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**

Overall summary

The inspection took place over two days, on 20 and 24 November 2015. The first day was unannounced, which meant the service did not know in advance that we were coming. The second day was by arrangement.

The previous inspection had been on 8 August 2014, when we found that the service was failing to meet four of the legal requirements we looked at. The four areas were: reporting safeguarding incidents, unsuitable premises, assessing and monitoring the quality of the service, and record keeping. We found that these four areas had a minor impact on people living in Mariana House, and asked the provider to send us an action plan stating what action they would take to meet those requirements. We received the action plan on 17 November 2014. During the current inspection we checked to see whether this action plan had been implemented and whether the service was now meeting legal requirements in those areas. Our findings are set out in our full report.

Mariana House is a residential care home situated in the Whalley Range area of Manchester. The home provides care and accommodation for up to 23 people. At the date of our inspection there were 18 residents. Mariana House

Summary of findings

is a large detached property. It has two lounges and a large garden. It has bedrooms on both the ground floor and first floor. The bedrooms have washbasins but no ensuite bathrooms.

The registered service provider is also the registered manager, and has been registered as manager since 2011. 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.

We found that people felt they were safe in Mariana House. We saw that medicines were stored securely, but that the cabinet for controlled drugs did not meet the legal requirements for safe storage of these medicines. We also found that records of medicines administered were not always accurate, and that the recording of controlled drugs was confused. We also found that medicines had run out on one occasion because they had not been ordered on time. We found there were no instructions for staff about when to administer 'as required' medicines. These issues were a breach of the regulation relating to the safe management of medicines.

We found there were no instructions for staff about when to administer 'as required' medicines.

We found that the risk of injury from someone rolling from their bed onto a mattress had not been identified or mitigated, and this was a breach of the regulations relating to assessing and reducing risks.

Staffing levels were adequate, although one member of staff suggested they could do with extra help at busy times. Bank or agency staff were not used.

Staff were well-informed about safeguarding vulnerable adults and knew what to do if they witnessed or suspected any abuse. Recruitment records showed that pre-employment checks were carried out for people applying to work at Mariana House.

There were two staff trained as infection control champions. The electrical appliances were regularly maintained.

People told us they enjoyed the food and we saw the mealtimes were pleasant. Most people's dietary needs were met.

However, we were concerned that recommendations by a hospital professional were not being followed for one person with specific dietary needs, who was at risk if the recommendations were not followed. This was a breach of the regulation relating to reducing risks.

Consent forms were not in use to record that people consented to the care and treatment they received. This was a breach of the regulation relating to obtaining consent.

Staff including the registered manager had not had training on the Mental Capacity Act 2005 (MCA). We did not see any mental capacity assessments. Two applications had recently been submitted under the Deprivation of Liberty Safeguards (DoLS).

Staff training was delivered mainly by one external trainer. Staff received regular supervision although we saw this was used to provide additional training.

There was access to healthcare professionals. The environment was comfortable but lacked provision for people living with dementia. We have made a recommendation that the provider should research ways to improve the physical environment for people living with dementia.

People living in Mariana House and their relatives were very positive about the care they received. We saw a homely atmosphere and encouragement for people to interact with each other. Staff were patient and respected people's dignity.

Mariana House supported people nearing the end of their lives. We had received a letter from a relative commending the home on its care for someone who had died there. Two people who were near the end of life were being cared for well.

People and their families were involved in the process of planning their care at the time of their admission. Care plans were thorough although not always specific to the individual's needs. However, we saw an example where a care plan had not yet been created, and another where the care plan did not reflect the person's needs. These failings were a breach of the regulation relating to person-centred care. Care plan reviews took place.

Summary of findings

There were activities available and people participated when they wanted to. Residents' meetings took place and the views they expressed resulted in changes. There had not been any questionnaires recently for families, but they were encouraged to express their views informally.

There had been no complaints recorded since 2011.

Families and staff expressed confidence in the leadership of the registered manager.

Staff told us they felt well supported by the registered manager and the deputy manager. There were regular staff meetings.

Following our last inspection audits of medication and of care files had been introduced. Two monthly medication audits had been missed, and we were not confident that the issues concerning the safe administration, ordering and effective recording of medicines that we found would have been identified by the audits if they had taken place. The system for auditing care files was in need of improvement, as it did not show what areas had been looked at. Other audits were not being done. We found there was a continuing breach of the regulation relating to assessing and monitoring the quality of the service.

Events were notified to the CQC as required, except for some accidents which should have been reported as serious injuries.

In relation to the breaches of Regulations you can see what action we told the provider to take at the end of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe in all respects.

Medicines were not always recorded accurately, or ordered on time. Controlled drugs were not stored securely.

In one case a risk of falls had not been identified.

Staff knew about safeguarding. Staffing levels were adequate. Recruitment processes were safe.

Requires improvement

Is the service effective?
The service was not effective in all respects.

The mealtimes were pleasant and people enjoyed the food. One person's specific dietary needs were not being met, which created a risk to their health.

There were no consent forms in use. There was insufficient training on the Mental Capacity Act 2005. Other training was delivered by an external trainer.

There was scope to improve the environment for people living with dementia.

Requires improvement

Is the service caring?
The service was caring.

There was a warm caring atmosphere. The staff were kind and people's needs were met, on the whole.

Support was given to people approaching the end of life, and where possible people were enabled to stay in Mariana House.

Good

Is the service responsive?
The service was not responsive in all respects.

Care planning ordinarily commenced before people moved into Mariana House. There were two cases where the care plan had either not been written or was lacking in detail.

A range of activities was available. Residents were able to express their views at residents' meetings which resulted in changes being made.

Requires improvement

Is the service well-led?
The service was not well led in all respects.

Families and other professionals spoke highly of the registered manager. Staff said they felt well supported by him and the deputy manager.

Some audits were being done but two medication audits had been missed and the care plan audits were lacking in detail.

Requires improvement

Summary of findings

Incidents were reported as required to the CQC except that some accidents had not been reported.	

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 20 and 24 November. The first day was unannounced; the second day was arranged on the first day.

The inspection was carried out by two adult social care inspectors on the first day, and one of them returned on the second day.

Prior to the inspection we reviewed the information we held about the service. This included notifications sent in by and about the service, and information received from relatives and members of the public. We contacted the contract officer of Manchester City Council for information about their recent monitoring visits.

Before the inspection, we asked the provider on 27 May 2015 to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we spoke with five people who were living in Mariana House, and five relatives who were visiting. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

We spoke with three members of the care staff, both cooks and the cleaner. We spoke at length with the registered manager and the deputy manager. We met the GP who visits the home regularly as all the residents are registered with their practice, and a district nurse.

We reviewed five care records, and daily notes, three staff personnel files, policies and procedures, menus and minutes of three staff meetings and three residents' meetings.

Requires improvement

Is the service safe?

Our findings

We asked people living in Mariana House whether they felt safe in the home. One person said to us, "Yes I feel very safe here. I never have trouble with anybody." A visiting relative told us, "The home has been a godsend because we knew [our relative] would be safe here." The environment was designed to be safe for residents. Bedrooms were accessible and comfortable, and communal areas were clean and free from trip hazards. All windows were fitted with restrictors which limited how far they might open, in order to keep people safe. This had followed a finding in our last report that the absence of window restrictors contributed to a breach of the regulations.

We looked at the ordering, storage and administration of medicines to determine whether they were safe. The deputy manager and two senior carers were the only people who administered medicines and took responsibility for ensuring the system worked safely. The training record showed that these three staff and seven others had received training in medication in April 2015. One of the senior carers told us they had also received detailed training in the administration of medicines as part of their National Vocational Qualification (NVQ) in 2012-13.

We saw that medicines were kept in a trolley in a small locked room. The trolley was brought out only when medicines were being given to people. This meant that medicines in the trolley were kept securely when they were not in use. However, we saw that the controlled drugs cabinet was not fixed securely as is required under legislation. Controlled drugs by their nature are required to be kept more securely than others. The security of the cabinet did not conform to the regulations regarding the storage of controlled drugs, namely The Misuse of Drugs (Safe Custody) Regulations 1973. These regulations require that "A safe or cabinet shall be rigidly and securely fixed to a wall or floor." This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(g) which relates to the proper and safe management of medicines..

We checked three people's Medication Administration Records (MARs) to see whether the giving of medicines was properly recorded. One person's MAR recorded that two medicines had been administered that morning, Friday 20 November 2015. However, we also noticed that there were tablets on top of the trolley. The deputy manager confirmed that these were tablets which that person had refused that morning, because they were still in bed. This meant that the MAR was a false record. This could have serious consequences for the person's health. Doctors and other health professionals need to know exactly what medicines have been taken and when.

We also checked a sample of controlled drugs to verify that the balance of medicines recorded in the controlled drugs record book matched the amounts in the cabinet. We found that the pages of the record book were nearly full, which had caused confusion. One page towards the end of the book had been completed down to the last line on the morning of 17 November 2015. This resulted in there being two sets of entries for the 18 November 2015. There was also no record of the medicine (Tramadol) being administered on the evening on 17 November.

We asked the deputy manager to explain the discrepancies. They explained why entries had been duplicated. They pointed out that the balance recorded in the controlled drugs record book matched the number of the tablets that were in the cabinet. We confirmed this to be the case. On the second day of our inspection we interviewed a senior carer who confirmed they had given the medicine on the evening of 17 November 2015. They said they had recorded it on the MAR, but not in the controlled drugs record book as there was no space.

The major cause of the confusion was using an old controlled drugs record book in which nearly every page was full. At our suggestion the deputy manager ordered a new book which arrived on the second day of our inspection.

The false recording on the MAR, together with the confused record in the controlled drugs record book showed a lack of accurate recording which created a risk to people's health.

On another person's MAR we saw recorded that they had not received any medicines on the morning of 13 November 2015. We asked how this had happened. The deputy manager told us that Mariana House procedure was to order new medicines when there was only two days' supply left. On this occasion the chemist did not have all the medicines in stock so had not sent any until the afternoon. This would not have happened if the medicines had been ordered earlier. A person's health and wellbeing

can be jeopardised if they do not receive their prescribed medicines. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(f).

Some people were prescribed medicines to be taken PRN or 'as required'. We asked the deputy manager how staff knew when to administer in such a case, especially if the person concerned found it difficult to express their needs. Their answer was that staff knew people's needs and could tell when people needed medicine (for example, pain relief medicines). Mariana House was not using 'PRN protocols', a set of instructions for staff for each person, describing the circumstances in which it would be advisable to give or offer a particular medicine.

In one case a person was prescribed Tramadol as required, but was receiving it twice a day every day. The deputy manager told us this was because they had said they wanted it every day when they arrived in Mariana House. This meant the doctor's instructions to give it as required were not being followed. Tramadol is a powerful painkiller. In the absence of a PRN protocol there was no way of ensuring this person received the medicine only when they needed it. Further the home had not taken action to request a review of the medication by the GP given that the medication was being taken daily.

We found that the issues relating to the safe management of medication were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(f) and (g).

We saw that a range of risk assessments were used in people's care files in order to protect them from risks. These included Waterlow risk assessments (which assess people's vulnerability to pressure sores), and risks in relation to malnutrition, falls, bathing, and moving and handling. We saw monthly reviews of these risk assessments in all files.

We saw the accident book which recorded accidents and incidents within the home. We were concerned about one person who was recorded to have fallen out of bed on 5 November 2015. There was only this one accident recorded in the accident book, but when we looked at the daily records in the person's care file we saw that between 5th and 20th November they had been found out of bed nine times. They were usually found on the 'crash mattress' which was placed next to their bed. This indicated to us a risk which was not being addressed. We raised this with the registered manager and deputy manager. They stated that the events in the daily records did not represent falls, but times when the person had moved across the bed and down onto the mattress. We obtained copies of the daily report records which on most of the nine occasions recorded that the resident had been found kneeling on the mattress at the side of their bed. On one occasion it was recorded that they themselves said they had "rolled off" the bed. On the night before our first visit it was recorded that they "had slid off their bed onto the crash mattress." We remained concerned that all these incidents had occurred and not been recorded in the accident book, save for the first incident on 5 November. The resident's bed was at a normal height which meant there was a drop down to the crash mattress. This represented a risk of injury, which had not been identified, and plans were not in place to mitigate the risk. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(a) and 12(2)(b).

The accident book also recorded an incident that took place on 21 November 2015, between the two days of our inspection. Two staff were using a hoist late at night to help move someone into bed. One member of staff recorded that the hoist "collapsed without warning" and hit the resident on the head. It did not cause a serious injury. One member of staff received a wrist injury. As this had only just occurred, the registered manager had not yet investigated whether it was mechanical failure or human error that caused the accident. He stated that he would find out, and take appropriate action to minimise the risk of recurrence.

We asked about staffing levels. During the day there were always two care staff and one senior carer on duty. Three staff remained on duty until 9pm each day. We saw the staff rota which confirmed that this many staff were assigned to each shift, and staff confirmed this to be the case. Often the registered manager and/or the deputy manager were available during the day to provide assistance if needed. At night there were two waking staff (i.e. staff who stayed awake through the night). One resident told us, "The night staff always answer the bell if you call."

There was a pool of 16 regular staff who worked at Mariana House. This meant that there was never a need for bank staff or agency staff. The registered manager explained that

Is the service safe?

he was able to cover staff absence. We asked what would happen if large numbers of staff were ill at the same time. He said that he and the deputy manager could provide cover and that using an agency would be a last resort.

A member of staff told us, "I think we work really well with the staff we have got." Another member of staff told us that if they could change anything they would ask for an extra member of staff at the time when most people wanted to get up in the morning, because that could be hectic, and also at bedtime. We mentioned this request to the registered manager. Similarly one visitor commented, "They manage things very well but there is a lot going on. At certain times it seems as though they need another pair of hands." However, other visitors said they were pleased with the availability of staff. Residents told us they never needed to wait long when they needed help.

We considered that this level of provision of staff was adequate for the number of residents. We asked the registered manager what would happen if the number of residents increased. He stated that he would increase the number of staff on shift, taking into account the needs of residents, although he did not have a formal 'dependency tool' which would assess people's needs and the appropriate staffing level. He said that in the past at times when the home had been full there had been one more member of staff on shift.

Staff told us they had received safeguarding training. The record of training confirmed that 14 out of 16 care staff had received safeguarding training in March 2015. Staff we spoke with had a good understanding of the different types of abuse that might occur in the home, and described the action they would take to keep people safe from harm. They said they would report any concerns to the registered manager immediately, and if necessary also to the police and to the CQC. One member of staff said that they hadn't witnessed anything that concerned them while working at Mariana House. They felt confident the registered manager would investigate thoroughly and deal with the issue.

We looked at records of recruitment for two recently recruited staff. We found that the application form only asked for the previous five years' job history, and did not include a request to account for any gaps in the applicant's career history. These details are important to verify that the applicant does not have a criminal record. We mentioned these aspects to the registered manager. We saw that all other necessary checks had been done. We saw that a certificate from the Disclosure and Barring Service (DBS) had been obtained before they started work at the home. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. We noted that the original DBS certificate was kept on personnel files. The correct practice is to keep only a note of the number of the certificate. By the second day of our inspection the certificates had been removed from personnel files.

We knew from previous inspections that the registered manager followed disciplinary procedures when necessary. This meant that any staff members who placed people at risk were dealt with appropriately.

Two members of staff had received training as infection control champions in February 2015. We talked with one of them who said the training had been delivered by Manchester City Council and "was excellent". We saw that equipment was available and in use to reduce the spread of infection. We saw the cleaner used a monitoring list for all bedrooms and bathrooms, ensuring daily cleans, spot cleans and deep cleans were done as scheduled. Hand washing equipment was available in each toilet area and bathroom. We saw hand hygiene instructions above all sinks. We tested the water temperature in several bathrooms and found it appropriate for use. There was a cleaning schedule and a fridge/freezer temperature monitoring system in use by the cook. Staff were wearing aprons to serve meals. All of these precautions were taken to reduce the risk of infection and keep people safe.

We checked certificates relating to the maintenance of the building and safety of the equipment, including hoists. We saw that the fire detection and fire alarm systems had been inspected and serviced in January 2015. The emergency lighting and electrical installation had been checked. The fire extinguishers had been serviced. The lift was serviced and maintained. A new boiler had been installed during 2015. The registered manager was still trying to obtain the building regulations certificate. We were satisfied that the premises were maintained to be safe for people living in Mariana House.

Requires improvement

Is the service effective?

Our findings

We talked to the cook and assistant cook on different days and observed mealtimes. Residents were enthusiastic about the food. One said, "The food is lovely, very good and is served beautifully." A visitor told us, "[My relative] loves the meals and has a good appetite." Another visitor said, "[My relative] is eating a lot better. They get plenty of drinks."

The food we saw served at lunch was attractively presented and appeared tasty. We saw no menus on the tables but the cook told us there were two food options available for lunch for everyone. We saw that people were offered a choice as the food was brought round. This meant they could see what was available. The dining tables were set with mats, plastic beakers (not glasses) and fresh flowers, which enhanced the mealtime experience.

The cook told us they spoke to new residents to ascertain their food preferences. We found the cook to be very knowledgeable about people's needs. They told us that care staff kept them informed about people's food preferences and special diets. People were supported with appropriate diets if they had Coeliac disease and would require a gluten free diet, or diabetes, or had experienced weight loss. Some people received supplements and/or fortified drinks. At the time of our visit there was no one who required culturally appropriate meals but the cook told us they had worked with a person's wife in the past to provide Chinese meals.

We were however, concerned that one person's dietary needs were not being met. We saw that a hospital-based speech and language therapist (SALT) had recommended a pureed (liquidised) diet. We were concerned to see that this person's risk assessment for swallowing rated the risk as "small" and stated "soft diet" but gave no explanation of the person's needs. They had a health condition which increased the risk of choking, which was the reason for the SALT's recommendation. A soft diet is not the same as a pureed diet. At lunchtime on the first day of our inspection we saw this person was given a fish pie. The registered manager told us that the pie had been specially prepared. He said that the person refused to eat pureed food. He added that the staff were experienced in supporting people with this particular health condition. However, our observation was that the person was not under constant supervision during lunchtime, as they were sat in an armchair round a corner in the main lounge, out of sight of the tables where most people were eating lunch and the staff were serving.

A mental capacity assessment undertaken whilst the person was in hospital stated they did not have capacity to make decisions with regard to their diet. If this person continued to refuse a pureed diet then there ought to have been a best interests decision to determine whether or not it was in their interests to receive a soft diet.

We found that there had been a failure to ensure this person's diet matched the SALT's recommendations, or alternatively to proceed down the correct route to assess their best interests. Continuing to give them a soft diet instead of a pureed diet represented a serious risk as the person was at risk of asphyxiation. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 12(2)(b) which requires providers to do everything practicable to reduce risks.

When we looked at care files we did not see any consent forms relating to care and treatment, the use of photographs, or self-administration of medicines. If a person is considered to have mental capacity to understand what it means, then there should be a way of recording their consent to care and treatment and different aspects of their life in the home. We did see on one person's file a family member who had been identified as the 'next of kin' had signed to consent to staff accessing the person's medical records. However, one person cannot give consent on behalf of another who either has capacity or lacks capacity to consent themselves unless they have the relevant power of attorney for health and wellbeing. There was nothing on the file to indicate that this person did have such a power of attorney.

The lack of consent forms showed that the provider had not followed the principle that care and treatment must only be provided with the consent of the person concerned. Failure to do so was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Is the service effective?

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

We checked whether the service was working within the principles of the MCA.

Providers are required by legislation to notify CQC when an application for a standard DoLS authorisation is either refused or granted. No such notification had been received since the last inspection in August 2014 or indeed at any time since the service was registered with CQC in 2010. We asked the registered manager about his understanding of DoLS. In the record of training there was no record that either the registered manager or any other staff had received training in the MCA or DoLS. Some staff told us they had an understanding of MCA from training received before they joined Mariana House. There were no mental capacity assessments on care files that we saw.

The registered manager told us that two DoLS applications had been submitted recently. Both of them had related to the use of bed rails. These are designed to keep people safer but because they stop people getting out of bed independently they can be seen as a restriction on their liberty.

The registered manager told us that the first application had been rejected because the assessors judged that the resident had sufficient mental capacity to decide for themselves whether to have bed rails. DoLS only applies if the person concerned lacks capacity to make the relevant decision. In the second case we saw a copy of the DoLS application on file. We also saw a DNAR form. This is a form which instructs paramedics and staff not to attempt cardiopulmonary resuscitation in the event of a cardiac arrest. On this particular form, dated 2 October 2015, the GP had written that the person "has full capacity to make decision." Under the MCA an assessment of capacity is specific to a particular decision. However, if the person had sufficient capacity to consent to a DNAR then it was likely they also would have had capacity to consent to using bed rails. This showed that this DoLS application concerning bed rails, like the earlier one, may have been made incorrectly.

We discussed briefly with the registered manager the impact of a Supreme Court judgment in 2014 which widened the scope of the definition of 'deprivation of liberty'. This now included having locked doors which would prevent someone lacking mental capacity from leaving the building if they tried. The registered manager undertook to consider the latest developments in the law. We found no evidence that anyone who wanted to leave was being prevented from doing so. Nor did we find any indication that any resident was being deprived of their liberty in any other way.

We asked staff about recent training. One member of staff told us, "We get lots of training. I've attended first aid, incontinence, safeguarding, moving and handling, infection control, food hygiene, dementia and end of life training in the last year." This corresponded with the record of training which showed that most staff had attended training during 2015 in those areas. There were some gaps. Despite what the member of staff told us, the record did not show anyone had received training in dementia care, or in mental health awareness.

Medication training had been provided by the pharmacist which supplied the home. All other training had been delivered in house by the same trainer who ran a small commercial training company. We asked whether one person could effectively deliver training in so many different topics, but both registered manager and staff confirmed their high opinion of all the training they provided. One member of staff said "They're really approachable and will answer any questions anyone has." Another staff member said: "He's equally good in all areas." One visitor said to us about the staff: "They know their jobs, it's evident in all of them. Their attitude is excellent."

Staff told us they received supervision once a month with their line manager and an annual appraisal. We checked three personnel files and found evidence to confirm that supervision sessions did take place monthly. However, we noted that the content of supervision sessions with different members of staff was identical. They were more

Requires improvement

Is the service effective?

like training sessions than supervisions. Each month a different training area was covered, such as falls, fire risks, whistleblowing, and infection control. We found a note dated September 2013 which contained a long list of topics to be covered in future supervision sessions for all staff. It was clear that this was still providing the agenda for supervision sessions. However, supervision should be an opportunity for staff to be able to raise their own issues and concerns, and for their line manager to discuss them individually, in order to support staff in their roles. We mentioned this to the registered manager who agreed to consider alternative ways to conduct supervision sessions.

We also noticed that annual appraisals had been conducted by staff at the same level. For example one senior carer had conducted another senior carer's appraisal. This is not best practice, as if the appraiser is on the same level and if they are not directly responsible for managing them day to day they cannot reach objective conclusions about the staff member's performance and training and development needs.

The GP told us they were a regular visitor to Mariana House because all the residents were registered with their practice. They commented favourably on the home's handling of health issues. Care records indicated that healthcare professionals visited the home regularly including chiropodists, dieticians, opticians, and district nurses. All visits by health professionals were recorded. We spoke with one district nurse who told us she had an excellent relationship with staff in the home and trusted them to call out a district nurse as soon as one was needed.

The environment was comfortable and suited to people in a residential home. The main lounge was spacious and well lit and there was access to the garden. There was a second lounge, and people had access to their bedrooms during the day if they wanted quiet or privacy. Bedroom doors were labelled with people's names in large print on laminated sheets. These notices were not attractive and appeared institutional. Appropriate photographs on the doors might be an improvement. Inside, people's rooms were bright and airy and were personalised with pictures, photographs, blankets, plants and ornaments.

We had pointed out in our last inspection report in August 2014 that there were no orientation boards or any signs to assist people living with dementia to find toilets, bathrooms, or their own bedrooms. We saw progress had been made in that there were now clear signs on bathroom and toilet doors. However, we did not see any specific items around the home which could help people living with dementia, no tactile objects, very few pictures or objects for discussion between people or with staff. There were no items for triggering memories.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Good

Is the service caring?

Our findings

We asked people living in Mariana House about how well they were cared for and supported. One person said, "I'm very happy here. The staff are good. We are helped in whatever way we need. There is always observation. No-one is neglected. We are well cared for." Another person told us, "All the staff are patient with us." A third person told us, "Everyone here is very kind. These people are my friends. We are like a big happy family."

We asked visitors the same question, and received positive feedback. "The staff are brilliant. It's a very nice place. You couldn't ask for more. I've always got a great welcome." Another visitor said, "It's very good. The staff are all caring. My relative is warm, comfortable and well fed." A third visitor agreed, "The attention and level of care is really good. I'm really glad [my relative] is in this home. The team care very well for her. They have gone over and above what might be expected."

Another visitor told us they had chosen Mariana House as a residential home for their relative because it was recommended by friends and because they had known a former resident. They said, "I have not been disappointed. It's outstanding. I couldn't fault it at all. The staff are always friendly. I couldn't wish for [my relative] to be in a better place."

The GP who was a regular visitor to the home told us, "I think it's spot on. They are really kind. They try their best to help. They are my eyes and ears here. They would let me know if someone was losing weight." One member of staff said, "I love it here. It's like a home from home. Everyone is well cared for."

During our observation we saw consistently good-natured interaction and cheerful banter between residents and staff, and between some residents with each other. There seemed to be genuine friendships between some people. We noticed that in the main lounge people were sitting in comfortable chairs at angles conducive to conversation. Such interaction between residents would enhance their wellbeing. There was a small dog which helped to create a homely atmosphere. Although the dog belonged to neighbours he spent most of his time in Mariana House and we saw many of the residents were fond of him, and none objected to his presence.

At lunch staff were very patient with people when they chose their food, and tried hard to encourage people to eat. We saw that staff respected privacy, always knocking on doors and waiting for an answer before entering. We saw that they explained to people what they were doing as they were doing it, for example transferring someone from their wheelchair to an armchair and vice versa. One visitor told us that in their opinion staff respected the residents' privacy and promoted their dignity.

Care files were kept safely in a lockable cabinet in the front office which meant they would not be open to view. However, family members were encouraged to access the records relating to their own relative. One member of staff told us, "I understand about confidentiality. I will always protect people's information."

The home had not yet taken part in any formal programme to develop and improve care for people at the end of their lives. At the time of our visit there were two people assessed as being near the end of life. We saw that staff had enough flexibility to spend some time with them in their bedrooms, while their medical and nursing needs were being met by district nurses.

The Care Quality Commission received a letter in July 2015 from the relative of a resident who had died earlier in the year after living in Mariana House for 10 years. They praised the staff for their attention to the resident's health needs and added: "[My relative] was treated with dignity and respect and given very good care. [My relative] had a very peaceful death. I would like [the registered manager], the deputy manager and all the staff to know how grateful my family and I are for the great care [my relative] received over the years at Mariana House."

We knew from notifications received that people approaching the end of life were encouraged to stay in Mariana House, unless there was a medical reason for them to go to hospital. In some cases people had been discharged from hospital to come to Mariana House when they were likely to have only a short time left. This indicated that the hospital and relevant professionals regarded Mariana House as a suitable placement for people at the end of their lives.

The two people who were nearing the end of life when we visited, were frail and in bed but all their needs were being met. We looked at the care records for one of these people and saw there were clear instructions for their care.

Good

Is the service caring?

Appropriate medicines had been prescribed and professionals were involved. Relevant documents had been completed correctly and were easily located on the file. These were the DNAR form (described above) and the Statement of Intent. This is a document which enables a GP to predict that death is likely within the next 14 days and record the cause of death in advance. We met a district nurse who came in specifically to see the person in question. She spoke highly of the staff and their ability to support both residents and their families in the last days of life.

Requires improvement

Is the service responsive?

Our findings

We looked at five care records of people who had lived in Mariana House for varying lengths of time, in order to see how well care was planned on an individual basis to match people's needs and preferences.

The care documents indicated that both residents and families were involved at the time of pre-admission assessment, giving details of people's life history, personal choices and preferences and discussing support needs. Daily records indicated that many families visited regularly and were kept informed about health matters. This supported what the registered manager told us, that this was a "family friendly" home where families were encouraged to be closely involved in their relative's care. One relative told us: "The admission was handled very sensitively to my mother's needs." We did not however see any care plan which had been signed by either the resident or a relative to indicate their involvement in the process.

We saw that people's needs were assessed in the areas of dressing, personal hygiene, mobility, interests and hobbies, eating and diet, night care, bathing, finances, social contact, continence and medical/nursing needs. Support requirements were listed on each file although these were not always individualised or based specifically on the person's needs as identified. In other words, people's care needs were assessed individually, but the support to be provided was not always planned specifically for that person.

We had a concern that in one case the pre-admission information was lacking and consequently the care plan was not adequate. The person concerned had very recently arrived in Mariana House, four days before our inspection started. We understood that this had been an urgent admission. This partly explained why there was very little pre-admission assessment information, but no care plan at all had been created. Staff told us they were waiting to speak to the person's partner. Another family member who was visiting told us his partner was unwell, but was at home and could be contacted on the telephone. We considered that a care plan should have been started, and the home should have considered what minimum information is needed prior to agreeing an admission, in order for them to ensure that a person's needs can be met appropriately and so that the staff know how to support the person's needs.

In a second case the care plan did not reflect a report from the hospital about the person's dietary needs due to a risk of choking. The same person had rolled or moved out of bed many times in the last fortnight but the risk assessment had not been reviewed and the care plan had not been updated to reflect that or to give information to staff or to visiting healthcare professionals.

The failures to have adequate care plans amounted to a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 9(3)(a).

On the care files there were charts which recorded nutritional intake and fluids taken, dietary needs, baths and showers, nail care, and weights. We saw a progress sheet in each person's care records which briefly recorded people's mood during the day, whether they had received any visitors, either relatives or health care professionals. There was space to record any bruising or health problems, and involvement in activities. These were completed twice each day. This meant there was a detailed record of each person's care and circumstances which would help the home and other relevant professionals to monitor each individual and identify any changes.

We saw that reviews were usually done monthly of care plans and risk assessments. These were recorded on a care review sheet. Often the review recorded "no change" and nothing else. In those circumstances there was no evidence to show how effective each review was.

We asked people whether there were any activities and whether they took part in them. One person said: "There is little entertainment. Very occasionally we have a choir. We always have a birthday party when it's anyone's birthday. We did have a violinist in. We could do with a bit more exercise. I would like some entertainment in the evening."

Visitors were more enthusiastic about the range of activities available. One said, "They have quite a lot of activities going on." Another visitor told us, "The entertainment is in the afternoon, mainly music and bingo. She likes highbrow stuff. They can't provide it. I'm not complaining." We did observe that several of the residents were mentally and physically able and might have enjoyed games, puzzles or other activities. We did see a staff member doing a quiz with a small group of people.

There was a piano in the main lounge. It was not in use while we were there, but the registered manager told us

Is the service responsive?

that it was tuned and people came in to play and lead singsongs regularly. One visitor commented, "They used the garden in the summer, we all had afternoon tea out there. It was very pleasant."

There was no member of staff designated as 'activities organiser' so it was the responsibility of all members of staff to organise activities when they were on duty. When we looked at a folder marked 'Entertainments' we saw an activity schedule for the week commencing 27 July 2015, but nothing more recent. The registered manager assured us that there were schedules produced each week. There were some activities advertised on a noticeboard. On the schedule we saw there was one activity or more listed each day: such as reminiscence; piano music; hairdresser; card games; activities with staff; flower arranging; exercise to music and Holy Communion. One resident confirmed that the priest came every Sunday. This schedule indicated that there was a range of activities available for those people who wanted to take part in them. Irish newspapers were provided as there were a number of people of Irish origin who lived at the home.

The deputy manager told us a number of activities were being planned for Christmas, including three parties. A small group of residents were due to visit the local school for a meal and a Christmas concert.

Residents' meetings were led by the deputy manager. We saw minutes of these meetings which had been held every three months in 2015. These were attended by between six to nine residents, and relatives could attend if they wished. Topics discussed included entertainment, meals, Christmas events and clothing going missing. Minutes did not include action points and no follow up was reported from one meeting to the next.

We saw that one residents' meeting had requested cooked breakfasts. This had been implemented and a few people were now having cooked breakfasts each day. Similarly the meeting had requested soup as a starter. This was now available at lunchtimes and in addition soup was served with afternoon tea. These changes showed that the registered manager responded where possible to the wishes of residents.

One member of staff told us, "The residents enjoy saying what they think and coming up with ideas." One resident told us they would like there to be a sign on each toilet door to show whether it is vacant or occupied. They added that they could close the toilet door when they were using it but there was no lock. We said we would pass on this idea to the registered manager.

There was no suggestion box available for relatives or other visitors to the home to use. The registered manager told us that Mariana House had not issued a questionnaire in recent years. He said that all of the families who visited regularly were able and encouraged to raise anything with him or the deputy manager. His office was off the hall by the front door, and either he or the deputy manager was available at most times. The relatives we spoke to said they were happy with the management of the home and would not hesitate to raise any issues they had. However, a suggestion box might be useful for people who were more reticent or wanted their issue to be raised anonymously.

We looked at the complaint book and saw that no complaint had been recorded since 2011. It appeared that this was a book for major complaints, and there was no separate book for recording minor complaints. This might be helpful as it would enable any repeated events or trends to be identified.

Requires improvement

Is the service well-led?

Our findings

We asked visiting relatives about their impression of how well Mariana House was run. Their comments were positive. One visitor said, "I couldn't fault them. I would recommend it without hesitation. The deputy manager is always available." A second visitor said, "I would recommend people coming in here." A third person said, "The management is excellent. My mother trusts them. I would recommend it to others."

The staff also expressed confidence in the management. Staff said they were confident in the abilities of the deputy manager. They felt they could approach the deputy manager with any concerns and they would take action and support them. They enjoyed working at the home. One staff member said, "I feel one hundred per cent supported by management. They are very easy to talk to." Another member of staff said, "I would bring a member of my family here as I know how well we look after people."

On 27 May 2015,well ahead of the inspection, we requested the provider to complete and send us a Provider Information Return (PIR). This is a set of details about the service which helps us prepare for the inspection. Providers should have this information readily available to them through the internal systems they are required to have to monitor and improve the quality of their service.

The provider did not return the PIR or supply the requested information in another reasonable format. At this inspection the registered manager told us he had not been aware of the request for a PIR. It had been sent by email to the nominated individual of the provider, who was also the registered manager. We asked to see his email inbox, and saw the email had been received on 27 May 2015. The registered manager told us that emails from the CQC normally went into a special folder, but this one had not. He added that he often received spam marketing emails from companies with names similar to the CQC. Nevertheless, we did not consider there was a valid reason for failure to submit the PIR, as the registered manager/ nominated individual ought to have identified and actioned the request. It is the CQC's policy that failure to submit a PIR, without a valid reason, means the rating under this section cannot be better than 'requires improvement'.

The registered manager explained to us his vision for the development of Mariana House. The home had strong links to a local Catholic church and had often taken in people from the local community needing residential care. He now foresaw a move towards specialism in dementia care, based on the changing needs of the population. He agreed that this would require both management and staff to become better trained in dementia awareness and the needs of people living with dementia.

The registered manager also told us he had plans to refurbish and develop the internal fabric of Mariana House, possibly including ensuite toilets or bathrooms where there was space. He explained how this was now more financially feasible than it had been. We have recommended in this report that attention should be given to developing an environment suitable for people living with dementia, especially if the home is to develop a specialism in dementia care.

The registered manager was responsible for most of the paperwork and administration, while also being familiar with the residents. The deputy manager was more closely involved in the day to day care and supervising the staff. The senior carers also played an important role. One of them told us they felt well supported by the management. They said they could and did phone the registered manager or the deputy manager (if off duty) at any time to ask for support or advice.

Staff told us that staff meetings took place regularly and were helpful. We saw minutes of the last three staff meetings held in April, June and August 2015. At the April meeting new responsibilities set out under the Care Act 2014 were discussed in detail. Issues such as activities were raised. We noted that the minutes of meetings had sections which appeared to have been copied and pasted from one to the next, which tended to reduce their usefulness as accurate records of a particular meeting. We mentioned this to the registered manager.

We saw that a 'medication information' book had been in use for staff to record when supplies of a medicine were running low, for example. The book had ceased being used, and we were told notes like this were now recorded on individual care files.

We also saw a medication audits file. An audit was supposed to be done at the end of each month. It involved a series of questions with boxes to tick. At the end of one

Requires improvement

Is the service well-led?

audit was the sentence "All medication has been checked and signed for, and checked against the MAR." The usefulness of this audit depended on the rigour with which it was carried out, and it was not clear from the paperwork how rigorous each audit was. Given the errors with regard to medication that we found on the first day of our inspection (described earlier) the audits of medication needed to be thorough. We were concerned to note that the last audit had been conducted on 30 August 2015, which meant that two had been missed by the time of our inspection in November 2015. We talked with the senior carer who was responsible for doing these audits. They apologised for the fact that two had not been done.

We looked at other audits. An audit sheet was present on each person's care plan, but there were no questions to be completed on this sheet so it was not entirely clear how it was used as an audit tool. Each sheet recorded whether any areas of the care plan had been updated. Each one that we saw stated "No action required". It was not possible to determine whether the audits were effective at identifying any errors or areas for improvement in the care plans.

We requested to see other audits in relation to infection control, falls and pressure care. These were not produced to us. Even in a small service quality monitoring is essential. There was an accident book, as was mentioned earlier, but there was no evidence that accidents were being analysed or lessons learnt. Following our last inspection the registered manager had introduced a new system to record any repairs or maintenance needed to the building.

At our last inspection we found that the service was in breach of the regulation relating to assessing and monitoring the quality of service provision. This was due to care plan audits not being recorded, and an absence of medication audits. The provider/registered manager stated in an action plan that he would introduce auditing and monitoring systems for care files and medication. He added that staff would be trained to use the new procedures. We found at this inspection that the audits had been introduced, but that they were not operating effectively.

We found that the medication audit had not been used for two months, and there was no evidence that the issues with regard to the proper and safe handling of medicines would have been picked up by the audits, if they had been done. There was also no evidence that the care plan audits were effective. There were no audits done in other important areas. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 17(2)(a).

When we asked to see policies and procedures we were shown a set of policies purchased from a commercial company. It was not clear how well if at all they had been adapted to the specific needs of Mariana House. They were also out of date in that they referred to Regulations dating from 2010, which were superseded in April 2015 by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An HR company was employed to provide advice and legal assistance if needed.

Mariana House like other services is required under regulations to submit notifications of significant events to the CQC. We knew from our records that notifications of deaths had been submitted, although we mentioned that sometimes there was insufficient detail given. In our previous report we had found that safeguarding incidents were not always reported and dealt with appropriately. This had been rectified as safeguarding incidents had been reported since then. The last safeguarding incidents reported were in November 2014 but we were not aware of any that occurred since then. Serious injuries were also reported. We saw the accident book which recorded accidents and incidents within the home. We saw that falls were recorded. One of these in July 2015 had been notified to us. Two others, in September and October 2015 respectively, had not been notified although the descriptions suggested they might have reached the criteria of a 'serious injury' which meant that they probably should have been notified. This indicated that the registered manager should review the guidelines for submitting notifications in line with the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The controlled drugs cabinet did not conform to regulations The recording on MAR sheets and in the controlled drugs record book was not always accurate Sufficient quantities of medicines were not always available to ensure the safety and meet the needs of service users PRN protocols were not in use to ensure service users received medicines only in accordance with medical instructions Regulation 12 (1) with reference to 12(2)(f) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks were not always assessed and mitigated relating to the health safety and welfare of service users Regulation 12 (1) with reference to 12(2)(a) and 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment were being provided without the formal consent of service users Regulation 11(1)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Accurate assessments of the needs of service users were not always carried out in a timely way Regulation 9(1) with reference to 9(3)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment In relation to dietary needs, the provider was not doing all that was reasonably practicable to mitigate risks. Regulation 12(1) with reference to 12(2)(b)

The enforcement action we took:
We issued a warning notice stating that
the service is required to become compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 May 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Quality monitoring systems were not being operated effectively to assess monitor and improve the quality of services provided. Regulation 17(1) with reference to 17(2)(a).

The enforcement action we took:
We issued a warning notice stating that
the service is required to become compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 May 2016.