Shaw Healthcare Limited

The Martlets

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

The inspection took place on 29 and 30 January 2018. The first day of the inspection was unannounced, on the second day of inspection the registered manager, staff and people knew to expect us. The Martlets is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Martlets is situated in East Preston in West Sussex and is one of a group of homes owned by a National provider, Shaw Healthcare Limited. The Martlets is registered to accommodate 80 people. On the first day of inspection there were 69 people and on the second day of inspection there were 71 people which accommodated in one adapted building, over three floors, which were divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. These units provided accommodation for older people, those living with dementia and people who required support with their nursing needs. There were gardens for people to access and a hairdressing room.

The home had a registered manager. A registered manager is a '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 home is run. The management team consisted of the registered manager, a unit manager, a clinical lead and team leaders. An operations manager also regularly visited and supported the management team.

At the previous inspection on 6 and 19 December 2016 the home received a rating of 'Requires Improvement' and was found to be in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to inform us of what they would do and by when to improve the key questions of safe and well-led to at least good. This was because there were concerns with regards to the management of medicines. Areas in need of improvement related to the deployment of staff and the timeliness of assessments when people's needs changed, incomplete records to document the care people had received and ineffective audits that had not always identified the shortfalls that were found at the inspection. At this inspection we continued to have concerns and the registered manager was found to be in breach of the regulations.

People did not always receive their medicines on time and systems to improve this demonstrated a service that was not person-centred. Records to document the administering of medicines were not always complete and did not always reflect the actions of staff. In addition, guidance to inform staff's practice on the administration of 'as and when required' medicines was not always consistent. The management of medicines was an area of practice that continued to be a concern.

People's needs were not always assessed nor care plans devised in a timely manner to ensure that staff were aware of people's needs and preferences. When there were changes in people's needs, care plans and risk assessments were not always reviewed to reflect the changes to ensure that people were provided with

appropriate care to meet their current needs. Care plans lacked detail, particularly in relation to people's social and emotional needs. People's life history, background and preferences were not documented to inform staff and did not provide an insight into people's lives before they moved into the home.

Some people, particularly those who were less independent, spent large amounts of time with very little stimulation or interaction with staff, other than when providing support to meet their basic care needs. Although sufficient staff to meet people's physical needs, the provider had not ensured that staffing levels enabled staff to spend quality time with people, engaging in meaningful conversations and occupation. Person-centred information was minimal and as a result people were not provided with stimulation or interests that were meaningful. The lack of person-centred practice was an area of concern.

There was mixed feedback with regards to the leadership and management of the home. There was low staff morale and although staff told us that they felt supported from their direct line managers, told us that the registered manager and provider were not approachable. Some staff demonstrated discontent, and although happy to provide care for people, were not happy with the management of the home. Some relatives told us about the tension that existed between staff and management and felt that this had contributed to a decline in their opinion about the home.

Quality assurance processes were not always effective. When audits had been conducted by external senior managers, actions to improve the shortfalls had not always been taken by the registered manager. In addition, the provider had not always followed-up to ensure that actions from previous audits had been completed. The registered manager and provider had not consistently monitored the systems and processes within the home to ensure that they were meeting people's needs and to continually improve the service.

Records did not always contain sufficient detail and were not always completed in their entirety. This related to people's end of life and healthcare plans, as well as records to document people's daily care. It was not evident if people had received appropriate care or if staff had failed to update the records. The leadership and management of the home is an area of concern.

Areas in need of improvement related to a lack of understanding and the practical application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) as well as the untimely response to responding to complaints that had been received.

We also made a recommendation about the planning of end of life care for people.

Despite the concerns found, people and relatives told us that staff were kind, caring and compassionate and our observations confirmed this. Comments from people included, "Kindness when they speak to you" and "Yes they do, it makes me feel at home with family".

People's privacy and dignity were maintained and they were treated with respect. One person told us, "They knock the door and shut the door when they do my care. They ask you before they do anything". People were protected from abuse as they were supported by sufficient staff that knew the signs and symptoms to look for and who knew what to do if they had any concerns about people's safety. Staff learned from instances and changed practice to ensure that people's well-being was promoted and maintained. People were protected by the prevention and control of infection.

People received support from external healthcare services when required and told us that they had faith in staff's abilities to notice when they were unwell. Staff were trained and competent and supported people in

accordance with their needs and preferences. People's hydration and nutritional needs were met and people told us that they enjoyed the food.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager and provider to take at the back 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 home was not consistently safe.

Medicines were not always administered on time and there were concerns with regards to the management and administration of medicines.

There was sufficient staff to ensure people's safety and meet their physical needs.

People were protected from the spread of infection. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. However, the provider had not consistently worked in accordance with relevant legislative requirements.

People were cared for by staff that had received training and had the skills to meet their needs.

Staff worked with external healthcare professionals to ensure that people received appropriate and coordinated care. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

Staff and management were kind and caring. People were treated with dignity and respect.

People were able to make their feelings and needs known and were able to make decisions about their care and treatment.

People's privacy and dignity were maintained and their

independence promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Not all people had access to activities and stimulation. People were not always supported to engage in meaningful activities.

People and their relatives were made aware of their right to complain. People were encouraged to make comments and provide feedback to improve the service provided. However these had not always been responded to in a timely way

People were supported to have a pain-free and comfortable death. However, advanced care plans were not always in place to ensure that people were cared according to their wishes and preferences.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

There was mixed feedback about the leadership and management of the home. Staff morale was low.

Records to document the care that people received were not always completed. It was unclear if people had not received appropriate care or if staff had failed to record their actions.

Quality assurance processes did not always ensure the delivery of care met people's needs and did not drive improvement.

The Martlets

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 29 and 30 January 2018. The first day of the inspection was unannounced, on the second day of the inspection the registered manager, staff and people knew to expect us. The inspection team consisted of three inspectors and two experts-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. In this case the experts-by-experience had experience of older people's services.

Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications and an action plan that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we asked the provider to complete a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 15 people, four relatives, 10 members of staff and the registered manager. Prior to the inspection we contacted the local authority. Subsequent to the inspection we contacted a Parkinson's specialist nurse, a paramedic practitioner, a community psychiatric nurse and a care manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for seven people, medicine administration records (MAR), five staff records, quality assurance audits, incident reports and records relating to the management of the home. 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 could not talk with us. We observed care and support in the communal lounges and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

The home was last inspected on 6 and 19 December 2016, the home was rated as 'Requires Improvement' and we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in December 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the management of medicines. In addition, an area in need of improvement related to the deployment of staff to meet people's changing needs. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure improvements were made. At this inspection people and their relatives told us that people were safe. When asked what made them feel safe, comments from people included, "Because there are people around, you can call all the time for help. I have friends and carers around me frequently" and "There are people around you that you can trust". However, although some improvements had been made we continued to have concerns and the registered manager was found to be in continued breach of the regulation.

The provider had implemented an electronic recording system (EMAR) for the management of medicines. Records for one person who required their medicines to be given on time due to a particular health condition, showed that on one day the person had not been administered their morning and lunchtime medicines as there were insufficient stocks of medicine. In addition, medicines that the person needed to take weekly had not been given for a period of two weeks due to an error inputting the medicines onto the EMAR system.

At the previous inspection medicines were not always administered on time. At this inspection, the time taken to administer medicines had improved as staff were proficient in the use of the EMAR system. However, records showed that for one person who required medicines to be administered at a certain time each day to assist them to manage their condition and maintain their mobility, they had frequently been given their medicines outside of the prescribing guidelines. Staff told us that the person often had their morning medicines late as the time that these were due coincided with the time of the staff handover and there were no staff available to administer the medicines. The registered manager explained that they had trialled setting an alarm to alert staff so that someone could leave the handover and administer the person's medicines. However, this had not been implemented fully and the person was still not receiving their medicine on time. During discussions with the person they confirmed that they needed the medicine to assist them to mobilise. The untimely access to medicines was raised with the registered manager who explained that they would discuss this with the person's GP to see if the time of the person's medicines could be changed. However, this demonstrated that the service was led by the systems within the home and that person-centred practice was not implemented.

At the previous inspection some people had been prescribed medicine patches that were required to be applied to alternate areas of the person's body. Records did not show where pain patches had been applied. At this inspection, there were continued concerns. Records had been implemented to record the location of pain patches. However records for one person showed that there had been no entries on the records for a month and staff confirmed that the records did not accurately reflect the application of the pain patches and therefore provide accurate guidance for staff when administering them.

At the previous inspection an area of concern related to the administration of 'as and when required' medicines (PRN). A quality audit that had been completed had identified that PRN medicine protocols had not always been completed and those that had been were not always up-to-date. At this inspection, there were continued concerns. Staff had been tasked to ensure that there were PRN protocols for people to inform and guide staff's practice and ensure the consistent administration of these types of medicines. However, records showed that PRN protocols were not consistent. For example, people that lived on the nursing floor had clear PRN protocols for the registered nurses to follow, whereas other people on the residential floors did not always have these. This meant that there was a risk that people would not receive their medicines when they needed them as care staff were not provided with consistent guidance to inform their practice. In addition, PRN protocols that were in place did not contain dates for review to ensure that the continued use of PRN medicines were required.

Most people's care plans had a number of risk assessments which were specific to their healthcare needs; these identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. However, it was not evident how people were involved in decisions about risk. People's risk of malnutrition was assessed, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk. In addition, people's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. However, records for one person showed that their MUST assessment had not been reviewed for a period of three months and their Waterlow assessment had not been reviewed for five months. A falls risk assessment had been completed and the person had been assessed as being at a high risk of falls, however, the risk assessment had not been reviewed for seven months. Records for the person showed that they had been registered as partially sighted. Despite this, no risk assessments or care plans had been amended to reflect the change in the person's needs and inform staff's practice. Risk assessments were not always complete or up-to-date and the registered manager had not assured themselves that people were being supported in an appropriate and safe way that met their current needs.

People who had been assessed as being at greater risk of developing pressure wounds did not always have clear care plans in place advising staff of the importance of repositioning, the frequency that this should occur and the positions that people should be positioned in. Repositioning records for people were inconsistent and it was not evident that people had been regularly repositioned to minimise the risk of developing pressure wounds. Most people had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses as well as regular support from staff to frequently reposition. However records and staff confirmed that one person did not have access to this type of equipment, despite being assessed as being at a higher risk of developing pressure wounds.

Although people's physical needs had been assessed, these had not always been reviewed nor appropriate care plans devised to ensure that staff were provided with appropriate guidance and to ensure people's needs were met. The registered manager had not done all that was reasonably practicable to ensure that care and treatment was provided in a safe way and was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns identified at the last inspection were in relation to medication records not containing people's photographs to assist staff to administer medicines to the correct person. There were no dates of opening for liquid medicines and medicines that had expired. There was a lack of guidance for staff with regards to the correct temperature to store certain medicines as well as the accessibility of safety alerts to inform staff's practice. At this inspection these had all improved and there were no continued concerns. At the previous inspection staff's competence had not been assessed in relation to operating the system and there was the potential that staff did not possess the relevant skills to safely administer people's medicines. At this

inspection registered nurses and trained staff had their competence regularly assessed to ensure that they had the relevant skills to operate the system and administer medicines safely.

Medicines were stored correctly and regular medicines reviews ensured that medicines to support people to manage their behaviour were monitored and their excessive use minimised. Documentation was in place so that information about people's medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital. Observations showed that people's consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. People told us that they were happy with the support that was provided. People, who were able, were encouraged to self-administer their own medicines and risk assessments were in place to ensure that there were safe mechanisms in place to enable this. The registered manager had notified us of a medication error that had occurred and had also reported this to the local authority. The registered manager had worked with the local authority and had reviewed their own procedures to ensure that the chances of this error reoccurring were minimised. This related to the systems in place for receiving medicines when people first moved into the home.

At the previous inspection an area in need of improvement related to the numbers of staff deployed to meet people's changing needs. At this inspection there was mixed feedback from people and staff about the sufficiency of staff. Staff told us that they were busy and that more staff were required during peak times. However, when people were asked if there were enough staff, one person told us, "Yes there is enough staff, I suppose so, yes they respond quickly". Another person told us, "They will respond quickly, if they don't, I whistle". Observations showed that staff were visible and responded promptly to people's needs. The provider used a dependency tool and people's needs were assessed on an on-going basis and this was used to ensure that the levels of staff aligned with people's assessed level of need. The registered manager ensured that staff's skills, experience and knowledge were considered when devising the rotas. When temporary staff were used, to ensure that staffing levels were sufficient, rotas showed that they had been allocated to work alongside an experienced member of staff. This ensured that staff had the relevant experience and guidance to meet people's needs. The provider had also employed a member of staff to be the clinical lead to oversee the nursing aspects of people's care.

The home is divided into eight units, each accommodating up to ten people. Staffing levels had remained the same since the last inspection and staffing rotas showed that a consistent level of staffing had been maintained. Since the previous inspection the registered manager had reallocated and deployed one member of staff to act as a 'floating' staff member. Observations showed that they were deployed to different units of the home at peak times to ensure that people's needs were met. There were sufficient staff to meet people's health needs and ensure people's safety. The provider had recognised that the staffing levels that had been agreed with the local authority had been set several years previously and that since then people's needs had now increased by the time they required residential care. The provider was in conversation with the local authority to reassess staffing levels in relation to people's increased level of need.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency. Accidents and incidents that had occurred had been recorded and monitored.

People were cared for by staff that the provider had deemed safe to work with them. Before staff started

work, information about their employment history as well as identity and security checks were undertaken. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. These pre-employment checks assured the provider of staff's suitability to work in the health and social care sector. There were further checks to ensure that temporary staff, who sometimes worked at the home, were suitable to work with vulnerable groups of people. Documentation also confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

People were protected from discrimination and harm. Observations showed that people appeared comfortable in the presence of staff. One person told us, "No, I don't feel discriminated and yes I am treated with respect and dignity". Another person told us, "I am feeling well-treated here". Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Mechanisms were in place to raise people's awareness of their own personal safety and to enable them to raise concerns. Regular residents' and relatives' meetings provided an opportunity for people to raise issues and discuss any concerns they had. The provider and management team had worked with the local authority when they had undertaken safeguarding enquiries and the management team had demonstrated a reflective approach to ensure that they learned from the outcomes of the enquiries to ensure people's safety. Records showed that the provider had also been proactive and had raised safeguarding alerts to the local authority when they were concerned about people's well-being.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People, when appropriate, were supported with their continence needs and had access to hand-washing facilities.

Requires Improvement

Is the service effective?

Our findings

People's physical health was assessed prior to, as well as when they first moved into the home. People and their relatives told us that staff asked for people's consent before offering support and our observations confirmed this. People's comments included, "They ask me questions and I answer or give them permission" and "They ask me first". However, despite these positive comments we found an area of practice that was in need of improvement.

People were provided with choice and able to make decisions with regards to their day-to-day care. However, staff did not always adhere to the legal requirements associated with assessing people's capacity to make decisions and to gain their consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Most mental capacity assessments that had been undertaken did not relate to specific decisions and instead assessed people's overarching capacity. When people had been assessed as not having capacity best interests meetings had taken place, however, these had only involved members of staff and therefore decisions were made on people's behalves without consulting or involving other relevant people. The provider had recognised that this was an area of practice that needed to improve. They had introduced an updated policy which advised staff to undertake mental capacity assessments in relation to specific decisions, in addition, best interests meetings were to be conducted involving relevant people to ensure that any decisions made on people's behalves were in their best interests. The registered manager had begun to implement this in practice and some new MCA assessments had been completed focusing on specific decisions. These related to people's understanding in relation to not being able to leave the building without staff support. Although these mental capacity assessments had been undertaken, a large proportion of people were living with dementia-type symptoms or conditions that could potentially affect their ability to make certain decisions. Staff had assessed them as having capacity as they had understood that there was a locked door to the home. Staff had not considered that the person lacked the capacity to safely go out of the home without staff support and had not consistently applied for DoLS authorisations.

Most people were not able to leave the home without being accompanied by staff due to issues related to their safety. However, there was a low number of DoLS applications made to ensure that people's liberty was not being restricted unlawfully. When this was fed back to the management team they explained that they would liaise with the local authority and make the appropriate applications.

The registered manager and staff had an understanding of MCA and DoLS. Staff were aware of people's changing needs and as a result mental capacity assessments were reviewed or renewed if changes had occurred. Staff ensured that practices that restricted people's freedom were minimised, when people

demonstrated signs of apparent anxiety or distress, staff supported them appropriately, using distraction techniques and engagement as opposed to physical restraint to manage potentially challenging situations.

Although the majority of people had their capacity assessed and staff had worked in accordance with the legislative requirements in relation to this, this was not always consistent and therefore is an area in need of improvement.

People told us and observations and records confirmed that they had access to external healthcare professionals. Records showed that relatives were involved in explanations and decisions about people's healthcare needs. People and relatives told us that they were confident in staff's abilities to recognise when they were not well and to seek medical assistance when required and our observations and records confirmed that people received timely intervention from healthcare professionals. One person told us, "If I need the doctor yes, I also have routine checks on my eyes, sugar levels, blood pressure and diabetes".

People and relatives told us that staff were competent and that they had faith in their abilities and skills. Comments from people described staff as "Yes, they are very skilled", "They are very good, they are people-friendly" and "Of course, they are very skilled". When staff were asked about access to learning and development opportunities they told us that they were happy with the courses that were available and that these assisted them within their roles. Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that staff can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. All staff, regardless of roles, had access to on-going learning and development. The registered manager and staff had recognised, and our observations confirmed, that staff would benefit from developing their knowledge with regards to people's specific health conditions, such as dementia, diabetes and Parkinson's disease and had recently contacted a local college to facilitate this. There were links with external healthcare professionals to provide additional learning and development for staff. Care staff held diplomas in health and social care or were working towards them. Registered nurses were provided with appropriate courses to maintain their competence and to ensure their knowledge and skills were current so as to support people with their nursing needs. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. The registered manager and provider recognised the importance of valuing and empowering staff. To recognise staff's contribution to the service, the provider had introduced the National STAR awards. These are the provider's own accolades that recognise staff who demonstrate excellence.

People's diversity was respected and people were treated fairly and equally. People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff. There was good inter-departmental working and effective communication took place to ensure a holistic approach to meeting people's care and support needs. Regular meetings took place to share information on each person to ensure people were provided with appropriate care that was consistent.

The home was designed in such a way that provided adequate space for people to enjoy time with one another. People also had their own rooms that they could use if they wanted to have their own space. People could choose to socialise with one another, enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather.

People told us that they enjoyed the food that was provided and had access to drinks and snacks throughout the day and our observations confirmed this. When people were asked about the food they told us that they were provided with choice and were able to change their mind if they were unhappy with their original choice. Observations showed that some people chose to eat their meals in the dining rooms whilst others preferred to eat in their rooms or at small tables in the communal lounges. People had a pleasant dining experience and were able to socialise with others. Staff were respectful and supported people appropriately when they required assistance to eat and drink. Aids and adaptions were made available for people to use to enable them to remain independent and to take into consideration their cognitive and physical abilities. For example, there were beakers with lids and handles that people could use if required. Comments from people, when asked about the food, included, "It's lovely" and "Reasonably good". One person when asked about the dining environment, told us, "I quite like it, you get to know people, there are people to talk to".

Good

Is the service caring?

Our findings

Without exception people and relatives told us that staff and management were kind, caring and compassionate. Comments from people included, "It makes me feel at home with family", "They are kind and caring" and "They speak to me nicely".

People and their relatives were involved in the development of their care plans, however, although it was not evident how people were involved or contributed to the on-going review of their care, people told us that they were able to approach staff to air their views and that they felt valued. People were happy in the presence of staff and willingly accepted support from staff that were happy and able to offer assistance. People were provided with additional support and sign posted to external organisations that they could access such as the local authority, if they required further support to be involved in making decisions about their care. Regular residents' and relatives' meetings took place to enable people and their relatives to share their ideas and be kept informed of changes at the home. The provider acknowledged that people and relatives might prefer to share their views and concerns in a different way and had asked some people to share their views by completing questionnaires. Additional support to enable people to share their views could be provided through advocacy services. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

The atmosphere was calm and people were cared for by staff that were understanding and patient. One person showed signs of apparent anxiety and distress. Staff demonstrated a good understanding of the person's needs and were on hand and responded promptly, ensuring that the person was provided with the space to express their feelings in a dignified manner. Observations showed that when staff responded to the person's needs that this had a positive impact on their well-being and they were observed to be calm.

People were encouraged and able to keep in contact with their family and friends. Visitors were welcomed in the home and observations showed relatives offering assistance to their loved ones during meal times. Visits from people's relatives and friends were not restricted and relatives and visitors told us that they were made to feel welcome at any time.

People's independence was promoted and encouraged. People could choose how they spent their time, some spending time in the communal areas, whilst others preferred their own space in their rooms or quieter areas of the home. Some people independently accessed the local community with the support of their friends or relatives. People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Staff were mindful of the impact receiving support, particularly with aspects of people's personal care needs, could have on a person's dignity. One person told us, "When they do my personal care they shut the door, when there is confidential information they talk to me in my room with the door shut". Another person told us, "They knock the door and shut the door when they do my care. They ask before they do anything". Observations showed staff knocking on people's doors and waiting for a reply before entering people's rooms and asking people's consent before supporting them with tasks. Staff attended to people's needs in a sensitive and

discreet manner. People's wishes, with regards to their preferences of male or female care staff, were ascertained and respected. Staffing allocation ensured that there were staff of different genders so that people's wishes could be respected and accommodated.

Information held about people was kept confidential. Records were stored in locked offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained.

People's diversity was respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

Requires Improvement

Is the service responsive?

Our findings

Most people and their relatives told us that people were happy. Comments from people, with regards to the activities that were provided, were positive and included, "Yes, we have a very busy activities schedule indoors. This keeps me busy and contented" and "Yes, very much so, I do enjoy that". However not all people had access to activities and there were concerns about people's access to stimulation and interaction to occupy their time. People's social and emotional needs had not been assessed and as a result there was a lack of person-centred information to ensure that people led enriched lives that met their needs and preferences.

People and their relatives told us that they had been involved in discussions about their care and had contributed to the care planning process. One person told us, "They come and ask about the need for doing your ears or toes. Staff will come and ask me questions about myself and make suggestions and ask me if I like it". Despite this, people's social and emotional needs did not always form part of the initial assessment and were not documented in people's care plans. One member of staff told us that they felt that the care records for people lacked information about the person and felt that this made it more difficult for a person when moving into the home. Records showed that there was little information about people's lives before they moved into the home and staff were not provided with guidance as to people's hobbies, interests and preferences. Some people were able to tell us about activities and pastimes that they enjoyed, however it was not evident how they were able to share this information with staff so that meaningful activities and occupation could be provided. Observations showed that some people, particularly those who were less independent, spent large amounts of their time in the same position, with little stimulation or interaction from staff other than to provide for their basic care needs. Although there were sufficient staff to meet people's physical needs, the provider had not ensured that there were sufficient staff to meet people's emotional and social needs. Staff were busy and task-focused and there were, at times, missed opportunities for conversation and interaction with people. One person told us, "I like to go to church on Sundays but due to lack of staff I can't always do this". There were minimal resources or activities available for people to engage with and occupy their time. One comment by a member of staff echoed this, they told us, "I don't think they get quality time. There are things like a few books and music but there doesn't seem to be any equipment here to use with them".

People told us that they used to be supported to go out of the home and had enjoyed outings to places of interests. However, staff told us that this had stopped as they did not have access to the minibus as this had been transferred to another of the provider's homes. Records showed that group activities had been provided for people to participate in, these included an external musician who had visited the home, bingo, a skittles event and darts. However, not all people, due to their health needs or location in the home, had equal access to the activities that were provided. Although minimal, care records for one person included their preferences and dislikes. Listed as one of their dislikes was bingo, however, individual activity records for the person showed that one of the few activities that had been provided to the person had been bingo. This demonstrated that although staff had asked the person their preferences and documented these to inform others, they had not ensured that the person's preferences and dislikes were taken into consideration when providing access to activities.

There was a lack of understanding as to what constituted a meaningful activity to occupy people's time. Individual activity records for other people had external healthcare appointments, podiatry and chiropody listed as meaningful activities that people had access to. Records of a recent residents' meeting contained comments from people, these included, 'I do love doing work, I hate sitting around doing nothing' and '[Person's name] said activities were low on the ground'. In addition, results from a recent survey that people had completed contained numerous comments about the need for more activities and stimulation. When the lack of stimulation and interaction was raised with the registered manager they told us there was one activities coordinator and this was not sufficient to meet the needs of all people within the home. They explained that two more had recently been recruited but had yet to start in post and that when these roles were filled there would be more opportunity for activities and one-to-one stimulation for people.

However, the registered manager had failed to ensure that the care and treatment of people was appropriate and met their needs and preferences. This was a breach of Regulation 9 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Regular meetings provided a forum for people to make their feelings known. People told us and records confirmed, that people were able to speak freely and air their views and concerns. People were informed of their right to make a complaint. Posters were displayed and people had been made aware when they first moved into the home. Most people told us that they had not had cause to make a complaint but were aware of how to do this and would not worry about any repercussions to their care. The management team and staff demonstrated a reflective approach to their practice and had reviewed how they worked and learned from instances. For example, changes to practice had been implemented as a result of some medication errors that had occurred. Some people told us that they felt that complaints or issues that they had raised "Had not always been fully followed-up". Records sometimes reflected this and showed that complaints that had been raised had not always been responded to in accordance with the provider's policy. An acknowledgment letter had been sent to people, however, a resolution to their complaint had not been provided in a timely way. When this was raised with the registered manager they explained that they had taken time to investigate the complaint, but had not yet responded to the complainant. This is an area in need of improvement.

Some people were able to plan for their end of life care and had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. However, records for one person showed that their end of life care plan had not been reviewed or updated since moving from a different care home. Information within the plan related to their wishes when residing at their previous home and did not provide up-to-date information for staff with regards to the person's wishes.

Staff received support and advice from external healthcare professionals to ensure people experienced a comfortable and pain-free death. The provider took precautions to ensure that they were prepared for people's conditions deteriorating. Advice had been sought from external healthcare professionals, equipment hired and anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Relatives were welcome and able to spend time with people at the end of their lives. According to the Social Care Institute for Excellence (SCIE) people with dementia should be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advise that providers of homes also need to ensure that they are prepared for situations and do their best to ensure that they know,

document and meet the person's wishes at the end of their life. Advanced care plans were not always in place for the people living at the service. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time. We recommend that the registered manager considers current guidance on advanced care planning so that conversations with people about their preferences at the end of their lives can take place.

People were encouraged and able to maintain relationships that were important to them. There were opportunities for people to interact with one another and develop friendships, as people had access to shared communal lounges and dining rooms. Comments from people included, "I talk to people, ask their name, exchange information" and "I talk to people, share stories and activities together". Another person told us how they kept in contact with their friends and relatives by "Writing letters, post cards and telephone calls". People were able to have visitors and told us that they were made to feel welcome and our observations confirmed this.

People could choose where they spent their time, some spending time in the communal areas of the home, whilst others chose to spend their time in their own rooms. People were provided with a call bell so that they could call for assistance from staff and told us that when they used their call bells staff responded promptly. One person told us, "We have a calling bell to call them when in need. They always ensure that we use it very well". For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were alerted and could go to the person to offer assistance. In addition, regular checks were undertaken when people were in their rooms to ensure their safety.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they had ensured people's communication needs had been identified and met. Staff told us this was looked at as part of people's initial assessments and formed their plans of care. Care plans contained details of the best way to communicate with people. Information for people and their relatives, if required, could be created in such a way so as to meet their needs and in accessible formats to help them understand the care available to them.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 6 and 19 December 2016, areas in need of improvement related to the maintenance of records and the quality assurance processes used within the home to ensure that the systems and processes were meeting people's needs. At this inspection these areas of practice had not improved sufficiently. There remains a concern regarding the overall ability to maintain standards and to continually improve the quality of care. This is the third consecutive time that the provider has been rated as 'Requires Improvement'.

The Martlets is one of a group of services owned by a national provider, Shaw Healthcare Limited. It is a purpose built building with accommodation provided over two floors which are divided into smaller units of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. The management team had experience within the health and social care sector and held appropriate management or nursing qualifications. There was a management hierarchy which enabled staff to be supported and supervised by team leaders who worked alongside them to meet people's needs. In addition, there was a clinical lead nurse, a deputy manager and the registered manager. An operations manager also regularly visited the home to conduct quality assurance audits and to offer support.

There was mixed feedback from people, relatives and staff about the leadership and management of the home. Some people and relatives were aware of the registered manager and felt that they were friendly and approachable. However, others were unsure who the registered manager was. Four members of staff were observed expressing feelings of discontent with them openly discussing their unhappiness about the management and systems within the home. Staff were unhappy with the apparent lack of equipment and resources to enable them to carry out their roles. However, when this was fed back to the registered manager plans had already been made to order items that were broken or required. Six members of staff that we spoke to told us that they were unhappy with the management of the home and felt that the registered manager and provider were unapproachable and that they only felt supported by their immediate team leaders. One member of staff told us, "It has got better but there is still a lot of room for improvement I believe". A relative told us, "The management has room for improvement in the running of this unit and you can sense that there are 'issues' between staff and management. There were a lot of good points about the home but these are currently being masked by the current negativity that exists around the home". One person and their relative told us, "This seems like a nice home but does need a bit of TLC (Tender loving care) and better support from management to make this a really enjoyable home for everyone".

There was a lack of oversight and action in relation to medicines management. One person, who required medicines to maintain their health and to manage their condition, had sometimes missed doses of their medicines due to insufficient stocks and had not always received their medicines in a timely manner. Although this had been identified by the registered manager action had not been taken to ensure that the person had their medicines on time and according to the prescribing guidelines to ensure that they were able to mobilise and manage their condition.

Records, in relation to people's care and treatment, were not always consistently maintained. This related to fluid, bowel, repositioning, medication and topical cream charts as well as assessments and records that were implemented to monitor people's health condition if they had experienced a fall. Records were not always completed in their entirety and these incomplete records made it difficult to ascertain if people had received appropriate care or if staff had failed to complete the required records.

When records of people's care were not monitored there was a potential risk that any changes in people's conditions may not have been recognised. This was echoed within records of a staff meeting in which the registered manager had asked staff to ensure that they 'tally-up' fluid intake by a certain time so that they can be signed off by a team leader to see if there was a concern straight away. There was a lack of information and detail in people's care records and records showed that one person's care records had not been devised and implemented in a timely way to inform and guide staff's practice and ensure that they received a service that met their needs and preferences. Falls management was not consistent. Some people who had experienced falls had been referred to external services such as the falls prevention team, however, others had not. For some people, risk assessments for their healthcare needs had not always been reviewed despite changes in their needs and incidents that had occurred. For example, a falls risk assessment for one person, who had been assessed as being at a high risk of falls, had been completed when moving into the home. Despite the person experiencing a high number of falls within the following months, the falls risk assessment had not been reviewed. In addition, a mobility care plan to assist the person with their mobility and inform and guide staff's practice did not contain sufficient detail.

Records showed that the completion of records had been raised by the registered manager within staff meetings; however it was not evident what action had been taken to follow-up on this area and ensure its improvement. Records for one person also showed that there had been a delay in assessing the person's needs and formalising care plans when they had first moved into the home. As a result the person's needs and preferences were not documented and shared with staff to inform and guide staff's practice and ensure that the person was cared for in a way that met their needs and wishes.

A quality management system was in place and both manual and electronic quality management systems ensured that regular audits of the service were conducted by the registered manager and other external senior managers and were monitored by the provider's quality team. The local authority also undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. Quality assurance audits had been conducted by external managers and a member of the provider's quality assurance team. Records of audits conducted eight months prior to the inspection highlighted areas of practice that needed to improve. These included the completion of records, the timely implementation of care plans when people first moved into the home and ensuring that detailed life histories and preferences were recorded in care plans.

There was a lack of monitoring and action by the registered manager and provider to ensure the shortfalls that had been identified by the audits, as well as those highlighted as part of the inspection, were improved and actioned. Records showed that audits that were to be conducted by the registered manager had not always been carried out. When the lack of audits for a period of four months was raised with the registered manager they explained that they had not been able to complete these due to management staffing issues and that they had had to prioritise their time. However, by the registered manager not completing actions and conducting audits, as well as the provider not following-up to ensure actions from previous audits were completed, neither parties were ensuring that they were delivering the service people had a right to expect and did not ensure that the service continually improved.

People and relatives told us that they had not been asked to complete questionnaires or surveys to enable

them to share their feedback about the running of the home and the care people received. However, records showed that surveys had been sent to people who lived at the home and they had provided feedback. Comments were not always positive and people demonstrated their dissatisfaction with various aspects of their care, this mainly related to the lack of activities within the home. One person had commented on a response to a complaint that they had made and had stated, 'Don't know who is in charge here'. When the results of the feedback were raised with the registered manager and they were asked what action they had taken in response, the registered manager explained that currently no action had been taken as they had been waiting to collate the results into a graph. However, the survey had been completed six months prior to the inspection. Other mechanisms to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving were in place such as regular residents' and relatives' meetings. Records of meetings showed that people and relatives were able to air their views and make suggestions about the care people received.

The registered manager and provider had failed to assess, monitor and improve the quality and safety of the services provided including the experience of people in receiving those services. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns with the oversight of the home, there was a relaxed and welcoming atmosphere and people, relatives and staff told us that the home was a nice place to live and that people were happy. When people were asked what positive difference living at the home had meant to their lives, one person told us, "I am happy and healthier". Another person told us, "I feel comfortable here". The provider had a set of objectives which provided staff with clear guidance as to the aims of the service provided. These objectives incorporated person-centred care, enabling people to live a healthy and happy life and promoting people's human rights. The provider ensured that staff were recruited who shared their values and who would work to achieve their objectives. However, it was not evident that working in a person-centred way was always implemented in practice.

Although there was mixed feedback with regards to the management of the home, staff were supported by their direct supervisors and had access to advice and guidance to inform their practice. Management of all levels had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns. Staff told us that they were involved and kept informed of any changes within the organisation. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings. Staff had access to regular one-to-one meetings with the management team and told us that they felt that they could approach team leaders at any time if they had any concerns or needed further support. Staff were provided with regular feedback on their practice to enable them to reflect on and develop their knowledge and skills to improve the support that people received. These forums also provided an opportunity for the registered manager to review the culture of the staff team and home to ensure that staff were mindful of the provider's aims and objectives.

People and relatives told us and records confirmed that the provider and registered manager demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Staff were encouraged to identify areas that could be improved upon and discussions had taken place in regular staff meetings. A whistleblowing policy informed staff of their responsibilities to raise any concerns. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

The provider and management team had recognised that links with the local community was an area for development and had plans to build links and relationships. The registered manager explained that once the activity coordinators were in post that people would be supported to visit the local community, who would also be invited to attend events held at the home. Relationships with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach and service and staff learned from other sources of expertise.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

The enforcement action we took:

We have issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users. Neither had they ensured the proper and safe use of medicines.

The enforcement action we took:

We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The registered person had not ensured that systems and processes were established and operated effectively to:

Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We have issued a Warning Notice