GCH (Martins House) Limited

Martins House

Inspection report

Jessop Road
Stevenage
Hertfordshire
SG1 5LL

Tel: 01438351056
Website: www.goldcarehomes.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Martins House is registered to provide accommodation and personal care for up 60 older people some of whom live with dementia. At the time of our inspection 47 people were living at Martins House. We previously inspected in December 2015 and found the service was meeting the required standards at that time.

The inspection took place on 11 August 2016 and was unannounced.

Since our last inspection there had been significant changes within the senior management team and new ways of working at a senior level were being implemented with the further development of a service quality improvement team. The registered manager who previously worked at Martins House had been transferred to another home owned by the provider after our inspection in December 2015. At the time of our inspection a manager had been recruited who was due to commence employment on 15 August 2016. The home was also without a Deputy Manager and the provider was in the process of recruiting for both positions.

Martins House had two managers since the registered manager's departure who had not registered with CQC and had both subsequently left the organisation. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We inspected Martins House due to concerns raised with us by the local authority. These were related to people's continence needs were not being met, care was not being provided safely and regularly reviewed, and there were concerns regarding the competency and deployment of staff to meet people's needs. We found at this inspection breaches of Regulations 09, 10, 11, 12, 13, 14, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. Following this inspection we took urgent action to suspend admissions to the home and sought urgent assurances from the Provider about how they would safely meet people's needs.

At this inspection we found that there were numerous permanent staff vacancies and as a result there was a use of agency staff mainly at nights. This led to inconsistencies in the quality of care people received. People experienced delays in getting assistance and also receiving care when they needed it. People's continence needs were not met in a prompt manner as required. Risks to people's health and well-being were not consistently identified and responded to positively. People's medicines were not administered at the times indicated by the prescriber. The environment people lived in was not effectively maintained and cleaned.

Staff shortages and lack of skills of some of the staff working at the home had impacted on care delivery, maintenance of records, and the management of medicines and people's access to health care professionals. Staff told us they did not feel supported and had not received appropriate training to carry

out their role. Staff morale in the home was low, and they told us they did not feel supported by the managers or the provider.

Permanent senior staff responsible for providing leadership on each of the floors of the home had limited support and training from the provider to be able to do this effectively. The training and development deficiencies had impacted on the care people received. People's nutritional needs were not consistently met and monitored. People were not freely able to choose what they ate and people were not always referred promptly to the range of health professionals when their health deteriorated.

People's dignity and privacy was not protected by some staff and people were not cared for in a manner that promoted their wellbeing and personal hygiene. Some people were observed to be left in an undignified manner; however we also found that some staff interacted with people in a kind and friendly way. Some of the people we saw were comfortable in the presence of staff and close relationships had been formed.

We observed staff delivering care and support in a task orientated way and there was little interaction seen between people and staff. People's social needs were not consistently met and there was little opportunities for them to pursue their hobbies and interests. People were unsure of where or to whom they were able to raise their concerns and complaints, and relatives told us that when they had recently raised complaints these had not been thoroughly responded to.

People did not always receive high quality care that was well led. The provider had not taken account of issues identified in other of their local homes recently to review and monitor the quality of care people received at Martins House. A service improvement plan recently developed was not sufficiently robust and did not identify many of the areas identified at this inspection. The provider had not sought to constantly monitor and review the quality and safety of care people received. Care records, and records relating to the management of the service were incomplete. Staff and relatives told us they felt the support from the provider was below of what they expected. The provider had not proactively engaged with people, relatives or staff to try to improve the service delivered. The provider had signed up to a complex care premium programme where they committed to improve staff training, moral and subsequently improve care to people however they failed to deliver on their commitment.

Following this inspection we took urgent enforcement action to restrict admissions to Martins House and imposed this condition immediately following the inspection. We also met with the provider to also seek urgent assurances that people's care needs would be met safely. We have reported our findings to the local authority, clinical commissioning group and local authority safeguarding team.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement are made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People gave mixed views regarding feeling safe living at Martins House; some people felt the home was safe, whilst others told us they did not feel safe.

People were not protected from the risk of harm or abuse because staff were sufficiently trained to identify and report any possible signs of abuse.

Equipment required to keep people safe, or support their health needs was not always in place when required.

People were not supported by sufficient numbers of staff deployed to meet their needs in a timely and safe manner.

People's medicines were not managed safely, and people did not always receive their medicine as intended by the prescriber.

People did not live in a clean and hygienic environment.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received training in key areas to support people's needs and training had not been regularly updated as required.

Staff were not supported by managers through supervisions and appraisals to ensure they had opportunities to develop skills and abilities to provide safe and effective care to people.

People who lacked the capacity to make decisions relating to their care were not supported in line with the Mental Capacity Act 2005.

People's nutritional needs were not consistently met and referrals were not always made to appropriate healthcare professionals when people's needs changed.

Is the service caring?

Inadequate

The service was not caring.

People's privacy was not respected or protected. Peoples dignity was not promoted and people went long periods of time without receiving basic personal care.

Peoples preferences around how they wished care to be provided was recorded, but not provided in this manner.

People did not always feel that staff or management listened to their views.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive personalised care from staff.

People were not provided with the opportunity to pursue their individual hobbies and interests, and people who chose to spend time in their rooms received little attention or stimulation from staff.

The dementia environment was not suitable to support the needs of the people who lived there.

Some people and relatives told us they were aware of how to raise concerns or complaints with staff but did not feel confident that the interim management arrangements will deal with their concerns

There were no arrangements in place for people or relatives to provide feedback about concerns or complaints they may had through forums or meetings.

Is the service well-led?

Inadequate

The service was not well led.

The home was without a registered manager, and the interim management arrangements had not been sufficient to provide clear leadership in the home, and to provide clear accountability that was understood by all staff.

There were no effective systems to monitor and improve the quality and safety of the service provided.

Previous areas of concern identified at other homes operated by the provider had not been reviewed, identified or acted upon at

Martins House.

There was not a robust system of governance in place that ensured people received care that was safe and of high quality. Meetings had not been regularly held with staff and feedback had not been consistently sought about the quality of care the service provided.

People's care records were not accurate and fit for purpose and did not reflect people`s current needs.

Most people told us they had poor communication with the interim management team.

Where local initiatives were available to work in partnership with key organisations, including the local authority, clinical commissioning groups, and voluntary training organisations to support care provision and improve care they had not done so.

Notifications of incidents had not been submitted to the Care Quality Commission as required.

Martins House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place at Martins House on 11 August 2016 and was unannounced. On 09 August 2016 we received feedback from health professionals about the quality of care provided that suggested the care and environment people were provided with was unsafe.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has experience of the type of services provided at Martins House.

Before the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff supporting people; we spoke with 12 people who used the service and the relatives of five people. We spoke with nine staff members, a member of the quality improvement team, the quality improvement director and three visiting health professionals.

We also reviewed the findings of a service monitoring audit carried out by the local authority. We sought feedback from the social care professionals who raised the initial concerns, and members of the local authorities commissioning team and local safeguarding team.

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 reviewed care records relating to 10 people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and associated management records.

Inadequate

Is the service safe?

Our findings

Some of the people we spoke with told us they felt safe living at Martins House. One person said, "Yes I feel safe here the staff work hard." However other people living in the home told us they did not always feel safe. One person said, "No I don't feel safe all the time, sometimes not knowing who the new staff are [Agency] at night is frightening." People's relatives also felt that at times there were concerns around people's safety.

Staff we spoke with were not all able to tell us how they ensured people were kept safe. One staff member said, "They are all safeguarded, that's our job." However they were unable to further explain how they would respond if they suspected a person had been harmed, and was not aware of the various ways people could be at risk of harm. Training records we looked at confirmed that staff had not received training in safeguarding adults from the risks of abuse as required by the provider's policy.
Where some staff identified concerns relating to a person's safety they did not consistently report this for further investigation. Staff told us they only reported an injury if they had witnessed it and did not report unexplained bruises found on people. One staff member said, "If it's bruising then I will do the body map and make a note, but that's it, and if I don't see them fall then I'm not reporting it as I don't know what happened." A second staff member told us, "If the incident doesn't happen in front of me so I witness it, then I don't complete an incident form." We confirmed this from care records that some body maps had been completed if a person had a bruise or fall, however also confirmed that these had not been further escalated as required. For example one person was found to have a haematoma on their right leg. This person was in pain and agitated. Lorazepam (medication to calm anxiety) was given, however no review of how the person sustained this injury. Later staff identified a blood blister on the same person's right elbow. A third person was seen to have bruising to their hand; this had been recorded in the body map but not reported to the management. This meant the provider had not ensured appropriate systems and processes were in place to protect people from harm, and to investigate potential abuse to people when it was reported.

People were left in their rooms whilst asleep with doors open and staff not supervising them. This placed people at risk of harm from other residents or visitors who may enter their rooms uninvited. One person was found on the top floor to be lying unclothed on top of their bed sheets. A plate of hot lunch was next to them and staff had clearly brought them their meal, left the door open, and left the unit unattended. This left the person at risk of harm and in a vulnerable position from other people resident in the home or visitors who had free access to this unit. This was confirmed by the quality team manager who also witnessed this person in their room.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety and wellbeing were not identified or appropriately managed by staff. Senior staff supervising Martins House whilst a manager was recruited were unaware of the needs of people living there. We asked about people who may have a pressure sore and were told of one unclassified grade 3, and were told there were no moisture lesions. However care records and staff we spoke with demonstrated there were five people with moisture lesions.

People at risk of developing pressure sores had in place the appropriate pressure mattresses; however when we checked to see if equipment was used when they were sat in the armchair we found it was not used for some of those who required this. This meant people were at risk of harm through developing pressure sores because staff were not using the required equipment to mitigate this risk. One person's relative said, "[Person] is safe but the care and attention has been sloppy at times they [staff] leave [Person] in the wheelchair a lot, I moaned about this and it has got better, but [Person]still got sores on their skin because of this but they are clearing up." Staff spoken with were unaware of any techniques they could successfully use to encourage the person to sit in an arm chair, and the accompanying care plan had not identified this area as a potential risk to the person's skin integrity or explained the risks of developing a sore to the person.

Risks to managing people's skin integrity were not managed to prevent further skin breakdown. We observed people had extensively dry and flaking skin on their ankles and legs which appeared red, inflamed and sore. People's care records did not document that staff had applied creams and emollients regularly, and were unable to establish that this had occurred by speaking with staff. We later confirmed through discussion with the quality manager that creaming regimes were required to be in place for these people, however this had not been completed. Furthermore we observed that people who resisted personal care had not been bathed, showered or washed for extended periods of time. A lack of appropriate hygiene for people increased the risk of complications associated with poor skin and personal care.

The senior team identified two people who they told us were at risk of falls, however during the inspection we found further people who were at risk from falling or had experienced unreported falls. For example one person had been referred to the GP for a sudden decline in mobility. This was in June 2016. The GP recommended that leg stockings to be used to reduce swelling to improve stability. Leg stockings were not used, and the person was not seen using them on the day of the inspection. A review of this persons care plan was last completed in July 2016 and considered them to be at high risk of falls. Staff had recorded that for all transfers, two staff were required, although it was not clear why as the person was able to mobilise, freely walking to the toilet during the night. Following a number of recent falls staff had subsequently not considered using equipment such as a sensor mat to alert staff when the person got up during the night. This person's family member confirmed to us that there had been four further falls in addition to the two recorded however these had not been documented and did not prompt a further review of the persons mobility needs. This person's relative told us that when they requested a sensor mat following a fall, staff told them they would need to wait for an assessment. This was not completed. When brought to the attention of staff a sensor mat was put in place immediately during the inspection; however, this person had suffered unnecessary falls in the interim period which had not been appropriately managed to reduce the likelihood of them recurring.

People's medicines were not managed or administered safely. People who required medicines to be administered at specific times or following specific prescribing instructions did not receive this. For example, one person required a medicine to be administered 30 minutes before food was given. Staff told us they had given the person, "…A bit of toast five minutes ago, I didn't know it needed to be thirty minutes." A second person's medicine was prescribed to manage the symptoms of their dementia and had not been administered. A third person had tablets to manage symptoms for their heart condition delivered the day prior to our inspection. The person should have been given one of these tablets however the same quantity remained in the unopened box, with a note suggesting that staff were still awaiting delivery of the stock, and were therefore not aware it had arrived. One of the medicines rounds continued until 11:20 on Butterfly unit. We asked the senior staff member why it had taken so long to administer people's medicines. They told us, "It always takes this long as there are so many medicines to give in the morning."

Staff were seen to cut tablets into halves however this is not following best practise as the staff member cannot be assured the person is getting exactly the right dose, and it is unhygienic to leave half a remaining tablet in an unsterile packet until the next dosage is due. The staff member we spoke with was unaware of the guidance around cutting tablets. This meant medicines prescribed for specific health related conditions were not given as the prescriber intended.

People did not live in a clean environment. We observed chairs were stained and had dried food debris on the arms rests. One person we observed was sat in their chair in their room with crumbs around their feet and brown sticky stains between the side of the chair and the seat cushion. A second person was observed to have food stuff ground into the carpet that was not cleaned during the morning of the inspection. Once it was later cleaned there continued to remain foods stains in the carpet. Communal areas were poorly maintained, floors and surfaces were sticky and carpets were unclean. Shortly after we arrived at the home, we saw three agency staff removing clinical waste bags from a downstairs bathroom where they had been stored overnight. This meant a malodour was emanating from this room, around areas that people lived and slept.

The lack of risk assessment and management of identified risks; unsafe medicine management; unsafe care delivery and poor infection control processes was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were insufficient numbers of staff deployed to keep people safe and meet their needs as care was delivered in a task orientated manner. When people summoned assistance they were had to wait a long period for a carer to assist them. We observed that that call bells were taking up to 10 minutes to be answered by staff. One person was pressing their call bell because they were distressed, and a second because they wanted staff to assist them. Both had to wait an extended period of time which increased their anxieties unnecessarily. We observed that one person fell asleep with their cereal in front of them from 8:25 to 9:45. Although staff popped in and out when bringing people into the room to have their breakfast, they made no attempt to wake this person up to encourage them to eat and drink.

The management team supporting Martins House had not considered people's needs when setting the staffing levels for the home. When we asked for a copy of an assessment tool to establish the number of staff required, the quality manager was unable to provide us with this. Assessments of people's dependency had been completed in some people's care records, to indicate the required level of care they required, however, these were ineffective as care had not been recently reviewed for many people, and was therefore unreliable to set staffing levels.

Staff worked in a task orientated manner and did not have sufficient time to spend with people when this was required. We found people were being left long period of times sitting in the dining areas, bored unstimulated and asleep. People, relatives and staff told us the home had a reliance on agency staff, particularly at night. Staff rota's we looked at confirmed that nights were reliant on agency use and as a whole, agency usage was 13 percent. On the morning of our inspection we found that six staff were on duty the previous night. One staff member was shadowing as they were new, two were permanent staff and three were agency staff. When we spoke with the agency staff only one of them were aware of people's needs. One staff member said, "We are short staffed in the afternoons and we use a lot of agency on the night shift, we have training put up on the board then it gets cancelled so it never happens, let's hope things change now CQC are in as this cannot go on." One person's relative said, "There are staffing issues here, and the regular staff are trying their best but with no manager at the helm it's bound to have an effect on the running of the home." One person said, "At night I am better off to not ask for help as the temporary staff are no good and can't help me."

Upon arrival we looked around the home and found numerous beds in bedrooms were stripped, and people were up and dressed. Some of these people were asleep in their chairs, and had been for a period of time. One staff member told us that people had to be got up in the morning because the bed sheets, nightwear and continence pads for people were soaked through because staff had not checked them during the night. One senior staff member said, "I have issues with the night staff, when we come in people are wet, or up when they shouldn't be. We shouldn't have to come to work and bed strip because the sheets are soaked, I can't say if it is laziness but we use a lot of agency who don't know people." One night staff member said, "We get people up, all of the two for transfers are up and dressed ready for the day shift. The night staff know what they are doing but not the day." Through discussions with the day and night staff we found there was a blame culture with neither looking to address the issues to ensure people's needs were met effectively, regardless of what shift they worked. One staff member commented, "There's no leadership on the floors, nobody organising or allocating our day so we know where we are based, the day staff think they are working harder than the nights and the night staff think they are working harder than the day staff, its petty and it's the residents who suffer."

This meant that the deployment, of staff, with the necessary skills to provide care to people when they required it had not been provided. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff did not receive appropriate support or professional development to carry provide effective care to meet peoples care needs. One staff member said, "Training goes up on the notice board in the staff room but then is cancelled." We found that important training subjects had not been provided to staff. No staff had undertaken training in areas such as supporting people with dementia, or mental health awareness. Staff demonstrated little awareness about the principles of good dementia care and they struggled to describe how to provide care and support for people living with dementia. For example some people had not been given showers or baths because staff did not know how to get people to agree to have one. One visiting professional said, "[Person] would love to have a bath, have their hair done and make up, but they can be time consuming and challenging, but, there will be that hour in the day when staff can assist them, but they don't have the skills to know when that hour is." Training records confirmed that of 46 staff, 32 had not undergone annual refresher training in moving and handling, and additional training in areas such as care planning, dignity awareness and challenging behaviour had not been provided to any staff.

Senior staff had not received training in areas such as care planning, assessing people's needs such as falls, nutrition or risk of pressure sores, and some told us they felt ill equipped to carry out their role. One senior staff member told us, "This morning they [Management] gave me the care audits to do, I've never seen one before and don't know what to do, but they don't show us, just tell us. Yesterday I was told to do the BMI (Body mass index) but again I didn't know what to do so looked on the internet luckily." The lack of staff training in key areas had negatively impacted on the quality of care people received.

This had contributed to staff morale in the home being very low with staff telling us it had recently been a very difficult period for them since the previous registered manager left. One staff member said, "I find it stressful here. At first I loved it but we are not getting any support. I haven't had any supervision either though I did get some induction training." Staff told us they had not received supervisions or an appraisal of their performance by either their line manager or any of the management team, in some cases this was for a period of two years. New staff had not had an appraisal of their performance by a manager and existing staff had not received regular observations of their competency. One staff member told us, "I cannot remember the last time I had supervision or training, morale is low and although we have been told that there is a new manager starting Monday I question if they will stay long considering the last three managers who left. I feel vulnerable and we are trying to do our best but it is a struggle, there are clearly issue's within the company as really good managers are throwing the towel in and leaving, I have had no whistleblowing training, no refresher training, this home is falling apart."

The provider was involved in a local initiative delivered in partnership with the local authority and local training providers that was designed to provide additional training to staff to enable them to provide enhanced care for complex conditions in care homes that was both high quality and sustainable. We found that staff had not been provided with the training needed to deliver this improvement in care, and the management team had done little to address this.

The failure to ensure there were suitably qualified, competent, skilled and experienced staff who were

supported to provide effective care was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection applications to deprive people of their liberty had been made for some but not all the people living in the home. The quality manager had recognised this and requested these to be done, however were not completed for people who required this. On the day of the inspection an assessment was being carried out for a person who required a DoLS application.

This meant people deprived of their liberty for the purposes of receiving care had not had an assessment carried out by the local authority and the appropriate legal authority put in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food at Martins House. One person said, "The food is nice and we are given choices of what we want" A second person said, "What I like is it's not messed about with, its good home cooking and I like that."

When people were at risk of weight loss we saw they were not consistently referred to a GP or dietician and where people had been referred, dietary advice was not always followed. For example, one person was seen by the dietician whilst they were admitted to hospital. Weekly weighing was required to monitor the persons weight, however when we asked staff if this was currently being carried out, they were unaware this was required. Weight records showed the person as weighed monthly, although this was not completed in June 2016 and not weekly and required. Weight loss was calculated by the inspector as 8.1kg since April 2016 and this person was observed to be left asleep in the chair throughout breakfast time with staff making no attempt to wake them or prompt them to eat. Further referrals to a GP or dietician had not been made, and their weight loss continued to be unresponded to.

We found further examples where weight loss had gone unidentified, or not responded to, and also where people had not been weighed as required. For example, a second person had been weighed in April 2016 and not again until August 2016. During this period the weight loss was recorded as 5.6kg, however the accompanying care plan recorded, "No change." Professional visit logs contained no evidence of GP involvement or dieticians. When asked, staff told us that nobody needed monitoring on the unit; however we had identified a number of people who had lost significant weight and did require monitoring.

We found that referrals to health professionals were made when required, however this was not consistent. A range of health professionals visited Martins House to support people's health needs such as the GP, mental health teams, district nurses, dieticians and chiropodists. However, we found during the course of this inspection that due to a lack of effective and robust reviews of people's needs, they were not always referred to health care professionals when their needs changed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Inadequate

Is the service caring?

Our findings

People we spoke with gave differing views about how staff treated them with dignity. One person said, "Staff are nice and I really like [Staff member] they are lovely and kind." However, our observations and feedback from other people and relatives demonstrated that not all staff maintained people's privacy or dignity.

When some staff provided personal care to people they did so behind closed doors, and most staff were seen to knock on a person's door before entering. However, whilst we in one person's room talking to them and their relative, a staff member entered the room. They did not knock to introduce themselves, or ask permission to enter the bedroom. They proceeded to walk around the room looking around, on the floor and shelves, and left, without apologising or giving any explanation as to why they had entered a person's room without permission. The person's relative commented to us once they left the room, "This is exactly what I mean, who are they? And what are they doing? This is my [Relatives] bedroom and they just walk in?"

We observed three further separate occasions where staff did not promote people's dignity when people were hoisted in a manner that exposed them inappropriately whilst in the hoist. One occasion was observed by the quality team manager who intervened and ensured the person's dignity was then met.

People's personal care needs were not met. Some people were not dressed in clean clothing; their hair was uncombed, unwashed and greasy. People's finger nails were dirty, and their toe nails were long, discoloured and some had begun to curl under their toes. One person was seen walking along the corridor when we arrived at Martins House. Their continence pad had clearly leaked and their trousers were wet. A second person was sat in their room, calling out for staff. When we entered the room they were sat in a chair in the corner underneath a window with a breeze blowing across them. When we held their hand they were cold to touch, had no socks or slippers on and were clearly distressed. We saw this person was dishevelled, had toe nails protruding past the ends of their toes and their feet were purple. Staff had not responded to this person, and did not do so for the ten minutes we spent with them in their room providing comfort. A third person was heard to walk along the hard floor with their toenails clicking as they walked with no slippers or socks on. We were unable to find from people's care records that they had received regular nail care by staff or by any professionals and staff did not know if people were regularly seen by a chiropodist.

Planned personal care had not been provided to people when required. Bath recording sheets were reviewed and demonstrated that between the periods of the 04 July 2016 to 08 August 2016, 11 showers and 16 baths were given to people living at Martins House. One person's relative told us, "I insist my mother is bathed every Wednesday and that does happen." There were 47 people living at Martins House on the day of the inspection, however, for eight people we reviewed there was no evidence of a bath or shower being given during this time period. No other evidence was provided to inspectors when requested to demonstrate the bath records retrieved from each bathroom were incomplete or inaccurate. We asked staff why some people living at Martins House had not been bathed or received their basic personal care. They told us that people at times refused personal care, and this was due to them having dementia. These people did not have any care plans in place to manage their refusals for personal care, and staff had not received the appropriate training to equip them to manage this positively.

We saw that people's bedroom doors were left open, both when people were in their rooms and also when they had gone to communal areas. People who were asleep in bed were visible to any person walking along the corridor, meaning their privacy and dignity had not been considered. Care records did not document whether people wished their doors to remain open or closed. In addition to the person reported elsewhere who was lying on their bed unclothed, we observed a number of other people who had their bedroom doors wide open whilst asleep, or whilst awaiting personal care who were in an undignified manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive consistent care from staff in a kind, caring and respectful manner. Some staff approached people in a calm and respectful manner, addressing people by their preferred name, and had developed close ties with the people they supported. However, one person told us, "The staff are caring but they are always so busy they don't have time to talk to people. There are a couple of carers [Agency] that are rather rude and I don't like them so I won't ask for help from them, I ask the staff I trust." We observed one staff member who was not an agency staff member at lunchtime assist a person with their creams. The staff member sat with the person who was alone at the table and was heard to say, "I know you are eating but I just want to put some cream on your forehead." Whilst saying this, and not waiting for the person to acknowledge them they put on their gloves and massaged the cream on the person`s forehead in the view of other people in the dining area and the inspector. This alarmed the person considerably who after they were interrupted, refused to eat anymore leaving half of their meal on the plate. We were further told by staff that this person was not eating well and they were monitoring this. This approach did not demonstrate that care was provided in a person centred manner, from staff who had awareness of the person's individual needs.

Care was not delivered in line with peoples preferences. Assessments that had been completed sought to understand people's life history, the times people liked to get up or go to bed, preferences around the gender of the staff that assisted them and when and how they wished to be bathed. We found that some of these had not been completed in line with people's documented wishes. For example, one person had documented in their plan merely, "To give [Person] a bath or shower from time to time." They had informed staff they wished to be bathed regularly, however in the previous six weeks we found they had been given two. This was also during a period of very high temperatures and did not promote people's personal hygiene to protect their dignity. We found further examples where people's preferences were not met. For example one staff member commented how a person liked to have their makeup applied, their hair brushed and combed, and to wear jewellery because it made them feel good. They told us about this person's usual daily routine, and how they liked to be cared for. However this person was later seen to be in an unkempt state and not in the manner that the staff member described them to us.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People we saw throughout the inspection were either sitting in communal lounges watching television or in their rooms. One member of staff was observed to be sat at the rear of the room watching the television with no interaction with people sitting there. Of the 15 people sat in the communal lounge at 10am, 10 were asleep, and one was heard to say, "I'm bored; I'm going back to my room." Staff told us there was due to be a visiting shop at 11am, however we did not see this take place and observed staff using a ball and a basket in the lounge, for which most people were uninterested in.

People who chose to spend time in their rooms were seen to be left with little interaction or stimulation. People told us that most staff did not spend time with them consistently or in a way that they preferred. For example one person's engagement and occupation care plan recorded that "[Person] is a happy and social person, we have chatted to [Person] who was singing and having fun in conversing with us." The care plan update stated that, "[Person] chooses to spend time in their room. Staff to interact with [Person] for their well-being." We spent time observing this person on the unit. Staff were only seen to interact with them when they were agitated and banging their cup on the table. They spoke with them when they brought their meal and drink, however no observation of talking or singing or encouragement was seen. Daily records did not record that staff had taken time to meet this persons individual preferences, and opposed to being the happy and social person staff initially recorded the person to be, they were observed to be withdrawn, agitated and sad. One person said, "The home just doesn't have a soul, it lacks the heartbeat it used to have and I hope we can get it back." We observed other people in the home who were sat in their room with little to stimulate them, some had the television turned on, however others were sat in a chair waiting for staff.

One staff member told us, "We have a good team here, the permanent staff are trying our best, we do activities here for the residents and we have a Friends of Martins group that supports us. They gave us money for resources and I know head office promised to donate £250 but we never did get that money."

There was little provided for people in relation to rummage or reminiscence items for people. People who lived on the dementia unit were not seen to interact with other people in the home, and were excluded from many of the homes activities. Staff told us that people living with dementia were not provided with opportunities to regularly leave the unit for fresh air or to go out for a walk or other activities. One staff member told us, "[Person] used to go out with a carer. We put a DoLS in and we stopped it because they were getting confused. They got agitated when they came back to the home so we stopped them going out." When we looked at the care plan, we saw that no efforts had been made to understand or address the confusion or agitation by staff or by managers. Staff we spoke with were also unaware of how to manage this person's needs to enable them to maintain as much independence as they could.

Across the home people's bedrooms were not always person centred, they were decorated in standard colours, and in many cases were not reflective of the personality or character of the person who lived there.

People received care which was not necessarily how they preferred, was not individualised and did not reflect their choices and this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

When we arrived at Martins House we found the environment was not well maintained, and had fallen below the standards required. Walls and doorframes around the home were damaged, furniture in some people's rooms were also damaged having laminate peeling from them and not in a good state of repair. Furniture within the lounges were full of stains on the seating that had not been properly maintained or cleaned. Carpets around the home and in people's bedrooms were unclean and requiring replacing. The décor around the home was bland and not Dementia friendly. On the dementia unit, seashells that were sharp were stuck and protruding from the wall by approximately four inches presenting a risk of people injuring themselves. We found further areas of wall that had exposed plaster that had not been repaired or made safe. The units were dark, poorly maintained and did not reflect best practise in relation to providing a stimulating, light and airy environment with adequate dementia themed items to support people with dementia. Within the home, the environment was similarly dark and poorly maintained.

Communal facilities, such as dining areas or lounges for people were only available on the ground floor and dementia unit, however for the other people there were no areas on their unit where they could choose to use. Other than people's bedrooms, there were no other places that people could use to entertain visitors or relatives privately, eat a meal with friends, watch television or spend time with a smaller group of people closer to their rooms. In some instances, people chose to not go to the large communal dining area. One person said, "I'm not going down to the canteen, its noisy and it makes me nervous, so I have to eat in my room on my own." Bathrooms in the home were cluttered with hoists and wheelchairs and not available to people to use.

When we spoke with staff they told us that the home had not been redecorated or properly maintained since the provider took ownership. A program of scheduled maintenance and redecoration was not in place, with maintenance staff employed from an external contractor, however regular checks to ensure the home was safe, such as health and safety reviews were also not regularly completed.

People lived in an environment that did not meet their needs, had not been sufficiently maintained and was not suitable to meet the needs of most people living there. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were not aware of who the manager was for them to raise concerns with. Relatives we spoke with were aware of the management changes and told us they had raised concerns with either the previous managers or the regional managers however did not feel their complaints were addressed appropriately. One person's relative told us, "I will complain but never hear back what the outcome is, or see anything to suggest they have taken my concerns seriously. If there are gaps in the management then nothing will be addressed." We were told that people or relatives had complained about areas such as cleanliness or rudeness of staff, however we were provided with no evidence to demonstrate these issues had been addressed.

Forums or meetings for residents and relatives had not been held so people were not able to raise concerns, or discuss improvements required within the home. Due to the changes in management and the disjointed approach the provider had to managing the home, this meant that people`s views were not sought and no improvements were made to the quality of the service provided.

People were unaware of who to raise concerns with, and complaints that had been raised were not thoroughly investigated and responded to this was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The home was without a registered manager, with the last registered manager transferring to another of the provider's homes in December 2015 and deregistering in April 2016. Since then, two managers had left Martins House with a new manager due to start the Monday after our inspection.

The provider did not have effective systems in place to ensure interim management arrangements were adequate when there was no registered manager. They had not learned from or used their experiences in their other services in similar circumstances and had missed the opportunity to intervene to ensure consistency and continuity for people, staff and others. Staff we spoke with were unaware of who they were to report to, or who was in overall control of the home. Effective systems for auditing were not robust and as a result the provider has failed to ensure it has effective oversight of the management of the service.

The provider requires effective monthly reviews are conducted by senior managers to carry out an assessment of key areas such as care planning, nutrition, safeguarding, incidents, and staffing levels. This had not been carried out as required, even where concerns were identified at other locations operated by the provider and overseen by the same regional team.

Systems that were in place within the home were not effectively used to monitor the quality of care people received. Incidents in the home had not been analysed to look for patterns or trends. Where incidents suggested people may be at risk, actions had not been taken to mitigate the recurring risk. People received a poor quality of care because the provider had not used this information to consider areas such as whether there were sufficient staff available, the skills mix of staff working on a particular unit, or whether the needs of people on one particular unit were becoming more complex, therefore requiring greater support. As reported elsewhere in this report, people had suffered harm as a result of poor incident reporting and management and responsiveness to the emerging trends.

The provider did not regularly review staffing levels to keep people safe. We asked to see how both the management team and provider monitored staffing levels. We asked to see a copy of the required staffing levels for the home however; no evidence made available to us that demonstrated a review of staffing hours had taken place. People's changing health and support needs were not considered when developing staffing rota's and dependency tools to assess staffing levels had not been used as required by the provider's policy. When we asked how many staff were required to be recruited, the provider had not undertaken a review based upon people's needs to identify the gaps in staffing numbers. Recruitment in the home had been a slow process, with very little emphasis placed upon recruiting skilled and competent care staff. Due to the changes in management this was an area that had not been given the urgency it required, leaving the home reliant on the use on inconsistent agency staff.

This meant that the systems in place to review and monitor the care people received were not effectively operated by the provider, which subsequently left people, relatives, staff and others at risk of receiving a poor level of care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were not accurately maintained to reflect the levels of care they required at the time. Staff completed daily records of care that people received retrospectively, in some examples three hours after they had provided care or given people food or drink. This meant the entry could not be relied upon to be an accurate reflection of the care received.

Care plans in areas such as nutrition, mobility and mental health did not contain sufficient detail to instruct staff to provide adequate care. For example, one person's care plan details that they could be vocal and resistant to receiving a bath or shower. It documented that staff needed to take their time and talk to the person as they will eventually consent. However, there were no details in this plan about how staff should manage people's personal care needs if they were resistant. Both permanent and agency staff spoken with were all unclear on how to support people and were unclear on people's individual needs. We found that this led to people not receiving care when they required this, for example when we looked at the daily notes these demonstrated that a bath or shower had not been given for the past two weeks for some people. However, some people's care records were ineligible and we were unable to decipher what they referred to. This was in key areas such as people's daily progress notes, or within their care plans, which presented a risk that key information about people's health needs may be misinterpreted or completely omitted. One member of the management quality team told us, "I have trouble implementing that staff should complete these as they go along after each task. I have put memo`s up on the walls, had staff in my office so it is a lengthy process to teach them." We observed this practice across two units, but no improvements since management had addressed this.

Where staff entered medicines into the medicine records by hand, they had not ensured this was witnessed by a second staff member and signed to mitigate the risk of inaccurate recording of the prescriber's instructions. New counts of medicines brought into stock were not accurately carried forward and tallied with existing tablets and opening dates were not recorded on the boxes of medicines. Where we found anomalies in recording whether people had received their tablets, these inaccuracies meant we were unable to reconcile these discrepancies and be satisfied people had received their medicine.

The provider had not ensured that an accurate record of the care and treatment provided to people was maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff said they felt the service was not well managed and did not provide sufficient resources to help drive improvement. The provider had not included people, staff or relatives in the running of the service and did not effectively seek their views. Feedback surveys had not been completed for people, relatives, and professionals visiting the home or staff. The provider had missed the opportunity to collate feedback and drive improvement based upon this. Staff meetings had not been held regularly with one staff member telling us, "Not for a long time have I gone to a meeting." A second staff member said, "What's the point of going to the meetings, nobody else goes."

All of these systemic failings in effectively managing the home had led to staff morale in the home being very low. Staff told us they felt unsupported by the provider, were unaware of the management changes, and were unaware of who was in charge of the home whilst a replacement manager was recruited. One staff member told us, "Gold Care has massively let down the managers and staff, they don't support us, I used to think the problem was the managers, but it must be the owners because of the lack of support the managers got which made them leave." One person's relative said, "No, it's not well led. I have raised my concerns, spoken with the manager and then the regional manager but it's all in vain because they smile, pretending to listen and nothing changes."

Where opportunities were available locally to help drive improvements in care the provider had not ensured these were taken up. A local care initiative was in place that had been delivered in partnership with the local authority and training providers. The purpose of this was to provide people with enhanced care that would provide better outcomes for people, reducing the number of hospital admissions and also strive to ensure staff felt better supported and confident in the manner they provided care. For example, benefits of the initiative included significant training opportunities on complex conditions for care home staff, gaining five advanced champions, in dementia, nutrition, falls & fragility, wound management and health. The purpose of this was to ensure each champion was equipped with skills to mentor, coach and train all staff in these areas. None of these champions had been implemented in the home; however the provider continued to receive the benefits and enhanced premiums from this scheme.

The provider had missed opportunities to develop and improve the service they provided. Where opportunities were available to work in partnership to improve care, support staff in a positive way whilst developing their skills and improving service development they had not done so. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the running of the service. The manager had not informed the CQC of some of the significant events identified through this inspection when required as they are required to do. These events related to incidents where people had or were at risk of suffering harm or neglect.

This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notification of other incidents The provider had not informed the Commission (CQC) of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) Care was not always provided with the care of the person receiving this. Where people were unable to give such consent because they lacked capacity to do so, the registered person did not act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation (1) (a) (c) (d) (e) The premises and equipment used by the service was not clean, suitable for the purpose for which they were being used, were not properly utilised or properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care

Receiving and acting on complaints

Regulation 16 (1)

Where complaints were received these were not reasonably investigated and necessary and proportionate action was not taken in response to any failure identified by the complaint or investigation.

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 Regulation 9 (1) (2) (3) (I) People's care was not delivered in a manner that met their needs, preferences or reflected their individual choices. People's nutritional needs were not sufficiently met to support their wellbeing.

The enforcement action we took:

The Registered Provider must not admit any service users, which includes service users seeking respite admission or who are admitted to hospital and wishing to return to Martins House without the prior written agreement of the commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (a) Peoples dignity was not maintained as people did not receive the basic personal care they required. People's privacy was protected, promoted or maintained.

The enforcement action we took:

The Registered Provider must not admit any service users, which includes service users seeking respite admission or who are admitted to hospital and wishing to return to Martins House without the prior written agreement of the commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment Regulation 12 (1) (2))a) (b) (c) (g) (h) Care was not delivered in a safe way. An

assessment of people's needs was not always carried out when required out and actions taken to reasonably mitigate the risks were not followed through. Care was not provided by staff who had the qualifications, competence, skills and experience to do so safely. People's medicines were not consistently managed safely and people were not protected from the risk of infection.

The enforcement action we took:

The Registered Provider must not admit any service users, which includes service users seeking respite admission or who are admitted to hospital and wishing to return to Martins House without the prior written agreement of the commission. The Registered Provider must undertake a full review of the needs of each service user and of their current level of risk which must be carried out by a suitably qualified person and the results detailed in writing in each service user's care plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (4) (c) (5) (6) (d) Systems and processes had not prevented people being at risk of harm or abuse and were not effectively operated to ensure concerns were investigated, immediately upon becoming aware of, any allegation or evidence of such abuse. Care was provided to people in a manner that was degrading and people had experienced harm through neglect. People were deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

The enforcement action we took:

The Registered Provider must not admit any service users, which includes service users seeking respite admission or who are admitted to hospital and wishing to return to Martins House without the prior written agreement of the commission. The Registered Provider must undertake a full review of the needs of each service user and of their current level of risk which must be carried out by a suitably qualified person and the results detailed in writing in each service user's care plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (dii) (e) Systems or processes were not operated effectively to ensure the quality and safety of the services provided were regularly assessed, monitored and reviewed to mitigate the risks

relating to the health, safety and welfare of people living at the home.

People's personal records and records relating to the management of the service were not accurately maintained.

Feedback had not been sought to continually improve the care people received.

The enforcement action we took:

The Registered Provider must undertake a full review of governance systems to ensure that they are accurate and relevant to the service.