Martha Trust

Mary House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

Mary House provides residential and nursing care for up to 13 people with profound and multiple learning disabilities. As a result of their disabilities people require support with all aspects of care including eating and drinking and with moving and handling. People were unable to communicate verbally and some used vocal sounds or body language and facial expressions to make their needs known. The building was purpose-built to meet people's needs. A hydro pool was on site with access to appropriately designed changing rooms to meet people's needs. A hydro pool is a pool used for water exercise and other therapy treatments. Facilities included an art room, a music room and a sensory room. At the time of our inspection there were 12 people living at the home.

We inspected Mary House on 19 and 23 December 2014 and identified a range of concerns. We took enforcement action and asked the provider to make improvements in staffing levels, care and welfare, equipment and in the monitoring of the service. Improvements were also required to be made in the management of medicines,

Summary of findings

nutrition, dignity and respect, complaints, records, staff training and infection control. The provider has written an action plan to address these improvements within a required time frame.

We inspected again on 06 May 2015 because we had received concerns about people's safety. At the time of this inspection, the timescales to meet our regulations had not yet expired. This inspection therefore focused on the concerns and checked whether some of the improvements had been carried out in regard to people's safety. At this inspection we found that improvements and compliance had been achieved in infection control, the management of medicines, records and recruitment. However further requirements were identified about the lack of sufficient staff with the right skills and knowledge and a lack of appropriate safeguarding procedures to ensure restraint was only used when absolutely necessary.

This inspection on the 20 July 2015 was to check whether appropriate action had been taken to implement improvements identified at our inspection in December 2014. We found that progress have been made although in some areas some improvements were still to be implemented. Although the timescales to meet our regulations had not yet expired in regard to the inspection of 06 May 2015, we found that the two further requirements identified at that inspection had already been fulfilled.

There was not a manager in post who had applied to become registered with the Care Quality Commission (CQC) at the time of our visit. A registered manager is a person who has registered with the 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. A newly recruited manager had not yet started their duties in the service.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were safe recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

All fire protection equipment was serviced and maintained.

People's bedrooms were personalised to reflect their individual tastes and personalities.

Staff knew each person well and understood how to meet their support needs. A relative told us, "We find that staff are more alert about and respond better than a few months ago to individual needs".

Essential staff training was up to date and additional training was scheduled to take place shortly. Staff had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal. This ensured they were supporting people to the expected standards.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005 requirements. However further applications that needed to be made were in the process of being completed.

Staff sought and obtained people's consent before they helped them.

The service provided meals that were in sufficient quantity and met people's needs and preference. Staff knew about and provided for people's dietary preferences and restrictions.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

Summary of findings

People and their relatives were involved in their day to day care. People's care plans were reviewed with the participation of relatives who were invited to attend the reviews and contribute.

Clear information about the home, the facilities, and how to complain was provided to people and visitors.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People's individual assessments and care plans were reviewed monthly and updated when their needs changed.

People were involved in the planning of activities. A broad range of suitable activities and outings was available.

The service took account of relatives' feedback, comments and suggestions. People's views were sought and acted on. Satisfaction questionnaires were sent to people's relatives or legal representatives, and the results were analysed and acted on. Staff told us they felt valued under the registered manager's leadership.

The acting manager notified the Care Quality Commission of any significant events that affected people or the service. The provider, directors and acting manager kept up to date with any changes in legislation that may affect the service. They carried out audits to identify how the service could improve. They acted on the results of these audits and made necessary changes to improve the quality of the service and care.

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 safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Safe recruitment procedures were followed in practice. Medicines were administered safely.

The environment was secure and well maintained.

Good

Is the service effective?
The service was not consistently effective.

The management team understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation. However, several assessments of people's mental capacity, the scheduling of meetings in people's best interest and several applications for DoLS were still in progress.

Staff were trained and had a good knowledge of each person and of how to meet their specific support needs.

People were supported to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Requires improvement

Is the service caring?
The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

People's relatives were consulted about and were involved in their family members' care and treatment.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when people's needs changed. The delivery of care was in line with people's care plans.

A range of suitable activities based on people's needs and preferences was available.

The service sought feedback from people's relatives and staff about the overall quality of the service. These views were listened to and acted on.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

There was not a registered manager in place.

There were new systems of quality assurance in place. This responsibility was shared between the provider, two directors and the acting manager. However, systems had not yet been embedded to check their efficiency could be sustained.

Appropriate audits were carried out to identify where improvements could be made. Action was promptly taken to implement improvements.

There was an open and positive culture which focussed on people. The management team operated an 'open door 'policy, welcoming people and staff's suggestions for improvement.

The staff felt supported and valued under the acting manager's leadership.

Mary House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was unannounced and was carried out on 20 July 2015 by two inspectors and a specialist advisor who is an occupational therapist. Occupational therapists help people with mental, physical or social disabilities to independently carry out everyday tasks or occupations and may introduce the use of equipment. The lead inspector re-visited on 21 July 2015 to complete the inspection.

Before the inspection we asked the provider 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. The provider had completed and returned the PIR which we took in consideration. We reviewed our previous inspection reports and the action plans that the provider had sent to us following our last inspections. We also looked at records that were sent to us by the acting manager and the local authority to inform us of significant changes and events. We spoke with a local authority case manager and a specialist lead nurse who oversaw people's care in the home. We obtained their feedback about their experience of the service.

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 spoke with three people's relatives to gather their feedback. We also spoke with the provider, two directors, the human resource officer, the acting manager, the practice and skills mentor, the physiotherapist, eight members of care and nursing staff, the administration officer, the cook and one member of housekeeping staff.

We looked at the premises and the equipment that was provided. We looked at six sets of records which included those related to people's care, medicines, staff management and quality of the service, and five staff recruitment files. We looked at people's assessments of needs and care plans. We observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out. We sampled the services' policies and procedures. We attended a staff handover meeting and made observations of staff practice when staff interacted with people.

Good

Is the service safe?

Our findings

Two relatives told us, “The staff keep the residents safe”, “If there are any crises, we are confident that [X] is in good hands and will be well looked after.”

Staff knew how to identify abuse and how to respond and report possible abuse internally and externally. Staff knew where the policy related to the safeguarding of adults was located. The policy was up to date and reflected theguidance provided by the local authority. Informative leaflets about who to contact in case of whistleblowing or safeguarding were provided to all staff in the service. Staff were clear of the action they would take if they had any concerns. They told us that they would intervene if they thought support was inappropriate and they knew how to contact the local authority. One staff member told us, “The residents depend on us for their safety.” All staff training records confirmed that staff training in the safeguarding of adults was completed annually was and up to date.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the numbers of staff with the right skills and knowledge appropriate to people’s complex needs. At this inspection, we found these improvements had been carried out. There was sufficient staff on duty to care for people and respond to their needs at all times. Before people came into the home, the acting manager and one director completed an assessment to ensure the home could provide staffing that was sufficient to meet their needs. People’s levels of dependency were reviewed regularly, and this information was used to calculate how many staff were needed on shift at any time. As a result of recent reviews staffing levels had been increased. A director monitored staff training attendance to ensure staff developped their skills and increased their knowledge. Rotas indicated sufficient staff were in attendance on both day and night shifts and that people received their one to one support hours as planned. The staff told us there were enough staff to care in the way people needed and at times they preferred. A relative told us, “The staffing levels have improved and [X] is now getting the one to one support that was agreed.” We observed staff were available to help people at various times and respond to people’s individual needs in a timely manner.

We checked staff files to ensure safe recruitment procedures were followed. The records we consulted were appropriately completed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and we saw that references were obtained from the most recent employer where possible. Gaps regarding previous employment were explained appropriately. Nurses’ registration with the appropriate authority was up to date. A system of disciplinary procedures was in place when any staff behaved outside their code of conduct. This assured people and their relatives that staff were of good character and fit to carry out their duties.

At our inspection in December 2014, we identified improvements that needed to be made in relation to risk assessments. At this inspection, we found these improvements had been carried out. Risk assessments were centred on the needs of the individual. These were updated to show when people’s needs had changed. There was a risk assessment carried out for one person who was at risk of choking. This assessment included recommendations from a speech and language therapist and these were followed by staff when the person ate their meal and was given their medicine. Another risk assessment about manual handling addressed several aspects of risk such as injury, skin damage, discomfort and feelings of exclusion should a wheelchair setting be altered without involving the person beforehand. There were comprehensive measures to minimise these risks, for example recommendations about daily checks of equipment and footwear, explanations to the person, appropriate training undertaken by staff about manual handling, adult protection and mental capacity. Staff followed the clear recommendations and guidance that was provided by the physiotherapist. All care staff had received training in first aid that was specific to people’s complex needs.

Equipment was in place to keep people safe when staff helped them move around. There was ceiling overhead equipment that allowed people to be moved safely across specific distances in each bedroom, bathroom and in the hydro pool. This equipment had been checked and serviced in March 2015 and the next scheduled dates for servicing were diarised. All slings used to keep people safe when they were helped to move around were individual to

Good

Is the service safe?

each person, named, and were selected in accordance to people's size and weight. Bed rails were provided for people to keep them safe in bed. The equipment was adjusted taking into consideration people's physical and psychological needs. For example, one person had clear bedrails on their bed to enable them to see through them. This promoted the person's engagement with other people and reduced social isolation.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the suitability of equipment. At this inspection, we found these improvements had been carried out. When people needed new equipment such as upgraded wheelchairs, they were referred to the appropriate services and staff followed up the referrals when necessary. The physiotherapist had submitted comprehensive reports to assist requests for funding for equipment to the Local Health Commissioners. The physiotherapist was completing an audit to check all equipment in the service. They had devised a 'traffic light system' to identify which equipment was safe to use, which equipment needed adjustment or new parts, or had to be replaced. They told us, "There have been some really positive changes with the equipment in the service."

We observed four instances of care staff using equipment to help people move to and from different places, for example from a wheelchair to a bed. All moving and handling procedures were correctly followed by staff who had received up to date appropriate training. The physiotherapist told us, "Staff training in how to move each person safely is ongoing to increase their knowledge and skills and staff skills have improved." The physiotherapist had completed individual assessments to show staff how to position and re-position each person in bed, in their chairs or when helping them move around. These assessments contained clear written and photographic instructions. There was a trampoline that was flushed at ground level to make it safe to use. Staff were receiving training to learn how to help people use this facility safely.

At our inspection in December 2014, we identified improvements that needed to be made in relation to medicines. At this inspection, we found these improvements had been carried out. The Medicines Administration records (MAR) charts were completed appropriately and monitored daily to ensure correct procedures had been followed. We observed medicines being administered and the correct procedures were carried out by staff. A checklist was in place in regard to the use of topical creams, and nurses checked there were sufficient quantities available. Protocols were in place to determine when medicines on an 'as required' basis had to be administered, for example for pain relief.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the management of incidents and accidents. At this inspection, we found these improvements had been carried out. There was an effective recording system for accidents and incidents that ensured relevant information was considered and analysed without delay. For example when bruises were identified, they had been appropriately recorded and investigated by the acting manager and the provider. The provider told us, "If any triggers are identified we then ensure that future risks of recurrence are minimised." The monitoring of incidents and accidents reports was discussed at each management meeting. This ensured that hazards were identified and actions were taken to reduce future risks of these recurring.

An environmental risk assessment for all parts of the service had been carried out. Maintenance checks included the nursing call system, vehicle, portable appliances, water temperature and lifting equipment. They checked fire protection equipment and recorded regular fire drills that were carried out. All scheduled and completed repairs were appropriately recorded in a maintenance log. Senior care workers were trained to check the hydro pool's temperature and chlorine levels each day.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the cleanliness of the service. At this inspection, we found these improvements had been carried out. A housekeeper worked six days a week and showed us their systematic system of cleaning the service. Cleaning schedules had been introduced and were still to be used by the housekeeper who told us, "These have just started and will be completed from today onwards to keep a record of what has been cleaned." Although schedules had not yet been completed, people's bedrooms, all communal areas were very clean, odour-free and welcoming. All surfaces had been dusted, polished or vacuumed. All bathrooms were clean and had been disinfected to reduce the risk of infection to people. The housekeeper had received training in the Control of Substances Hazardous to Health (COSHH) and in the safeguarding of adults.

Good

Is the service safe?

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks. It included clear guidance for staff to follow. The staff knew where this plan was kept and understood how they should respond to a range of different emergencies including fire. Staff had been trained to use the fire policy in practice and to use the fire protection equipment around the home. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and equipment throughout the home. Staff were aware of the emergency evacuation procedures. When asked to describe what steps they would take during an emergency they demonstrated a sound knowledge of the procedures to follow. They knew how to help each person according to their individual needs and this was recorded in personal evacuation plans in emergency 'grab bags' located by the exits. These plans had been updated to reflect people's support needs, medical history, allergies and how they could be moved out of the service if necessary, such as if they required 2:1 support. First aid boxes were checked and replenished when needed and these checks were appropriately recorded by the nurses.

Requires improvement

Is the service effective?

Our findings

Relatives told us the staff were skilled and efficient. One person said, "The staff really know what they are doing, they know and read [X] well" " The staff seem to be communicating more with the families now, this has improved a lot, we are kept well informed" and, "The staff are more alert, more 'on the ball' than they used to be, it is so much better." Staff told us, "We get really good support from the provider, the directors, the nurses and the acting manager; quite a few changes have really paid off over the last few months, the staff are more involved."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who were unable to come and go as they pleased or when they needed continuous supervision to keep them safe. Improvements had been made, such as when people used bed rails or restrictive straps or belts in their wheelchair, their mental capacity to consent to these restrictions had been assessed. When people had been assessed as not having the mental capacity, discussions with their legal representatives had taken place in their best interest. This ensured people's rights to make their own decisions were respected and promoted when applicable. However, some of the applications to the DoLS office to authorise these restrictions of liberty had not yet been submitted, which meant the system in place in regard to the process regarding the MCA and DoLS was not yet fully effective. Some mental capacity assessments and best interest meetings were still to be completed. The provider and acting manager told us these assessments and applications were in progress and were scheduled to be completed shortly.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the processes of a particular restraint. Following this inspection, we were provided with records that showed the restraint had been lawfully applied and was still current. Demonstrating good practice, the provider had taken steps to review the reasons why this restraint was used and had discussed with appropriate parties how less restrictive options could be considered. As a result, the restraint had been replaced at specific times with one to one support from staff.

At our inspection in December 2014, we identified improvements needed to staff training in the principles of the Mental Capacity Act (MCA) 2005 and DoLS. At this inspection, we found improvements had been made. The staff had received training in the MCA and DoLS online and also face to face with a qualified trainer. They were knowledgeable about people's rights relating to mental capacity and consent. One member of staff told us, "Even if a person may not have the capacity to consent one day they may have it the following day so we must never assume they cannot consent or automatically decide for them" and another member of staff said, "Mental capacity is all about making decisions and deciding what is in people's best interest." This showed staff had gained a good understanding of MCA key principles from their training.

Essential training was provided so that staff were knowledgeable and able to deliver care to people effectively. Additional training specific to people's needs was provided, such as epilepsy awareness. Staff told us, "This training was really excellent, the qualified trainer had experienced epilepsy themselves, therefore was able to explain to us what happens and how people feel when they have a seizure" and, "The training standards have improved; there is more face to face training where we can ask questions and relate the training to our day to day work." One member of staff had requested 'intensive interaction' training to appraise more effectively how people may feel when they had difficulties with communication. This training had ben facilitated. The provider had scheduled sensory training provided by an expert on sensory needs. Staff told us, "We look forward to this, hopefully after the training we can provide intensive sensory activities at any time people want it."

Staff training was monitored by the human resource officer who ensured staff attended and were scheduled for refresher courses when needed. Updates of attendance were discussed at weekly management meetings. When some of the staff had failed to demonstrate the appropriate knowledge at the end of their training, they were trained again until they were able to do so. Training needs for the service was discussed every six weeks at a clinical governance meeting with the senior management team and action was taken to meet these needs. Disciplinary procedures were in place if any staff behaved outside their code of conduct and these procedures were followed appropriately. This assured people and their relatives that

Is the service effective?

staff were fit to carry out their duties. For example the human resource officer told us, "We give staff as much notice as possible for their training and monitor when they do not attend; three consecutive non-attendance means that disciplinary action is taken."

All staff received an appropriate induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. New recruits were subject to a six months' probation period before they became permanent members of staff. They were provided with a staff handbook which included the service's policies and procedures relevant to their role. They worked towards acquiring the 'Care Certificate' that was introduced in April 2015. This care certificate is designed for new and existing staff and sets out the learning outcomes, competences and standard of care that care homes are expected to uphold.

One to one supervision sessions for staff were regularly carried out in accordance with the service's supervision policy. Staff's training and support needs were discussed at supervision. A member of staff said, "This is useful, this is when we reflect on our practice and bring up any issues." An annual appraisal of staff performance was scheduled for all staff to ensure expected standards of practice were maintained. This ensured that staff were appropriately supported and clear about how to care effectively for people.

Staff were supported to gain qualifications and study for a diploma in health and social care. A member of staff said, "I was encouraged to enrol for the diploma and provided with a lot of support." A practice and skills mentor had been commissioned by the provider and was providing support to staff and monitored their skills and knowledge. Practice checks were carried out by the mentor, the physiotherapist, nurses and the acting manager to ensure staff followed appropriate standards of practice. The role of senior support workers had been created to ensure staff undertook more individual responsibilities. The physiotherapist told us, "The new structure with senior support workers will initiate positive change." A system of 'leads' or 'champions' in a particular field such as dignity, communication or infection control was being set up. This meant that staff could specialise in areas and offer guidance to other staff.

Staff knew how to communicate with each person effectively. People communicated with eye contact, facial and body language or vocally. Staff were able to interpret what people wished to convey and understood people; they responded to people with smiles and verbal encouragement. They ensured they were positioned at people's eye level to facilitate interaction and provided appropriate physical contact and engagement. Staff were aware of the support their colleagues offered to people and took over when they thought it appropriate. For example, one person appeared to have lost interest in their meal and stopped responding to the member of staff who helped them. After a short while two members of staff swapped places with each other to promote a new interaction. The person responded to a different face and voice and resumed eating their meal. This means staff used effective strategies to encourage people's engagement.

We observed staff handing over information about people's care to the staff on the next shift. Staff discussed each person's current health and medical needs, appetite and responsiveness to other people or staff. Information about incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, moods and behaviour was shared by staff appropriately. Nurses updated people's care plans each month and informed the staff of any updates. This system ensured effective continuity of care.

At our inspection in December 2014, we identified improvements that needed to be made in relation to people's oral health. At this inspection, we found these improvements had been carried out. Dental hygiene training had been provided by a dental nurse to staff in May 2015. Care plans included clear instructions for staff about how to keep people's teeth and gums clean.

Staff followed the recommendations in people's care plans.

People's wellbeing was promoted by regular visits or referrals to healthcare professionals such as a chiropodist, a dentists and an optician. People were weighed regularly and their weight was monitored. People were referred to a G.P. when they were unwell or when substantial changes of weight were noted. They were referred to neurologist consultants for regular reviews or when there were concerns about their health. The physiotherapist's input had been increased and people had access to regular physiotherapy treatments. A relative told us, "The physiotherapy is absolutely brilliant."

Requires improvement

Is the service effective?

Staff completed positioning records when people needed to be repositioned to promote their skin integrity. No one in the service was experiencing pressure wounds at the point of our inspection. Vaccination against influenza was carried out when appropriate and when people's legal representatives had provided their consent. Records about people's health needs were kept and information was communicated to staff to ensure effective follow up was carried out. People's families were informed of any decline in people's health and of any health appointments that were made for them. This system ensured that staff communicated effectively with relatives when people's health needs changed. A relative told us, "We are kept in the loop about everything, the staff are communicating with us much better than before."

The cook kept information about each person's dietary requirements in the kitchen. When a dish had to be mashed to facilitate a person's swallowing, it had been presented to look exactly like a dish that had been kept whole. For example, there were two identical-looking lasagne dishes, however one had been modified. The cook told us, "That way people do not feel any different." All meals were cooked with fresh ingredients and local produce was used when possible. Emphasis was placed on presentation. The cook said, "I like the meal to look pretty and appealing for the residents." There were themed days, for example Caribbean food day. Support workers gave feedback to the cook when people had liked or disliked a particular dish and menus were planned and altered accordingly to people's wishes. For example, they had reported that a dish's texture was too thick and the cook had improved this. People were offered fluids throughout the day. Food and fluid intake charts were completed for everyone at the service and records showed what people ate and if they refused meals or drinks. The charts were monitored daily by the nurses. Appropriate one to one support was provided at mealtime and people's pace was respected.

The premises were adapted according to people's needs. There were a physiotherapy room, a sensory room, a hydro pool, large lounges and dining rooms for people to use. There were two laundry rooms and one clinical room. Corridors were wide to accommodate people's wheelchairs and all areas were well lit and welcoming. The bedrooms were spacious and there were large adjoining bathrooms which contained an adjustable bath, graded floor shower with full length shower bench, accessible toilet and basin. Where needed specific toilet chairs were in place. There was a spacious kitchen and several kitchenettes for staff to us with people. The garden included colourful seating areas, a wheelchair swing, a trampoline flushed at ground level and an enclosure where chickens were kept. This provided a welcoming environment where people could be visually stimulated.

Good

Is the service caring?

Our findings

Relatives told us they were very satisfied with the way staff cared for their relatives. They said, "The staff are very kind and patient" and, "The staff approach is very good." One specialist nurse who oversaw the care of a person living in the service told us, "I have no concern about the care that is delivered; the staff are definitely caring and knowledgeable."

At our inspection in December 2014, we identified improvements that needed to be made in relation to people's independence and dignity. At this inspection, we found these improvements had been carried out. We spent time in the communal areas and observed how people and staff interacted. There was a calm atmosphere where people were encouraged to express themselves and staff responded in a timely manner. Staff spent one to one time with people to offer support and companionship. There were frequent friendly and appropriately humorous interactions between staff and people. Staff addressed respectfully by their preferred names. All staff cared for people's wellbeing and paid attention to what mattered to them. For example, staff were attentive to people's moods and talked with people before they helped them go from one location to another. One member of staff told us, "We are careful to assess whether people would prefer to go to another room or not and we talk with them beforehand and ask them."

Care plans included instructions for staff to follow when helping people with their personal needs. People were assisted discreetly with their personal care needs in a way that respected their dignity and each person had their own named individual sling that was used to help them transfer.

The staff encouraged people to do as much as possible for themselves. For example, people ate independently when they were able to do so or helped prepare vegetables before meals with staff. A member of staff had reported to the management team how a person had eaten independently and had taken pride in the person's achievement. The member of staff was enthusiastic and excited about the person's progress with their independence. The staff had received training in 'Active Support' which is a way of providing assistance to people that focuses on making sure they are engaged and participating in all areas of their life. People were encouraged to practise independent movements when they participated in activities and their autonomy was respected.

Staff cared for people in a way that showed they knew each person well. They used people's preferred names. They used appropriate touch and humour. During handovers staff spoke about people respectfully and maintained people's confidentiality by not speaking about people in front of others. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. This ensured staff were aware of people's individual requirements.

Clear information about the home and its facilities was provided to people and their relatives. The service had a comprehensive website that was easy to navigate and contained up to date information. People's families were provided with newsletters about the service. The service's complaints policy and procedures were displayed in the service. There were information boards in corridors to remind staff and visitors about people's perspectives when they experienced epilepsy and communication difficulties. For example, how they may feel about noise and unforeseen events. These boards were renewed regularly to bring information on other topics relating to people who lived in the service.

Each person had a named nurse and two to three allocated keyworkers. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need and developing a supportive relationship with them. People's relatives were informed of who their family member's keyworkers were, although one relative we spoke with was unsure of their identity. This had been raised at a family forum meeting and the provider told us a board with photographs of all staff on duty was in progress.

People or their relatives were involved in their day to day care and treatment. Each nurse was allocated to two to three people. People's care plans and risk assessments were reviewed monthly by the nurses to ensure they remained appropriate to meet people's needs and requirements. The nurses sent the care plans to relatives every six months requesting their feedback. A relative told us, "We are always invited to annual review meetings, but

Good

Is the service caring?

we can always discuss the care plans in between if we feel something should be changed." This ensured that people and their relatives' involvement in their care and treatment was promoted.

Good

Is the service responsive?

Our findings

People's relatives told us the staff responded very well to their family members' needs. They told us, "We find that staff are more alert about and respond better to individual needs", "We used to lack a certain type of input such as more awareness and more physio but this has definitely improved with more training and also with the increase in the physiotherapist's hours." A local authority case manager and a specialist lead nurse who oversaw several people's care in the service told us, "I visited four times recently and found the staff followed people's support plans well and that families were involved as they should be" and, "The nurses in Mary House know the residents very well, they understand their condition and fully respond to their needs."

At our inspection in December 2014, we identified improvements that needed to be made in relation to care planning and staff awareness of individual care plans. At this inspection, we found these improvements had been carried out. Care plans included people's life history, individual needs and risk assessments relevant to every aspect of their care, support and treatment. Attention was paid to what was important to people. Emphasis was placed on what each person liked or disliked and care plans were centred on people's individuality. For example, a person preferred their food to be presented in a specific dish, wished to have baths rather than showers, liked to go to bed at a certain time and disliked noise. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. Nurses reviewed each person's care plan monthly or as soon as people's needs changed. They updated them to reflect these changes and provide continuity of care and support. Nurses ensured care staff were aware of any updates. All the staff we spoke with were able to tell us how each person's support ought to be delivered. This matched the recommendations in people's care plans. We spoke with three key workers who demonstrated a thorough understanding of each person's needs and perspective. One member of staff told us, "It is important to respond in a certain way that is specific to each person to maintain a proper engagement with them." Another member of staff said, "Each resident is unique, so their support plans are unique too."

Before people came to live in Mary House, a comprehensive transition plan was followed to allow people time to decide if they wanted to live permanently in the service. This also allowed staff to get to know the person and adapt their plan of care. People's files about each aspect of their care included completed documentation of 'What is important to me' and 'How best to support me'.

This ensured people could be confident the planning of their care was centred on their individual needs and requirements.

At our inspection in December 2014, we identified improvements that needed to be made in relation to the planning of activities. At this inspection, we found these improvements had been carried out. The provider had implemented an 'Active Support' care framework which includes an activity plan to allow people to express and follow their interests. The practice and skills mentor had started to work with individuals, families and staff to create individual activity plans that enabled people's engagement and involvement. These plans included how to present different options of activities to people giving them an opportunity to express their preferred choice. 'Intensive interaction' training was scheduled for staff in September 2015.

People were supported to take part in local events outside the service whenever possible. A member of staff told us, "We get so much time to do things with the residents here." We observed staff conversing with people and involving them with household tasks such as laundry, cleaning their rooms and preparing meals. A person held their laundry in their lap and felt different textures and temperature while they interacted with a member of staff who loaded appliances. The member of staff told us, "We involve the residents in each activity even if they cannot take the physical lead." Another person was watching television that had been placed into position so it could be seen clearly. A member of staff selected a golfing programme as they knew the person enjoyed watching sport. The member of staff watched and monitored the person's facial expression and talked with them to check this selection of programme was appropriate. Sensory equipment was available and used. An expert sensory advisor was scheduled to assess how people would respond to new equipment using 'eye gaze technology'. This is a computerised technology that tracks people's pupil movements to identify what interests them the most. The provider described to us new sensory

Good

Is the service responsive?

books that had been ordered, to stimulate people's interest. These included 'stories in a bag' where a specific story was accompanied by visual and auditory accessories to provide a physical way of communication.

A broad range of daily activities suitable for people's recreational needs was available. Activities were arranged depending on what people wanted to do each day. People were consulted about their preferred activities using individual methods of communication and staff recorded when they had enjoyed any activity or when they had declined to participate. Each person had daily access to the hydro pool and was assisted with physiotherapy sessions. People attended a day centre, with support from staff, where activities such as art and crafts and activities based on visual and auditory stimulation were available. In house activities included visits from a pet-therapy service, watering plants and light weeding, playing music, pampering with a manicure and make-up sessions, looking after the chickens that were kept in the grounds. Ten pin bowling equipment had been purchased after people had particularly enjoyed an outing to a bowling alley.

People were helped to go out regularly and this reduced people's social isolation. Key workers supported people to go on outings of their choice. Two people had recently attended a singing concert. People had visited farms during the lambing season and were taken out to cafes and shops. There had been a recent 'Wimbledon day' theme where people had enjoyed scones, strawberries and a barbeque. Staff planned two similar activities monthly and a Caribbean night was planned in the pool area with palm trees and an exotic food barbeque later in the month. A poster was displayed for relatives with relevant information on activities. The provider organised regular fun raising events where all people and their families could be involved, such as a 'Sandwich prom' and 'car challenge' trips abroad. People's friends and families were welcome to visit them at any time, participate in activities or share a meal and people's birthdays were celebrated.

People's bedrooms reflected their personality, preference and taste. They were individualised and contained personalised decorations, photographs and accessories that were meaningful to people.

Family forum meetings that were chaired by a relative were held monthly and recorded. Every other meeting included staff or a member of the management team. Issues that were raised were responded to. For example, at the last meeting, parents had requested the provider carried out improvements to communication between people's families and staff. As a result, a director had included 'family communication' in staff supervision records to monitor how key workers involved families. One relative told us, "The management team seems to pay more attention to communication on the whole."

People's relatives were aware of how to make a complaint. The complaint policy and procedures that had been updated in January 2015 were displayed in the service. We looked at recent complaints which had been addressed according to the service's policy. When complaints had been found as substantiated, lessons had been learned and action had been taken to ensure such complaint will not recur. For example, a complaint about communication with families about referrals to healthcare professionals had been addressed satisfactorily. As a result, the nursing staff followed new procedures to keep relatives informed. This meant that people could be confident that their complaints were responded to.

Requires improvement

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People's relatives told us, "The management of the place is definitely improving" and, "We look forward to having a permanent manager around to provide consistency and stability." Staff told us, "There is so much improvement, the whole team have worked ever so hard to improve the standards and it is paying off." Staff told us they could come to the acting manager, the skills and practice mentor or any of the directors for advice or help. All of the staff we spoke with told us that they felt valued working in the home. Two staff members told us, "We are getting proper training so we can take proper care of the residents", "I love this place, I would not want to work anywhere else" and, "We are a good team and we work well together, there is guidance, advice and support."

At our inspection in December 2014, we identified improvements that needed to be made in relation to the lack of a registered manager, effectiveness of audits and documentation. At this inspection, we found that some improvements had been carried out although new systems had not yet been fully embedded.

Audits were completed and when a shortfall was identified, clear remedial action was scheduled. However, it was too early to fully ascertain whether the monitoring process was effective in ensuring all actions had been completed. Audits were carried out by several directors and the acting manager . In the absence of a registered manager, these audits were not consistently monitored by a designated person who had responsibility for monitoring the quality assurance at the service to ensure they were fully effective. Clinical governance meetings were held every six weeks that included the senior management team, the acting manager and human resource officer. All remedial action that followed our last inspection was monitored for implementation and progress at these meetings. The provider told us, "We have worked round the clock to drive improvements and so much has been done, also more needs to be done and this is a work in progress." Additionally, the provider planned to commission an external quality assurance assessment service in October 2015, to support the newly recruited manager and monitor all existing quality assurance systems.

The directors and acting manager carried out regular audits to monitor the quality of the service and identify how the service could improve. We checked audits that were carried out for infection control, medicines, complaints, incidents and accidents, health and safety, maintenance of premises, deprivation of liberty and care documentation. They were appropriately completed although a system of documented cleaning schedules had not yet been used by housekeeping staff. The provider and acting manager showed us the process they had started to assess people's mental capacity regarding certain decisions. This was a positive improvement, however not all assessments had been completed and further applications relevant to DoLS had yet to be completed and submitted. There was no registered manager in post, however a candidate had been appointed to start in September 2015. A relative's representative had been invited to be part of the panel during the interview process.

Policies were appropriate for the type of service, were reviewed annually and were up to date with legislation. They were fully accessible to staff for guidance and were easy to read. They were updated regularly by a director and staff were made aware of any updates by way of 'staff bulletins' that accompanied their payslip. Staff also held summaries of key policies in their staff handbooks. One member of staff told us, "The policies are simple and very clear; they are a good point of reference."

The acting manager, the directors and the provider were open and transparent. The acting manager consistently notified us of any significant events that affected people or the service. A meeting with people's relatives, the provider and trustees had been held to discuss concerns that arose since our last report and share plans for improvement.

The provider had ensured improvements in the service had been implemented as per their action plan in response to our requirements. These included an increase in staffing levels, the appointment of a new permanent manager and a skills and practice mentor, an increase in physiotherapy involvement, a change of documentation system throughout the service, a comprehensive staff training programme, and the implementation of an 'Active Support' care framework. The management team and acting manager were visible within the service and were able to observe staff practice, interaction and engagement with people. This provided staff with guidance and encouragement.

We witnessed a management meeting where topics and issues were discussed at length. These included staff

Requires improvement

Is the service well-led?

training and competency, assessments of people's mental capacity, equipment, and the monitoring of accidents and incidents as well as updates about people's individual needs. The provider checked on the progress that had been attained since their last meeting, and tasks were clearly allocated to staff with scheduled completion dates. This ensured the members of the management team were clear about the action that needed to be addressed within a set time frame.

Staff team meetings were held monthly to discuss the running of the service. Staff contributed to the agenda and were able to speak freely. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. Staff told us these meetings were an opportunity to raise concerns, share good practice and learn from each other. Additionally, there were house meetings held monthly between senior support workers and the management team and a monthly meeting between the nurses and the acting manager.

This system of communication meant that people's changes in needs were discussed and responded to appropriately.

Surveys were carried out to assess people's relatives satisfaction about the overall quality of the service. One survey had just been completed and was in the process of being audited. The surveys indicated relatives had acknowledged positive improvements about the delivery of care and the cleanliness of the environment. When issues had been raised by relatives, action had been taken. For example when a relative had complained about their family member's oral hygiene, staff training had been provided and an oral hygiene plan had been introduced and followed by staff.

The provider spoke to us about their philosophy of care for the service. They said, "We strive to provide our residents with the absolute best life possible, and as part of that vision I want to see our staff develop to become even more creative and focussed on helping our residents achieve everything they want." From what people and the staff told us and from our observations, the staff took action to implement these principles in practice.

All records and documentation that we saw were easily accessible, well organised, completed, maintained, updated appropriately and fit for purpose. Computerised data was password protected and backed up on an external device to ensure it would be retained in case of power failure. People's files were stored securely and confidentially. Archived files were appropriately stored and disposed of safely within legal time frame requirements.