted. People's health needs were well managed by staff so that they received the treatment and medicines they needed. Staff responded effectively to people's needs and people were treated with respect. Staff interacted with people very positively and people responded well to staff.

The culture of the service was open and person focused. The registered manager provided clear leadership to the staff team and was an active presence in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from avoidable harm and abuse.
Risk assessments were comprehensive and reduced hazards.
Staffing numbers met people's needs safely.
Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were trained and supported.
Consent was being sought and the principles of the MCA complied with.
People received adequate food and drink.
People's healthcare needs were being met.
Premises met people's needs and the building was well equipped and suited to meet people's needs.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information effectively.
People and their families were involved in their lives.
People were treated with respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded to people's needs.
Complaints were responded to appropriately.

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive.
The management team provided clear leadership to the staff team.
Quality monitoring systems had been effective and led to change.

Mary 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.'

This inspection took place on 4th and 5th August 2016 and was unannounced. The inspection team consisted of one inspector.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. 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.

As some people who lived at Mary House were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, deputy manager, five staff, two professionals and five relatives. We looked at a range of records about people's care and how the home was managed. We looked at four people's care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Mary House in August 2015 when we rated the service requires improvement.

Good

Is the service safe?

Our findings

People were protected against the risks of potential abuse. Staff were knowledgeable about safeguarding risks and their roles in protecting people. One staff told us, "If anything comes to light I would alert a senior or a manager. I've never had any concerns but would go to the local authority safeguarding team, the head office and notify CQC." Another staff told us, "If I got no action from the management team I would go higher to the SMT [senior management team] or even to the police." Relatives felt that people were safe. One relative told us, "I think X is very well protected and there are no problems there at all." Another relative told us, "I have no issues with that [safety]. I'm happy everyone knows what to look for and are vigilant and look after everyone with the right amount of care. This is evidenced from the fact that X is happy and they keep body maps and let me know about near misses."

People had access to information about safeguarding and how to stay safe. The culture in the home ensured people were aware of safeguarding. There were signs around the home in appropriate locations prompting staff and visitors to be mindful of safeguarding. There was a sign on the back of the toilet door explaining who is vulnerable, what is harm or abuse, what action to take and what happens next. The information was up to date and meant that those involved in peoples' lives at Mary House were aware of what to look out for to keep people safe and what to do if they felt people were at risk. Safeguarding training had been given to all staff and competency tests on safeguarding had been carried out by the management team during staff handovers.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. Risk assessments were included in care plans to cover key areas of people's lives such as nutrition and hydration, medication and pain, and food allergies. Each section of the care plan contained a risk assessment and the assessment showed a reduction in the potential hazard after control measures had been applied. Care plans contained detail about areas considered to be of heightened risk such as epilepsy, where people had their own epilepsy care plan which included a risk assessment.

People were enabled to take carefully assessed risks as part of living an independent and fulfilled lifestyle. There were examples of this in how the service used positive behaviour support plans. One person had a plan in place that meant they were supported in their wheelchair due to the risk of staff being hit. The service had questioned the reasoning behind this decision and involved a physiotherapist in assessing the person. The manager argued that movements perceived as hitting were in fact reflexes and that supporting the person out of their wheelchair at times was beneficial. The positive behaviour support plan was changed and records showed that this helped the person to manage their anxiety.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs and to enable them to lead full and active lives. One person's relative told us, "I was at Mary House yesterday and there were plenty of staff in yesterday." Another person's relative told us, "Yes there are enough staff as they've employed extra staff when X moved there. Because they have to have one to one staffing 24 hours a day they went out and employed extra staff." During our inspection visit people were being supported one to one for most tasks such as social outings or for domestic household support.

The registered manager described how planners were made with people based on what they enjoyed or wanted to do. Families were consulted and in order to meet people's needs the staff team was increased. There was a minimum staff risk protocol that set the minimum number of staff in the building. The shift planner and resident's planner dictated what happened each day and this was planned for. People's needs were identified and the rota was set accordingly from this.

The service followed safe recruitment practices that ensured that staff were suitable to work in a care setting. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. Files were kept for each member of staff and included a new starter checklist, employment application and interview questions.

There were safe medication administration systems in place and people received their medicines when required. There was a separate locked room where medicines were stored and the keys were held securely. Creams were stored in a locked cabinet with a box for each person. This meant that people's medicines were not mixed up. Medicines that required refrigeration were stored in a fridge and the temperature of the fridge and the room was recorded regularly. Other medicines were being stored correctly and were being signed in and out of the building following best practice guidance.

Medicines were stock checked every night and equipment to treat people's conditions, such as syringes were stored separately for each person. During the medicines round a trolley was used to transport medicines to people. On the day of our visit medicines were given to people during their meal. Good practice guidelines were followed and people received the correct medicines safely. People could choose how to receive their medicines. One person preferred to take their medicines on top of their food and staff supported them discreetly to take their prescribed dose. This meant that people felt in control of their medicines and took them regularly.

An audit of medicines occurred once a week in which each person's medicine was counted. However, we found that there was no running total for the number of expected tablets. This meant that a staff member may not know the correct number of tablets they should expect (to be in stock?) for each person. We recommend the registered manager reviews the way medicines are audited to ensure all future audits are accurate.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person's relative told us, "They're obviously trained and they are open to suggestion. We have no problem approaching staff to suggest new things or to say if something should be changed and we are listened to." Another relative told us, "They're starting to use Makaton with X and they have got to recognise her laugh when she's happy and when she's being cheeky." One staff told us, "We have mandatory courses but also do extra training. We also did intensive interaction. It works really well for X who will put her hand and on to your face, which is nice."

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Records showed that there was a comprehensive training programme in place to meet people's needs. Courses were available to staff in areas such as moving and handling, epilepsy awareness and profound, multiple learning disabilities. These courses were supplemented by specialist training that individuals required to meet their needs like administration of oxygen. In addition the registered manager had introduced competency training in different areas to ensure that staff understood the training they had been given and could recall the key points. The competency training was delivered as part of the staff handover. During staff handover the shift leader looked at the shift planner and the planned activities and allocated staff to support people with their activities based on staff experience and peoples preference.

People were supported by staff who had supervision (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "I just had supervision this week and its every 2 months with appraisals annually. It's always really helpful to discuss things with the manager or deputy". Staff told us they felt supported by the registered manager, and other staff. Comments included: "I feel well supported. We talked about doing associate nurses course and the deputy manager offered to help. They give us reassurance and we can ask for help." A new member to the staff team told us, "I've been supported through everything. The managers always come out to talk and interact and check I'm OK and I'm doing things correctly."

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

At our inspection in August 2015, we identified improvements that needed to be made in relation to submitting applications to the DoLS office to authorise restrictions of liberty. At this inspection we found that improvements had been made and the system in place regarding the MCA and DoLS was effective. At

our inspection in August 2015 we identified improvements that needed to be made in completing mental capacity assessments and best interest meetings. Following this inspection, we were provided with records that showed that mental capacity assessments and best interest meetings were complete and effective.

The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe. People's files contained MCA assessments for specific decisions such as consenting to health checks. The assessments took account of people's right to make decisions that include risks and checked they understood the consequences of doing so. The assessments promoted least restrictive practice. One person had been approved for a medical intervention by a DoLS which restricted their movement to ensure their safety. The service had used MCA assessments and best interest decisions to safely remove the medical intervention during set times on a daily basis.

People appeared to enjoy mealtimes. One relative told us, "Whenever we've been there it looks good. I'd eat it! It's a very good quality of food and looks very appetising. She's happy with it. Food is well presented." Another relative told us, "X is tube fed and we get reports and he has a dietician and everything he needs." Mealtimes were a relaxed and social time for people. The serving of food and the support people were given were not rushed and staff interacted well with people, talking about their day or plans for later on.

People had access to a good, balanced and nutritional diet. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. There was a photo menu on the wall for a four week menu plan. The chef used the "Safer food better business" system to ensure food safety was complied with. Safer food better business is an initiative run by the Food Standards Agency. Where the fridge contained opened food this was labelled so staff knew when to dispose of it and all food was stored following good practice guidelines. The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. One person was nil by mouth but had taster sessions once a week following a referral to the speech and language therapist.

People were offered fluids throughout the day. There were pre-printed hydration charts which were being recorded consistently and signed by staff. There were similar charts for nutrition which were completed regularly, documenting all that a person had eaten or refused. The charts were monitored daily by the nurses and the four charts we observed were being completed without any gaps or errors. Appropriate one to one support was provided at mealtime and people's pace was respected.

Staff promoted people's health by monitoring and responding to their changing health needs. People's care records showed relevant health and social care professionals were involved with people's care. People who were tube fed had regular input from the specialist nurse who made recommendations which were followed by staff. Care plans were in place to meet people's needs in these areas and were regularly reviewed. People with conditions such as epilepsy had access to consultant neurologists. One person who suffered from bouts of vomiting had been referred to a dietician. This resulted in the dietician writing to the persons' GP to have their medicines reviewed.

People had health action plans which showed regular reviews of health needs by the persons' named nurse, referral to dietician if there was a problem, and how to encourage the person with food and fluid intake. The registered manager promoted good health care as part of the culture of the service. There was a noticeboard in the corridor with 'health week' displayed with a different topic each week for staff to learn about. The previous week to our visit was men's health week.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People had a health action plan which described the support they needed to stay healthy.

The premises provided a good environment for people to live in. There were very good facilities for people to access and records showed that people used the facilities regularly. One relative told us, "Our general impression was a definite yes compared to other homes and the atmosphere is good and being purpose built is very helpful." Staff commented, "I think it's a really nice accommodation, the standard of equipment and facilities is impressive with the pool and all the lifting gear" and "We have the sensory room with music, bean bags and mattress. X really likes the switches with vibrating pads they control with the switches and X loves the tactile sensory objects we have." The hydro pool was used daily and people were supported two to one at poolside to support with all transfers. All of the staff had specific 'Hydro Training Safety Award for Teachers'. The deputy manager commented, "The hydro pool offers a range of holistic benefits for our resident group. It has benefits across the physical, emotional, psychological and social spectrum. Our hydro pool is an enjoyable and fun experience enhanced by our specialist sensory light and sound systems which are switch controlled by the pool users. We have regular pool parties where groups of residents access the pool together, supported by staff, and have themed social events such as Hawaii, Surfing and Beach Days. The pool area was decorated with all the relevant props and music for these events."

As a purpose built home the corridors were wide to accommodate people's wheelchairs and all areas were well lit and welcoming. The bedrooms were spacious, and personalised, and there were large adjoining bathrooms which contained an adjustable bath, graded floor shower with full length shower bench, accessible toilet and a basin. There was a cinema room where music activities are held and spacious kitchen areas and dining areas, with well-presented gardens that were accessible to people with mobility issues. The gardens had a sensory area for people to enjoy different smells and colours, seated areas for privacy, shaded areas, a pond and a trampoline in a recess in the floor for which staff had rebound training for safe use of the trampoline. This meant that people had the space to move freely around the home and could find a quiet place if they wanted to. The home also had two sensory rooms, one with sensory lights and another with switch gear where people could control lights, vibrations and sounds by turning the switches on and off.

The premises and equipment at Mary House enabled people with severe communication difficulties and physical disabilities to remain healthy and engaged in the world. People we observed clearly enjoyed engaging with the sensory room, and the switch gear, and were able to interact with the staff and their peers. The deputy manager told us, "The sensory room has specialist projectors, lights and floor lights, vibrating benches, aromatherapy air streams, tactile touch areas, a sound system, musical instruments, bubble tubes, wonky mirrors and a host of other equipment. It engages the resident's senses of sight, sound, touch and smell. It also has switch technology integrated so the residents turn on and off the equipment and receive immediate sensory feedback from their choices. Again it offers the opportunity for intensive interaction between the residents and support staff on a 1:1 basis. This is significantly important for people who do not communicate intentionally as it links a person to their external environment. The sensory room is also used for facilitating specialist learning sessions with a therapist. These sessions support the residents to use switches and other adapted technologies."

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One relative told us, "X has been upset a few times e.g. when family leave so the staff go in and spend time with them. At night if X is distressed they go in and sing with them. One of the nurses was singing and clapping along to the film whilst she was watching it with X when I was there, so she was being involved with X and not just sitting with them. They show signs of affection with X which X likes as she is very touchy feely; they support X with appropriate personal contact otherwise X would be isolated as an individual." Another relative told us, "It's the way they work with Y and talk about Y to me. I will watch what they do with other people and they are very caring and the manager would not employ people who aren't caring."

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. One person was crying out and three members of staff supported her to find out what was wrong, by changing the DVD she was watching, using headphones and other interventions. After a while the person cried out again and staff quickly intervened moving them outside their room and moving the TV so they could still see the film. Staff were able to describe the different presentations by which the person cried out or moved if they were in pain. Staff sat and read the paper with people in the morning and people were relaxed and engaged. There were sensory stories, such as stories about a fashion show where people can feel different materials, that staff use with people to develop relationships and as a means of involving people in personal interactions

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Staff told us, "There's a lot of observation that goes in to care planning. Before they come to Mary House there are lots of assessments. As most people are non-verbal there's a lot of observation and getting to know the person. Care plans are reviewed regularly and families have input in to them." Where people could not make their preferences known, families were involved. One relative told us, "Yes day to day decisions X is involved and the [staff] discuss with her what they will do. If there are any major decisions we are always advised. The home always involves us if there is money to be spent and make sure we're happy with what's going on." Another relative told us, "She's given decisions on a daily basis by staff. She can gesture towards things and the home always ask us for opinions and our views and our view is taken on board and is generally taken as the governing factor. They have asked us to help choose a new wheelchair and they always ask us if a decision is made: it's a joint decision and they listen to us as we know X. On all things they listen and they're always there to meet and talk about things."

Care plans captured peoples' voice and preferences so that they received the care and support they needed in the way they wanted it. Records showed one person's plan advised, "I am a very tactile person and enjoy things that make noises…and this makes me laugh. I don't like being on my own without something to watch or follow." We saw staff making animal noises with the person and ensuring that they had noisy toys to hand. The person responded happily and was engaged with their support session. Another care plan noted, "X may lack capacity to make some major decisions, but this does not mean that she cannot decide what to wear or do each day." There were examples of what choices to offer to the person and how they would communicate their preference.

People's dignity was respected by staff. One relative told us, "They always close bedroom doors if doing personal care or changing and everyone will knock on the door and also around cleanliness and hygiene and being dressed well. They make sure people are dressed nicely and appropriately and just because you have a disability you shouldn't spend all day in track suit bottoms and t-shirt just because it's easier for everybody. They don't speak over people and they include them in the conversation and respect their dignity as a person to have the right to be included in conversations." Another relative told us, "Yes they do they shut curtains and doors if changing pads and people knock on the door to enter a room. They let him know where they are washing him so he knows where he will be touched."

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. During one music session staff were clapping hands over hands with people to a drum beat to involve them in the activity when they were losing focus. This worked well for people and they pulled the arm of their support staff closer to them so she was hugging them. Another person made a vocalisation so staff repositioned them. When this didn't work the staff took the person out of the room and they returned two minutes later with a drink. The person was happy and continued the activity.

Good

Is the service responsive?

Our findings

People received a person centred service. One relative told us, "Yes the care service is personalised in that the programme suits her and is designed around her preferences. What X's life is like is very much the best I could possibly wish for her: to be as independent and as normal a life as possible." Another relative told us, "We've noticed with all of the residents they [staff] cater to them differently. X is different and has a different personality so they are treated differently." And another relative commented, "Yes she definitely gets to do the things that she likes, which isn't what the other people like. They still go out and socialise together. If I was to say can X do so and so, they would definitely do their best to facilitate that." Observations on the day of our inspection showed that people received a highly personalised service, often with one to one support. Sessions in music therapy, sensory play and use of the hydro pool were delivered in a way that took account of people's differences to engage them fully in the activity. People evidently enjoyed the one to one, personalised support they received in these sessions.

We found that that staff were responsive to people's needs and demonstrated a good knowledge and understanding of the support people required. A recently recruited member of staff told us, "It's brilliant for residents; the things they do, they way staff treat them. Residents are always going out on trips. Here people are always involved. Even if a staff is sorting bedrooms out they have the resident with them to involve them and help them to be independent." Another staff told us, "The activities are really good and centred around what people like. X likes open spaces as he grew up on a farm, so he works on a farm. Another person chose their own furniture. We go for walks on the seafront, the theatre, banger racing, and the animal park. We're always looking for new activities for people. X doesn't like loud noises so we've taken him to bluebell steam railway, museums, and parks." Records showed that one person who on a medically restricted diet enjoyed going to cafes with staff. When it was questioned whether this was appropriate staff sourced flavoured swabs to use to give the person the sensation of taste at the café. This meant that the person could access the things they enjoy and have their sensory needs met.

Activities were person centred and varied to reflect the different interests of people. This was shown in the reports that were sent to relatives every month. These reports detailed how different people did different activities according to their needs and preferences. For example, in one month one person went to a zoo, a farm, had a sensory play session and a pool party, whereas another person had been to the west end, the cinema, and coffee shops/shopping trips on many occasions in the same month.

Records showed that daily notes recorded for people matched their activities charts, demonstrating that people were being consistently supported to do the things they enjoy. On the second day of our inspection the activity chart for the afternoon showed three people were on a trip to the circus, one person was gardening, one person was doing arts and crafts, one person was reading with their key worker and doing arts and crafts, one person was having a sensory session, one person was cooking, one person had support to clean their home and two people were having a music session. Records showed that this was typical of an afternoon with similar levels of activities for morning times across the month of records we looked at.

Care, treatment and support plans were personalised. The examples seen were thorough and reflected

people's needs and choices. One care plan set out how a person liked to be supported in the hydro pool, and their specific requirements at night. The information was consistently filtered through the care plan showing the type of support and even the type of chair the person preferred. When we asked a member of staff about the person they knew their needs and commented, "Our care for residents is centred on their needs or preferences. X supports herself in the hydro pool with floats under her arms, which works well for her. She's also very particular at night about where she wants things and we do it to respect her wishes." The staff was able to talk in detail about the night time routine that was important to this person and contained in the care plan. This meant that people were receiving the individualised care they had been assessed for.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been six complaints since our last inspection and these had been investigated thoroughly and people and their relatives were satisfied with their responses. The complaints procedure was in an easy read format that would enable people to understand how to make a complaint. One person had not been happy with dental care so the registered manager had involved a dentist and learning disabilities liaison nurse to review the oral care plan. All complaints had been handled promptly and the complainant received an answer.

Mary House ran a family forum where families had the opportunity to be involved in the governance of the home and be kept up to date about changes and developments. There had recently been an issue at one family forum meeting where three families had expressed dissatisfaction. The senior management team had produced an action plan and had written to all families and their relatives' care managers to set up separate meetings to discuss the points raised and come to a resolution. Records showed that the issues had been present for some time with the manager addressing them appropriately. Actions around this issue had included protecting the welfare of people and staff as well as resolving any dissatisfaction. This difficult episode showed that the service was handling complaints openly and fairly.

Good

Is the service well-led?

Our findings

The registered manager and the management team provided leadership to the service. One staff told us, "[the manager] has been very good for this house. Things needed to change and in the past it wasn't as pro-active, for example with people going out. They go out of their way to get things people need and they explain why things need to be done." Another staff told us, "The management are always supportive; since [the manager] been here she's been great. They [the management team] are very approachable. One relative told us, "I like the management team. I think they're working very well and I like them and get on well with them. If I have concerns they do their best to sort them out." Another relative told us, "[The registered manager] and I have a very strong relationship now and she listens to what I say now. The CEO is excellent and provides good leadership." Another relative told us, "The manager's enthusiasm is rubbing off on to the staff. There are younger staff there and they have more energy and suit the residents they've got there."

The management team were actively involved in raising standards and making improvements. The deputy manager told us, "I sit in on one hand over a day and do teaching sessions based on need. For example I've done teaching around MCA and by the end of the week the staff can repeat back the main points of the Act. We have a monthly nurses meeting where we have a teaching session: the last one was diabetes and looking at subcutaneous [under the skin] scan for blood levels. We also have monthly house meetings with teaching sessions and have recently done positive behaviour support; we've also done the ultra-violet hand washing test to make sure people know how to reduce the risk of infection." Leading teaching sessions in regular meetings meant that the management team were showing strong leadership to the staff and improving the skills base of the staff team to achieve better outcomes for people.

The service promoted a positive culture that was person-centred, open, inclusive and empowering. One relative told us, "I think it [the culture in the home] is very good. It's not quite the family atmosphere it was but that will improve now they've got to know each other. They're very caring and are starting to gel as a group now. All the changes have been for the good." another relative commented, "The atmosphere in the home is lovely. It's very calming. When I visit I don't want to go back home. Its calming you get treated lovely everybody's friendly and I just love it there." The registered manager was able to provide evidence to show how a culture change has been led at the service. The registered manager described how staff and families are now doing things with, and not for, people.
People were supported to maintain family relationships and to be involved in life choices. We saw examples of how families had been encouraged to shop for items with their family member instead of buying it for them. Capacity assessments had been completed and people were making choices on their toiletries based on smells and their reactions. The culture we observed on the days of our site visit was a person focused culture where people's independence was promoted. This culture came directly from the management team and their focus on promoting person centred care to encourage people to be more autonomous.

Relatives were empowered to contribute to improve the service. There was a family forum which was chaired by a 'family rep' who is a parent of a person at Mary House. The role of the 'family rep' was to listen to families and liaise between families and the manager and then feedback with the manager.

At our inspection in August 2015, we identified improvements that needed to be made in relation to a registered manager being in post. At this inspection, we found the required improvement had been made and a registered manager was in place. At our inspection in August 2015 we also identified improvements that needed to be made in relation to quality assurance systems being embedded to check their efficiency could be sustained. At this inspection we found that improvements had been made as the registered manager was making the necessary checks to ensure the quality of service delivered was good and taking action to remedy any short falls. Quality assurance systems were robust and resulted in action plans which led to change where needed. For example a kitchen audit highlighted the need for a pedal bin for infection control purposes and this was ordered swiftly.
There was a strong presence from the senior management team who conducted periodical quality reviews as well as spot checks on the service. The registered manager told us, "There's an audit schedule. Care plans are audited monthly; we have medicines audits where we recently changed pharmacy due to errors. We have a mealtime checklist that is completed as a spot check. There are first aid and infection control audits." The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

People benefitted from a staff team that was supervised and assessed regularly by the management team. People were received regular supervisions and appraisals. New staff worked for two weeks as supernumerary with the first week training and the second week shadowing staff. After 2 weeks senior carers met with the person to see if they were confident to work on the rota. This provided new staff with sufficient time to get to know peoples' complex needs and were being assessed by staff and managers. There was an external assessor to help staff to work through the Care Certificate. Staff team meetings were held monthly to discuss the running of the service. Staff contributed to the agenda and were able to speak freely. Records of these meetings showed that staff were complimented on good practice and reminded of competency checks to complete. Staff told us, "Communication in the team is really good now and we can talk about any problems as a group and with the manager who will help us." There were house meetings held monthly between senior support workers and the management team and a monthly meeting between the nurses and the registered manager.

The registered manager valued staff and relatives feedback and acted on their suggestions. An annual staff survey was completed and the findings were fed back through the clinical governance meeting. In the last survey in February 2016 feedback from nurses about who in the staff team was doing well was used to invite people to the office and thank them and note officially how they had improved. Mary House also sent out family surveys but does not always get a good response. As a learning outcome the service will be sending out separate surveys for each site and following up with calls to relatives.

The management team had a clear vision of the home for the service with a focus on increasing assistive technology to improve people's independence and mobility. The registered provider is fundraising for tracking for powered wheelchairs so people could move themselves around their home. The manager spoke about her plans for using interactive sensory games and eye controlled technology.