Mr Anthony Doherty

Mariana House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Mariana House is a residential care home in Whalley Range in south Manchester. The home is registered to provide care and accommodation for up to 23 people. At the date of our inspection there were 19 people living in the home, all of them women. Mariana House is a large detached property. It has two lounges, a dining area, and a large garden. It has bedrooms on both the ground floor and first floor. The bedrooms have washbasins but no ensuite bathrooms.

This inspection took place on 4 and 5 January 2017. The first day was unannounced, which meant the service did not know in advance that we were coming. The second day was arranged on the first day of our inspection.

At the previous inspection in November 2015 we had found breaches of four regulations, and judged that the service required improvement. We issued two warning notices, in relation to two of the breaches.

Those five breaches at the last inspection related to the storage and recording of medicines, assessment of risks, obtaining of consent, timeliness of care planning, and quality monitoring systems. At this inspection we found that some improvements had been made in all these areas, although there was still room for improvement, as set out in the full report. The warning notices related to failure to assess correctly and implement advice regarding dietary needs, and secondly to failure to operate effective audits, in particular of care plans and medication. We found that sufficient improvement had been made in these two areas.

The registered service provider is also the registered manager, and has been registered as manager since 2011. He was not present during this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had appointed a manager on 30 August 2016, who was present during the inspection. They told us it was their intention to apply to become registered manager. We refer to this person as "the acting manager" in this report.

There had been an incident in October 2016 when someone living in Mariana House had walked out of the building and been found in a neighbouring road. Action had been taken to prevent a recurrence and the home had co-operated with the local safeguarding authority. However, the person's care plan and risk assessment had not been updated after the incident. We judged there had been a breach of the regulation relating to assessing risks.

In September 2016 a person suffered a mini-stroke, and there was evidence that it had not been recognised from symptoms earlier in the day, resulting in a delay calling the ambulance. This was a breach of the regulation relating to reducing risks to people's health and safety.

There was information about people's mobility in their care plans but there was no immediately accessible information for the fire service in the event of an emergency. The acting manager created a file of emergency evacuation plans during our inspection.

The layout of the building was safe for people to move around, with the exception of one doorway. We also saw furniture creating an obstacle in a corridor at one point.

We checked on the ordering, administration and storage of medicines and found that it was much better than at the previous inspection. The provider was now meeting the regulation in relation to the management of medicines.

Staffing levels were constant and met the needs of people living in the home. There had been little recruitment recently which created some pressure on the staff rotas. When people were recruited, safe recruitment methods were used, although we have made a recommendation that the application form should be updated.

Accidents and incidents were recorded but there was no analysis of the causes with a view to reducing the recurrence. We saw records relating to maintenance of the building. The home was fresh and clean, and there was an infection control lead who carried out regular audits.

Since the last inspection Mariana House had introduced a form for people to give consent to their care and treatment. However, we found staff practice did not meet the requirements of the Mental Capacity Act 2005. We found that medicines were being given covertly (without the person knowing) and bedrails were in use without mental capacity assessments and without best interests decisions having been made. This was a breach of the regulation relating to consent.

Staff had received training in the Mental Capacity Act 2005 and in the Deprivation of Liberty Safeguards (DoLS). Applications under DoLS had been made but were still awaiting authorisation by Manchester City Council.

Training was provided by an external provider and we saw there had been several training sessions in the autumn of 2016. Supervision was provided regularly to support staff, but there had been no annual appraisals for two years.

Despite a recommendation in the previous report, the environment still required some attention, to make it more suitable for people living with dementia. The failure to respond to feedback in our report was a breach of the regulation relating to good governance.

People liked the food and the cook had an understanding of people's dietary needs. The mealtimes were a pleasant experience. People were supported to access health services.

People living in the home and their relatives spoke highly of the staff and the care provided. The service had a homely atmosphere. Staff worked to maintain people's dignity and were sympathetic to their needs. People were well dressed and well presented.

We saw a good example of reducing a person's anxiety by getting a family member to speak to them on the telephone.

Staff at Mariana House were equipped and prepared to cater for the needs of people at the end of life.

The acting manager was implementing new care plans. These were very detailed although perhaps a little too long in places. Family members were encouraged to supply a biography about their loved ones so that staff would have more personal knowledge about them. The system was an improvement on the one at the previous inspection, and assisted staff to deliver person-centred care.

The care plans were reviewed each month. However, necessary updates were not always carried out.

There was a programme of activities for every day of the week. Not everyone wanted to take part, but those who did enjoyed them. A favourite was singing songs led by a volunteer who was themselves a relative of someone living in the home.

The menu on the wall was intended to enable people to know what they would be eating, but the wrong menu was pinned up while we were there. The acting manager was creating a new menu which would meet people's needs better.

There was a clear complaints policy and we saw from the record that complaints were investigated and a response made to the complainant.

The home had a good reputation amongst relatives and professional visitors. The rating from the previous inspection was not displayed either in the home or on the home's website. This was a breach of the relevant regulation.

Medication audits and care plan audits were considerably better than they had been at our last inspection, although not many care plan audits had yet been carried out. Other audits were also being carried out.

There had been one staff meeting in the last four months but more were planned.

We found several examples of incidents or events which should have been reported to the CQC.

Following the last inspection we had not received an action plan or any response to our two warning notices. This was the responsibility of the provider. We regarded this seriously. noted that the Breaches found in the last inspection had largely been remedied, although we found new breaches at this inspection. We found evidence of improvement, thanks largely to the appointment of the acting manager, although there was still room for further improvement. We considered that the breaches and other issues identified at this inspection represented a further breach of the regulation relating to good governance.

We found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Two incidents had occurred which showed the service did not always assess the risks to people living in the home or reduce them effectively.

The systems for managing medicines were safe and well monitored.

Staffing levels were sufficient and recruitment processes were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

A consent form had been introduced. However, we found examples where the principles of the Mental Capacity Act 2005 were not being followed.

Staff received training and supervision to support them in their work.

The food was good but there was some scope to make the home more suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People's dignity was maintained and the staff were kind and sympathetic.

Relatives had favourable views of the quality of care provided.

The home was equipped to meet the needs of people at the end of life.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A new style care plan had recently been introduced. This provided detailed guidance for staff. Reviews of care plans were carried out but not all necessary updates were made,

A range of activities was provided for those who wanted to take part. The menu on the wall was incorrect and was not accessible to people living in the home.

The complaints policy and procedure was clear and effective.

Is the service well-led?

Requires Improvement

The service was not always well led.

The rating from the previous inspection was not on display as required in the regulations.

The system of audits was greatly improved compared with the previous inspection. There was scope to improve the analysis of falls. We found in a number of areas that the governance of the home had failed to react to events effectively.

Although the provider had not responded proactively to the findings of the last inspection, the appointment of an acting manager had generated improvement.

Mariana 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 two days, 4 and 5 January 2017. The first day was unannounced which meant the acting manager did not know in advance. The second day was by arrangement.

The inspection team comprised an Inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had knowledge and experience of caring for older people.

Prior to the inspection visit we gathered information from a number of sources. We looked at the notifications sent to the Care Quality Commission by the registered manager and the acting manager. Services are required by regulations to notify certain events to the CQC. We contacted the relevant contract officer of Manchester City Council about any recent monitoring visits, and a local social worker who had been involved in a recent incident.

During our inspection we spoke with 11 people using the service, seven visiting relatives, and six staff, including the acting manager and deputy manager. The registered manager who is also the registered provider was not present during our visit. We spoke with two health care professionals including a GP. We looked at five care records. We also looked at records relating to staff, medicines management, building and equipment maintenance and the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Mariana House whether they felt safe, and people answered that they did. We asked visitors whether they thought the home was a safe place and they also responded positively. One visitor said, "I feel she is safe."

An incident had occurred in October 2016 which raised concerns about the safety and security of the building. While workmen were bringing in replacement windows they left the side gate and side door of the house open. A person living with dementia in the home had walked out unobserved. Staff could not find her within the building and immediately began a search, but she was found by the owner of a house on a nearby main road about 20 minutes later, after she had walked up to their porch. The police returned her to Mariana House, having suffered no injury.

The acting manager reported this incident to us in sufficient detail, and informed us that the home was installing safety gates at all exit doors to prevent people leaving in the same way. The acting manager also made a safeguarding alert to the local authority, as was correct. The investigating officer contacted the CQC and expressed the view that the new safety gates, which were waist high, were themselves a safety hazard and should be removed, and instead an alarm system used. They contacted the CQC again at the end of November 2016 to inform us that the safety gate by the side door had not yet been removed, and that the acting manager had not yet put any system in place to alert staff should anyone leave the building via the side door.

By the time of our inspection the safety gates had all been removed, and an alarm system was in place and working. This showed that the service was responsive to advice from the safeguarding investigator, although they had not implemented the advice immediately. We also saw that a new padlock had been installed on the side gate, so that if someone did get out into the garden they would not be able to exit onto the road, as the garden perimeter was secure. This meant that the provider had responded appropriately to the safety lapse in October 2016 in terms of securing the building and garden area.

The acting manager also showed us a new external CCTV system with nine cameras which might show someone leaving the premises if a similar event occurred. However, the system was not continually monitored so it would not contribute to alerting staff if someone left the building. It was more relevant to securing the premises against intruders.

There were risk assessments in people's care files which listed the risks associated with each person and ways to monitor and reduce them. For example, one person was confined to bed, and we saw there was a position change record, to record how often she was turned into a different position to reduce the risk of pressure ulcers.

In the case of the person who had left the premises in October 2016, we checked her care plan and risk assessment. The care plan had been reviewed in October 2016 two weeks after the incident but the review stated "No changes required." The risk assessment had also not been updated following the incident. We

asked the acting manager whether there ought to have been a new risk assessment following the person leaving the building. They pointed out, correctly, that the existing risk assessment referred to the person being restless and inclined to wander about the building and sometimes into other people's rooms. But we considered it ought to have been updated to reflect the recent event and remind staff to be vigilant about the person's whereabouts at all times. The failure to assess the risk to this person's health and safety in the light of the serious incident was a breach of Regulation 12(1) and 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence of another incident in September 2016 which had been investigated internally. An ambulance was called at around 6pm. Statements were taken from staff on duty that day, and one care assistant stated that they noticed before lunch that something was wrong, because they observed a change in the person's condition. They said they reported this to the senior member of staff on duty. This meant the ambulance could have been called six hours earlier. With this medical condition, getting early medical attention can be vital in terms of reducing its effect.

This incident had not been identified as possible neglect, and so had not been reported to the local authority or notified to us as a safeguarding incident. The acting manager had held a counselling supervision with the senior member of staff on duty that day, who ought to have sought medical help earlier.

There was evidence that avoidable harm on that occasion might have been reduced if medical help had been sought sooner. This was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about fire precautions and in particular whether personal emergency evacuation plans (known as PEEPS) were readily available for the fire service in the event of an emergency. These plans should include a brief summary of each person's mobility needs and what help they will need to be evacuated. The acting manager told us they were not aware that the service had a PEEPS file. There was information in the care plans about each person's mobility, but this was not readily accessible in an emergency situation. The acting manager agreed that a PEEPS file was needed and began to create one while the inspection was in progress. They then informed us the following week that the file was complete and placed where it would be available for the fire service.

We looked around the home and saw the environment was safe and the layout of the building was designed to be safe for people with limited mobility. A number of people were able to move around independently mainly using Zimmer frames or other mobility aids. Care had been taken to minimise trip hazards. We saw there was quite a narrow doorway between the main lounge and the smaller lounge, which people had to navigate through to access the toilets. When someone was sitting in an armchair adjacent to the doorway inside the smaller lounge, this increased the risk of an accident. We mentioned this to the acting manager who acknowledged the issue and agreed to consider rearranging the furniture.

We also saw at one point early in the morning that a large hoist and two tables had been placed outside a bedroom door on a downstairs corridor. The acting manager explained to us that they had been placed there only temporarily, in order to prepare to use the hoist to move someone out of their bedroom to the bathroom. This was understandable to the extent that the bedrooms were quite small and there needed to be space to manoeuvre the hoist safely. However, only one of the tables had come out of the bedroom and the acting manager did not know where the other one had come from. Together the tables and the hoist presented an obstacle to anyone trying to get past with a Zimmer frame, as the corridor was not wide. Moreover they would present an obstacle to evacuation of the home by the fire service. The acting manager

agreed with our assessment of the risk and said they would discuss with staff ways to reduce the blocking of corridors.

We looked at the storage and administration of medicines where several failings had contributed to a breach of regulations in our last report. We saw that the cabinet for keeping controlled drugs was now securely fixed to a wall, as is required under legislation. We checked the stock of controlled drugs and found it tallied with the amount recorded in the controlled drugs register. This was an improvement on the last inspection. The medicines fridge was in the same room and the temperature was checked and recorded daily.

We observed the administration of medicines, and saw that the member of staff carefully recorded the medicines given on Medicine Administration Records (MARs). These recorded that people received their medicines as prescribed.

At the previous inspection we reported that one medicine had not been given, because it had been ordered two days before it was due to run out but the pharmacist did not have any in stock. We saw there was now a better system for ordering medicines, when required. Most medicines were on a repeating four week cycle, but when medicines were needed they were written in a communication book and the order placed in plenty of time. Last time Mariana House was not using 'PRN protocols', a set of instructions describing the circumstances in which it would be advisable to give or offer a particular medicine. We now saw that 'instructions' for PRN drugs were written out and kept with the MAR sheets, enabling staff who were administering medicines to check as they went along. We also observed staff asking people whether they wanted a paracetamol, for example, which is a PRN medicine used for pain relief.

In these respects the service had remedied the failings regarding the storage and administration of medicines and was now meeting the regulation.

We asked about staffing levels. The acting manager told us there were three staff (including one senior care assistant) on duty in the mornings, three in the afternoon and early evening until 9pm, and two at night. Staff stated this was the case, and we saw that the staff rotas confirmed these numbers. The two at night were 'waking nights' which meant they stayed awake during the night. We asked what degree of flexibility there was and were told that the deputy manager, who was a member of the care staff, now came in at 7am rather than 8am, in order to help the night staff with those people who wanted to get up at that time. The deputy manager confirmed this was the case, and we saw from staff rotas that the staffing levels had been sustained during the Christmas and New Year period.

The acting manager told us that they had assessed the level of people's needs against the staffing levels, although they had not used a formal 'dependency tool' which can be used for this purpose. They were satisfied that the number of staff was sufficient to meet people's needs. We asked people whether they thought there were enough staff. Some people needed assistance to get to the toilet for example, or with other aspects of personal care. One person told us, "I am a bit impatient. I don't like to be kept waiting too long. On the whole they are very good. I ring the bell and I can't always get help. At night I seem to get quicker treatment, but I have to wait my turn always." Another person said, "They are pressed for time and I sometimes have to wait." A visitor commented, "Ideally there would be more staff. I think they do a good job."

We saw during our visit that call bells were responded to quickly. Although staff were busy, they had time to stop to chat with people during the day. There were staff on hand at lunchtime, including the cook, to ensure that everyone had their food. The acting manager said they or the provider were always available to

help out if needed during office hours. But this did not usually apply after 5pm. We concluded that the staffing levels were adequate to meet people's needs and keep them safe, but they needed to be monitored in case of changing needs or an increased number of people living in the home.

One issue that staff mentioned to us was that the staff complement had been reduced and that it was sometimes difficult to find staff to cover a shift if a member of staff was ill. We witnessed this on the first day of our inspection when an evening part of a shift from 4 to 9pm could not be covered and the deputy manager had to stay on, which meant they had a 14 hour day from 7am to 9pm. They and the manager told us that this was unusual. The service did not use agency staff, but did have five bank staff who could be called on if needed, but were not always available.

Part of the cause of the lower staff complement was there had been little recruitment within the last year. The service was in the process of appointing a new bank staff, but was waiting for their Disclosure and Barring Service (DBS) certificate before the person could start. This is the correct process. The DBS keeps a record of criminal convictions and cautions, which ensures that employers have relevant information about potential employees, and helps to prevent unsuitable people from working with vulnerable groups. We saw from staff files that the recruitment process included obtaining proof of identity and references. We noted that the application form had not been changed, although this was something we mentioned in our last inspection report. It did not ask applicants to explain any gaps in their career history, which is important to ensure that they have nothing to hide. We explained this to the acting manager who agreed that the application form could be changed.

We recommend that the application form be revised to conform with best practice. We are concerned to note that this was not done following the last report, and further failure to act would be regarded as a breach of regulations.

The staff were trained in safeguarding and told us they always looked out for any changes in people which might indicate abuse. They told us they would report any abuse or suspicion of abuse. Only one safeguarding incident had been reported to us since the last inspection. This related to the person going missing from the home. The failure to obtain timely medical assistance had not been identified as neglect and had not been reported as a safeguarding incident which it should have been. We did not become aware during the inspection of any other incident or any other possible abuse which ought to have been reported.

Accidents and incidents were recorded on people's care files and in an accident file. Since September 2016 the new acting manager had introduced 'post accident/fall observation forms' which they required staff to complete for 72 hours after the incident. This was intended to protect people from any delayed effects of the incident or injury.

We looked at records relating to maintenance of the building. We saw that the provider had invested in a new roof and new windows, and there was a rolling programme of refurbishment and redecoration of the bedrooms.

Fire alarms, fire doors, and extinguishers were checked regularly. We saw evidence of electrical appliance, and emergency lighting testing in June 2016. There was a certificate to state that the new boiler (installed in 2015) was compliant with building regulations. The acting manager did not provide any evidence that the water system had been tested for legionella. They said the paperwork was with the provider. A new test for legionella was carried out shortly after the inspection.

Mariana House had a full time cleaner. The building smelled fresh and clean apart from one bedroom where

the person had specific health-related issues. The carpet had been replaced with flooring in this room to assist with cleaning. One regular visitor confirmed that the building usually smelled fresh: "There's a nice atmosphere, it doesn't smell." The dining area was clean and looked attractive. The tables were cleaned straight after lunch and there was no food left on the floor.

The most recent infection control inspection by an officer of Manchester City Council had taken place in January 2016 when the home had scored 70%, which meant there were some improvements needed. An action plan had been drawn up, which included having an appropriately trained 'named lead' for infection prevention and control. We saw that one of the staff now filled this role and was due to attend specialised training in February 2017. This showed that the provider was willing to invest time and resources in improving infection control within Mariana House.

Requires Improvement

Is the service effective?

Our findings

Many of the people in Mariana House were living with dementia, at different stages of development. This meant that their capacity to consent to their care and treatment and to make decisions might be affected. We looked at how well the service was applying the principles of the Mental Capacity Act 2005 (MCA). The 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.

At the last inspection we had found a breach of regulation in that there were no records that people had consented to their care and treatment. This time we saw that a "Consent to Care" form had been introduced which stated: "I have read [the care plan] or have had the contents explained to me", followed by space for the person to sign. There was also space for a relative to sign next to the words "I agree." The form did not make clear whether the relative was giving consent to the care and treatment, but that was the implication of the form. As was stated in our last report, one person cannot give consent on behalf of another who lacks capacity to consent themselves, unless they have the relevant power of attorney for health and wellbeing. There needs to be a best interests decision, which can involve the relative but they are not the sole decision maker.

We discussed the form with the acting manager who devised a new form of words and sent it to us immediately after the inspection. The new wording was clearer. If a relative were to sign the form, they were not giving consent but agreeing that the care was in the person's best interests. We considered that the introduction of the form after the last inspection, together with the new revised form, meant that the service was now compliant with the regulation in this respect.

We saw that staff had received training about the MCA in November 2016. We asked the acting manager about their understanding of how the MCA applied in the care home. They told us, correctly, that a mental capacity assessment should be used if there was a doubt about someone's mental capacity to make a particular decision. We saw that mental capacity assessments had been used correctly and were kept on people's care plans. However, we did not see evidence that separate mental capacity assessments were used for separate decisions, as is required under the MCA.

We saw one example where the form had been completed even though it stated at the top that the person had capacity. This suggested possible confusion about the process. The form itself stated that if the person had capacity there was no need to answer the remaining questions. We discussed this with the acting manager who acknowledged that care needed to be taken when dealing with such assessments. However, the error had not directly impacted on the person in question.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We requested to see the provider's policy on DoLS. This was detailed and accurate. At the last inspection we reported that the service had not sent us any notifications of DoLS authorisations. This was still the case. We saw a log of DoLS applications which showed that nine applications had been made since the arrival of the new acting manager at the end of August 2016. We also saw the file of completed applications. The acting manager told us that they were aware of the circumstances in which a DoLS application needed to be made. An application had been made for the person after they had walked out of the home in October 2016, as was described earlier. The nine applications had not yet been decided by Manchester City Council, but they were correctly completed and gave reasons why the authorisation was requested.

We noted the log stated that one authorisation had been granted for a three month period in April 2016. This ought to have been notified to us at the time. However, the acting manager had since then placed a note on the log stating correctly that CQC needed to be notified when an application is granted (or refused or withdrawn).

We found two examples where the principles of the MCA were not being followed. One person was receiving her medicine covertly, which meant that it was disguised in a drink. The deputy manager explained to us that this was necessary otherwise she would not take it. There was a letter on her care file from her GP stating that he agreed with the medicine being given to her crushed. However, that is not the same as receiving it covertly. In any event the GP's authorisation was not sufficient. Because the person was living with dementia there ought to have been a mental capacity assessment to determine whether they could consent to receiving their medicine this way. If they could not, then there needed to be a best interests decision. A DoLS application had been submitted for this person but with no mention of the covert medicine.

The second example was the person who was confined to bed, and bedrails were in use for her safety. We saw there was a safety risk assessment for the use of bedrails. However, there was no mental capacity assessment and best interests decision, as there needed to be. This was because the bedrails would prevent the person from getting out of bed if she tried.

In both these examples we found that best interests decisions had not been made. This meant the principles of the MCA had not been followed. We also considered that separate mental capacity assessments had not been carried out for separate decisions, as mentioned above. This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training was provided to staff mainly by a private training provider, whom we happened to meet during the inspection. We saw evidence that the new acting manager had arranged training in the autumn of 2016 for all care staff in moving and handling, safe handling of medication, safeguarding, MCA and DoLS, child protection (relevant for when children visited the home), infection control, and food hygiene. Staff told us they had received this training and found it useful to have it delivered in person in a classroom setting. Fire awareness and fire marshal training, and dementia awareness training were planned within the next few weeks. This training would help to ensure staff had up to date skills and knowledge to effectively support the people who lived at the home.

There had been no recruits since the new acting manager started in August 2016. They stated that new staff would undertake the Care Certificate, a nationally recognised induction programme for staff new to care. It is not necessarily appropriate for staff who already have experience working in care, for whom other qualifications might be more suitable.

We saw from the records that supervision had taken place regularly with staff during 2016, although a few

sessions had been missed. Supervision had been given by the deputy manager. They told us they had adopted the suggestion made in our last report that supervision sessions should not normally be a way of delivering training. Supervision should provide an opportunity for line managers to meet with staff, give feedback on their performance, identify any concerns, and offer support, assurances and learning opportunities to help them develop. The deputy manager said they now held such supervision meetings in which staff could express themselves. We saw records of supervision meetings which confirmed this was the case, and staff themselves agreed that the supervision had changed.

There had been no annual appraisals for two years. Appraisals differ from supervision in that they offer staff the opportunity to look back over the past year and discuss aims and objectives for the following year. The acting manager agreed to plan appraisals during 2017.

In our last report we made a recommendation that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia. This time we noticed that some improvements had been made, in relation to signage and noticeboards with pictures on. There was still scope for further developments. For example, bedroom doors were still labelled with people's names in large print on laminated sheets. These notices were not attractive and appeared institutional. We saw that one person had a photograph of themselves on their bedroom door. There were still few adaptations such as tactile objects, like dementia dolls, or items for triggering memories. This was a failure by the provider to act on feedback from the previous inspection. This was a breach of Regulation 17(1) and (2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living in the home about the food. One person said, "The food I have is always nice, it's always hot, not a lot of it, but enough." Other comments were, "The food is cooked on the premises and it's good." "It's usually good food here. They have a great chef."

We talked with the chef who had worked in Mariana House for eight years. The kitchen was well equipped and conveniently located with a hatch into the dining area. The chef told us this enabled them to keep an eye on the progress of meals, and to see which foods were preferred, and also to see if any individuals were not eating as well as normal. If this happened, they would report it to the care staff. We asked if they had a list of special dietary needs such as diabetes, or people needing a gluten free diet. They told us they knew this information but it was not recorded anywhere in the kitchen. We suggested it might be useful to have a list for other staff working in the kitchen or in case a replacement chef had to be found for any reason.

We observed the lunch. The dining area was bright and airy. Some people remained in their own rooms or chose to stay in the lounge areas to eat. The majority sat around the dining tables, each set for four people. There was a happy atmosphere with singing before the meal. There was also background music. Each person's place was set with knife, fork and spoon. Each person had a beaker of juice. Some people had fabric aprons to protect their clothing, others had none.

There was a choice of hot meal – salmon, beef or quiche. People were shown each dish to help them choose. Each meal was plated up with mashed and roast potatoes, broccoli and cabbage; the beef meal was also served with gravy and Yorkshire pudding. All the meals were hot and looked appetising, and well presented. One person told us, "The meal has to be tender. They cut it up for me, they are very helpful that way."

The chef told us they were aware of people who were losing weight and might need dietary supplements, and also of people who were overweight and might benefit from eating smaller portions. People's weight was measured each month or more often as required. However, the scales had been out of use in December

2016. The acting manager was seeking either to repair the existing scales or purchase new ones. They subsequently confirmed that new rechargeable batteries had been purchased and the scales were functioning again.

We saw from care files that people had regular access to healthcare professionals to look after their general health needs. Records were kept of visits to or from healthcare professionals including the district nursing team, opticians, GPs, chiropodists, the mental health team, physiotherapists, speech and language therapists, and dieticians. People also went regularly to the dentist. Most of the people in the home were registered with the same local GP. We met the GP who told us they visited the home usually every other day. This was not only in response to being called out, but proactively to keep an eye on everyone's health. The GP had a good working relationship with the acting manager and also the provider. They told us that Mariana House looked after people's health well.

Good

Is the service caring?

Our findings

We asked people living in Mariana House about how they found the staff and the care provided. One person said, "Of its kind, it's a good place." Other comments were: "I am well looked after, No complaints", "The staff are so caring, so kind, I can't ask for any more", and, "They are very good; they bring me drinks. There is always someone to help me." Another person said, "I can't find any fault."

We also asked visitors their views on the care provided to their loved ones. The comments were again very positive. One relative said, "It's a homely feel, not posh, but caring." Another visitor commented on the care provided: "Mum is not an easy person. She can stretch the staff. I have admired their patience." Two people commented on the numbers of staff available in relation to the care provided: "They are very good. They are very stretched", and "Ideally there would be more staff. I think they do a good job. They are very caring." Another visitor said, "My relative had a fall, and they could not have done more for her, looking after her and making sure she was alright."

We looked at some cards received from relatives on display in the entrance hall. One person wrote, "Words cannot express how grateful I am to you all for making Mum's birthday so special. She loved every minute. You are all 'angels' and believe me it is appreciated not only by the residents but by their families." Another family had written after their relative had passed away: "We sincerely appreciate everything you did to make her comfortable."

In many ways there was a genuine sense of homeliness in Mariana House. The staff were mainly long serving and had got to know the people living in the home very well. There was warmth and compassion in the way they addressed them and referred to them. We saw that staff were kind, considerate and patient when supporting people and meeting their needs. For example, after lunch one person had spilled a little food on her top. The deputy manager ensured that staff changed the person's top, maintaining her dignity. We saw that privacy was respected. Staff knocked and waited for an answer before going into a bedroom. In one person's care file it was emphasised that, "It is important that [name's] privacy and dignity are respected at all times." This person chose to stay in her room at all times, and the care plan stated, "This isolation is a personal choice and one that is to be respected."

There were some aspects of the environment where there was scope to enhance the caring atmosphere. The name sheets on people's bedroom doors were not supportive of a relaxed environment. On one bed there was a typed notice advising staff not to use the bedrails as they were tied down and not in use on that bed. The notice was fixed to the foot of the bed facing inwards. Even if the person could not read the notice, family visitors might. The acting manager agreed that one would not have a notice like that fixed to one's own bed at home, and it detracted from the homely atmosphere. They moved it immediately to a less conspicuous place. We saw another similar notice about the clothes a person should wear fixed to the front of a wardrobe, although the acting manager stated it was there at the request of the family. Such information would be better placed in people's care files where it would be more confidential and not appear institutional.

Confidentiality was valued within the home. At a team meeting in September 2016 it was stressed that "Information needs to be kept within this building and must not be discussed with or shared with parties other than those who are entitled or need to know."

Because some of the people at Mariana House were living with dementia they were unable to express their thoughts and feelings to us. To understand their experience we conducted an observation to watch how well they were cared for. Some people were dozing in their armchairs but staff checked from time to time to see if they were comfortable and offer them drinks. Staff talked to people with kindness and encouragement. People evidently cared about their appearance. They were dressed in clean, well-fitting clothes and their hair had been brushed or combed. The hairdresser had been the previous day, and people told us they came once a week. We saw in the laundry that all clothes were labelled with people's names. The acting manager told us they requested families to label clothes when people moved in. We heard no complaints about clothes going missing or people being given someone else's clothes to wear. This was a further example of respecting people's dignity.

We saw a good example of a thoughtful and caring approach by staff. During our observation in the lounge one person was becoming distressed, talking to herself about shopping that was needed. The deputy manager noticed this and asked the person what the problem was. The deputy manager said "I will get your daughter on the phone" and did so, bringing a cordless phone to the person in the armchair. This enabled her to have a chat with her daughter, after which she became much calmer, and it seemed her anxiety was allayed. The deputy manager told us afterwards that they adopted this approach quite often with some people living in the home and it worked very well. This was a sympathetic approach in this particular situation.

We looked at how well Mariana House was able to care for people nearing the end of life. Several people had DNACPR forms on their care file. These are forms which instruct paramedics and others not to carry out cardiopulmonary resuscitation if someone has a cardiac arrest. The forms we saw were correctly completed and valid, but they were hard to find within the care files. In an emergency a paramedic needs to see the original form immediately. We suggested to the acting manager that the forms should be placed prominently at the front of each file, which was done immediately after the inspection. that the acting manager also confirmed there was an updated list of people with a DNACPR readily available in the office.

The home had not yet taken part in any training programme for end of life care. However, we knew from notifications received that Mariana House was able to cater for the needs of people at the end of their lives. Several people had passed away in Mariana House during 2016. The district nursing team were involved, and anticipatory drugs and related equipment had been obtained. These are drugs that are used for example to control pain and help with breathing. We saw evidence that the home worked closely with local GPs to prepare the necessary paperwork when it was thought someone was nearing the end of life. The GP told us that they were happy to allow Mariana House to care for people at the end of life. This supported the view that Mariana House was able to care for people up to the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

The acting manager told us they were in the process of creating new care plans for everyone living in the home. We looked at five care plans, a mixture of old and new style plans. We saw that the new care plans were an improvement on the older ones, not least because they were set out clearly in sections and indexed so that it was easy to find a particular section. The care plans covered all the necessary aspects of care, including personal hygiene, mobility, dressing, continence, medical/nursing needs, eating and diet, bathing, finances, social contact, interests and hobbies, and night care. We did consider that some parts were quite lengthy and it was not always easy to spot important information. For example, one person had significant hearing loss. Although this was mentioned in the middle of one section of the care plan, the information was easily missed. It would be important for a new member of staff or professional visitor to know immediately the extent of the hearing loss as otherwise they might be less able to meet the person's needs.

We noted that families were invited to supply a short biography of their family member. Not all had done so, but where they had it gave staff a good insight into the person's history, family and interests. This enabled staff to engage with people in a person-centred way, by holding conservations about events in their past and topics of interest.

Each section of the new care plans had a sheet for monthly review or 'evaluation' where the staff could record that they had checked the care plan and identified any changes needed. The idea was to record the changes on this sheet so they could be seen at a glance. We mentioned earlier that one person's care plan had not been updated when it should have been, following the incident when they walked out of the home. All the other care plans we looked at had been updated. The acting manager told us they were planning to introduce a keyworker system so that a particular member of staff would take responsibility for one or two people's care plans, including keeping them up to date.

At our last inspection we had found a breach in relation to care planning and ensuring that care plans met people's needs. This time we considered that the new style of care plans formed the basis to enable Mariana House to deliver effective person-centred care, provided they were updated regularly. The example of the care plan which had not been updated when it had been reviewed demonstrated that attention needed to be given to keeping care plans up to date.

We asked about activities within the home. There was an activities schedule on a noticeboard in the main lounge. There was no activities organiser, so it was the responsibility of the staff on duty to ensure that activities took place. On Mondays there was 'laundry' and Tuesdays 'cleaning'. We asked how people could be engaged in these activities meaningfully, but staff told us this meant folding the laundry, and cleaning the tables. Some of the people living in the home, but not all, enjoyed taking part.

On other days there were entertainments. One relative told us they had seen a game of bingo, but only a few people had been taking part. We met one relative who volunteered their time once a week to lead singing, of Irish or other appropriate songs. They told us that occasionally they brought someone in to play the piano. There was a small grand piano in the corner of the lounge, but we learnt it was not very often played. One

person told us, "I really like the sing song, but I wish there was more music." One visitor told us "They are really good here at making a fuss of people's birthdays. They have a party and a cake, it's great." A local Catholic priest came to lead Mass every Sunday, which was important for those people who had a history of involvement with the Catholic church. A record of what activities each person had taken part in was kept in their care file.

When we arrived after breakfast, and after lunch, we noticed that the TV sets were on but with the volume turned down. We asked why this was, and staff told us that this is what people preferred for a time when they were relaxing after a meal. Two people sitting in armchairs told us this was correct. This was an example of the staff responding to people's wishes and allowing them to control their environment.

There was an A4 weekly menu on another notice board, next to the hatch. The menus were on a three week cycle. The writing was small and there were no pictures of the food. We noticed that the day's menu bore no relation to the food that was served at lunchtime. We queried this with the chef, who admitted they had accidentally put up the wrong week. If people had asked staff in advance what was for lunch, they would have been given the wrong answer. We mentioned this to the acting manager, because it was not helpful to any of the people in the home and especially those living with dementia.

The acting manager showed us a new menu they were in the process of devising. This was on a four week cycle but each day had its own page, with appetising pictures of the food on offer. This menu would meet the needs of people much better than the current system.

We asked relatives about communication from the home. One relative said, "I feel if they needed to inform me of anything, they would phone me. I have every confidence in them." Another person said, "If there was a problem, I would go to [the deputy manager], I know them best. I never had to complain, but I hope I would be listened to." One relative said, "Overall we are very happy. We always get a good handover (from staff). Mum gets all the attention she needs, not all the attention she would like, there is a difference." (This was said humorously.)

We asked to see minutes or evidence of recent residents' meetings, but the acting manager could not provide any. They stated that they were planning to hold meetings in 2017. There was a questionnaire at the front desk for relatives to complete and a separate one for visiting professionals. This had only just been introduced so we did not see any completed forms.

We obtained a copy of the home's complaints policy and procedure which was clear and concise. The provider was named as the complaints manager. We saw a complaints log which had been maintained since September 2016 with the arrival of the new acting manager. The log recorded the details of the complaint, including complaints which had been made verbally, and the action taken to investigate the complaint and resolve it. The log included a complaint about the alleged failure to seem prompt medical help. In three instances meetings had been held with the families to allow them to explain their views, and the acting manager had been able to address their concerns effectively.

Requires Improvement

Is the service well-led?

Our findings

One person living in Mariana House told us, "I would recommend this place to anybody." Someone else said, "I am grateful for what they do." A professional visitor stated they would "wholeheartedly" recommend Mariana House. They said the home worked very closely with the local medical service. A member of staff commented on the change brought about by the new acting manager, and said, "I feel much better supported now."

Following our last inspection in November 2015 Mariana House was given the rating of 'Requires improvement'. It is a requirement of the regulations that providers display the rating received in their last inspection conspicuously within the home and also on their website. The rating was not displayed within the home. The acting manager told us they were not aware of the requirement to display it. However the provider had been clearly informed of the requirement in the letter that accompanied the final report. Mariana House had a website which did not display the rating. It had a link stating, "View our inspection report"; but the link did not work when we checked it immediately prior to our inspection. Failure to display the rating both on the website and in the home was a breach of Regulation 20A(2)(c) and 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the acting manager about audits. The failure to carry out effective audits had been the subject of one of the warning notices following the last inspection. We saw that the stock of medicines was checked weekly. The MARs were checked each week to ensure they were complete and that the amounts recorded as given tallied with the stock remaining. We saw completed forms used for this purpose, and saw evidence that the acting manager checked the forms as part of their medication audit. This was a much better system than had been in use at the previous inspection. We noted that it had been introduced in October 2016, shortly after the arrival of the new acting manager. This meant that the provider had been slow to respond to the findings of our last report, but that there was now a functional system in use.

The acting manager had introduced a care plan audit tool which was a systematic method of auditing care plans, checking that they contained all the necessary information and that the details were correct. We saw a schedule to record the auditing of care plans in 2017. Only two care plans had been fully audited in the last four months of 2016, since the acting manager's arrival. A third audit was in progress. They explained that they had been focussing on transferring the care plans into the new format. They also stated that they had identified a member of staff to become care plan coordinator, and that this person would do initial audits from now on, bringing any issues or queries to the acting manager.

We saw other audits took place. The infection control lead carried out infection control audits every quarter during 2016. These involved a detailed checklist which we saw had been completed methodically. The acting manager did regular walks round the building looking for any physical defects that needed repair. We saw that the staff had been reminded it was the responsibility of them all to report any items needing repair to the senior person on duty. There was also a monthly audit of the accident file. We saw that although the accidents, and in particular falls were recorded, there was little or no analysis of the possible causes of the accidents. For example, there were a lot of 'unwitnessed' falls when people had fallen in their bedroom, but

no examination of whether there were any common factors (such as time of day, or items of furniture) which might be contributing to these falls. We did note, however, that when a particular person was experiencing a series of falls appropriate professionals were informed.

We considered that the system of audits was greatly improved since the last inspection. We found for instance that the administration of medicines was now safe and efficient, and this could be attributed to the more robust audit process. However, we did not consider that the provider was now compliant with the regulation about good governance. They had not identified that the risk assessment and care plan had not been updated after the person had left the home unobserved. They had failed to identify the delayed summoning of medical help as a safeguarding incident. The analysis of accidents and falls was not sufficient. They had allowed the staff complement to reduce to the point where replacement staff could not always be found if someone was ill. PEEPS were not correctly gathered in one file until this inspection, and DNACPRS had not been prominent in care files. The principles of the Mental Capacity Act 2005 were not being followed. There had been no staff appraisals. The rating from our last inspection had not been displayed and the new acting manager had not been made aware of actions that followed our last inspection. This amounted to a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had only been one team meeting in the last few months, shortly after the acting manager came into post. Eleven out of 17 staff had attended, and two of those who did not were night staff. The minutes were made available for staff who did not attend. We saw from the minutes that a lot of information had been imparted to staff, but there had also been the opportunity for them to raise matters. The acting manager told us, and staff confirmed that they were free to approach the acting manager at any time. The acting manager said they had intended to arrange another meeting in December 2016 but this had not been possible. They would hold regular meetings during 2017.

The acting manager was aware of reporting requirements and was keeping a log since September 2016 of notifications submitted to the CQC. Notifications contained sufficient detail and were sent in promptly. We came across two incidents which should have been reported but had not been. One was an injury in April 2016 where a person had fallen. No injury was immediately apparent. Two days later they went to hospital where a fractured wrist was discovered. This ought to have been reported to us as a serious injury. The second incident was the probable failure to identify that someone had suffered a TIA, as mentioned earlier. This had happened in September 2016 soon after the acting manager was in post. There had also been the DoLS authorisation, which should have been reported. This had been before the acting manager was in post. We have written to the provider to inform them any further failure to send in notifications as required by law will result in enforcement action.

We obtained an updated copy of the service's statement of purpose, a document which every service provider should have. It stated that Mariana House's first aim is: "To promote a relaxed, secure, care free and stimulating environment for residents to live." This aim was being met except that there was scope for more stimulating activities.

After the last inspection we requested an action plan, namely a written report of the action the provider intended to take to achieve the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not submit an action plan by the deadline or at all. We also sent two warning notices dated 27 February 2016. These set out details of two breaches of the regulations which we regarded as more serious. One of them was because it was similar to a breach in the preceding inspection; the other was because it related to a serious risk to the health and safety of an individual living in the home. Each warning notice required the provider to become compliant with the relevant regulation by 31 May

2016.

At this inspection we checked whether the provider had addressed the breaches of regulations identified at the last inspection, including the breaches that had been the subject of the warning notices.

We considered that the appointment of an acting manager in August 2016, who was due to apply to become registered manager, was a significant step forward in addressing the issues at the home identified at the last inspection. Some of the breaches had been remedied. We found breaches of Regulation 12, relating to safe care and treatment, but these related to different aspects of safe care and treatment from those that constituted the breach at the last inspection. Having a manager in post would increase management capacity to run the home safely and deliver effective care.

The provider was not present during this inspection and we were concerned that the acting manager was unaware of some of the issues from the previous inspection. They had read the report, but had not seen the letter requesting an action plan or the warning notices. They had also not seen the infection control report from January 2016 or the report of the contract officer of Manchester City Council from May 2016. This meant that the provider had not shared with them some of the issues that needed addressing within the home. Nevertheless, the steps that the acting manager had taken and had planned, were conducive to improving the home and if carried through would help to ensure compliance with regulations. We were mindful that they had been present in the home for a few months, and would need more time to ensure all the necessary improvements were implemented.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 in relation to service users who were unable to give consent Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always assessing the risks to the health and safety of service users Regulation 12(1) and 12(2)(a) The provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of service users Regulation 12(1) and 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not being operated effectively to ensure compliance with the requirements relating to good governance Regulation 17(1) The provider had failed to act on feedback from the Care Quality Commission in its last report in relation to improving the environment for service users living with dementia Regulation 17(1) and 17(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The most recent rating of the service provider's performance was not displayed on the provider's website or in the premises Regulation 20A(2)(c) and 20A(3)