Quality Care (Surrey) Limited

Marlin Lodge

Inspection report

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23 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service in July 2015 and rated the home as Good overall. When we inspected the service on 22 and 23 November 2017 we rated the service as Requires Improvement overall. This is the first time Marlin Lodge has been rated as Requires Improvement overall. This inspection was announced the day before we visited. This was to ensure a member of staff would be present to let us into the home.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Marlin Lodge provides personal care and accommodation for people who have a range of learning and physical disabilities. Marlin Lodge can provide care for up to 17 adults. At the time of the inspection 15 people were living at the home. Marlin Lodge comprises of two houses next to each other.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission 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.

When we visited the home we found there were issues with the culture of the service. How people were spoken to and how staff interacted with people was not conducive to a caring and friendly culture. Staff were direct with people, or treated them in a way which was not adult like. Audits which were to test the quality of the service were not always effective. The provider was not completing any additional quality monitoring checks to support the registered manager to identify issues and offer a subjective view of the service.

These issues constituted a breach in the legal requirements of the law. There was a breach of Regulation 17 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we asked the provider to take at the back of the full version of the report.

Staff had a good understanding of what would constitute abuse and harm. People were supported to be safe with elements of day to day living and when they accessed the local community. People had risk assessments in place which generally gave information for staff about how to manage people's needs.

Allegations of potential verbal harm were not investigated in a way which was open with actions taken to learn from mistakes made. Some people's medicines and confidential information was not always stored in a safe way. We also identified some hygiene issues in some people's bedrooms and bathrooms.

The practice of staff when supporting people with sensory needs and the way they sometimes engaged with people and supported them was not always effective. Training and the competency of staff was not robustly monitored and evidenced.

Healthy lifestyles and what this means was promoted by the service and some people had been successful in achieving their goals of being a healthier weight. . People's meal experiences lacked a social input.

We concluded that staff did not intend to be direct and task focused with people, but this culture had developed and was not monitored. Staff practice was sometimes disrespectful and people were spoken to in an infantilised way at times. Staff were not chatty and comfortable with people. Meaningful relationships had not been formed with people. Despite most people and the staff had been at the home for a long time.

People's aspirations were being identified by staff who set goals with people and met with them to discuss their care on a weekly basis. However, these were often limited in scope. Time and thought had not always been applied to see how some people's goals and ambitions could be fulfilled. Social opportunities were taking place but most people were not able to access their interests because they lacked the funds to do so. However, creative ways were not considered and staff did not always advocate for people to access these.

The staff said they felt supported by the registered manager and people were familiar with them. When we raised issues with the registered manager they sent us an action plan identifying some of the key issues we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service needed to improve how they promoted people's safety.

The service was not supporting people how to identify and respond to potential discrimination.

Some people's medicines were not being stored safely.

Staff recruitment checks were not fully robust.

People's confidential information was not stored securely.

Staff had a good understanding about how to respond to potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff practice was not being monitored and effectively evidenced.

There was limited value to people's meal experiences.

The service was promoting healthier lifestyles but there were times when this could be improved upon.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff practice and interaction with people was largely direct and task focused.

People were not always treated in an adult way.

People were not always treated in a respectful way.

Advocate services and external organisations were not used to support people to receive advice and information that people requested.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's aspirations and interests were not being meaningfully explored with plans in place to try and make these happen, in a way which fully involved the person.

People's sensory needs were not explored by the service.

We were not confident complaints were managed in an open and transparent way.

People's end of life needs and wishes were not fully captured.

Is the service well-led?

Requires Improvement

The service was not always well led.

The way that people were treated was not always conducive to a caring, friendly, supportive, and open culture.

The audits completed were not always effective.

The provider was not completing any quality monitoring checks.

The registered manager was open to our findings.

Marlin Lodge

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 site visit started on 22 November 2017 and ended on 23 November 2017. We gave the service 19 hours' notice because the home was small and we understood most people went to day opportunities during the day. So we wanted to ensure a member of staff would be present to let us in.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert-by-experience has personal experience of caring and supporting a person who had a learning disability.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with nine people who lived at the home, three people's relatives, three members of staff, and the registered manager. We looked at the care records of three people in depth, the medicines records of six people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and, safety records completed at the home.

Due to technical problems, we did not receive a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

We inspected Marlin Lodge in July 2015 and found the home was safe. At this inspection in November 2017 we found some areas where improvements were required.

During our visit we spoke with one person who said, "[Name of member of staff] shouts at me if I break the rules." We saw in this person's care record that it stated that the person can often make this type of allegation about staff, when they are in shops. We spoke with the registered manager about this comment. The registered manager asked us and this person to join them to have a conversation about this. During this meeting the registered manager did not ask open questions to find out what had happened. The way this was handled was not an appropriate way to investigate this allegation. The fact this person had a history of stating staff shouted at them heightened their vulnerability to be harmed in this way. We spoke with the registered manager about this. They had not considered this heightened risk before. Nor had they considered other ways to protect this person and support staff to manage potentially difficult situations with this person.

We also noted when looking at another person's record that they too had a history of making allegations about staff. Again there was not a solid plan to manage these types of situations other than identifying this issue in their care records. We spoke with the registered manager about this issue. We asked them to consider a different approach about how they would manage such potential situations in the future.

Alternatively, when we spoke with staff about how they protected people from potential abuse and harm, staff had a good understanding about how to do this. Staff told us the possible signs that a person maybe experiencing harm in some way. This included people presenting as withdrawn. Staff told us that they would tell the registered manager if they had concerns. Two members of staff out of the three we spoke with said they would approach the provider if they did not feel their concerns were being acted upon and then us at the Care Quality Commission (CQC). One member of staff said they would contact the local authority safeguarding team if they felt their concerns were not being addressed. These members of staff told us that they had the contact telephone numbers for the local authority and the provider. There was a file in the staff room which one member of staff directed us to, which had the local authority safeguarding telephone number.

When we visited the home on the second day as we rang the doorbell, a member of staff who had not worked on the first day we visited the home came to the door. They opened the door and left the building. Leaving us free to enter the building. They did not ask who we were or check our identification badge. This is not safe practice. The member of staff should have checked who we are before they left the building.

During the inspection we looked at a sample of three people's records. We looked at one person's record who was nutritionally at risk and was at risk of being too low in weight. Staff were not consistently recording exactly what the person was eating and drinking and the amounts. Staff were weighing this person weekly and charting the weight totals. However, there was no reference to their body mass index to check they were

of the correct weight for their height. On balance we could see this person's weight was slowly increasing and the registered manager told us that staff reported to the GP if this person's weight decreases. We concluded that appropriate action was being taken to manage this risk, but there were elements of how this risk was being managed which could be improved upon.

When we looked at people's records they were generally accurate and up to date. However, there were times when information to guide staff about how to manage some people's needs and the risks to their safety was not documented. For example, we looked at one person's record who had epilepsy. It stated that staff were aware of pre-warning signs that this person may experience a seizure. However, this information was not recorded in this person's record. This would have acted as a further prompt to supporting this person's safety.

We found that one person's file was broken which made it difficult to access. We were not confident that the staff were regularly accessing this person's file. We asked the registered manager if staff regularly accessed people's records to ensure they kept their knowledge up to date so they can keep people safe. We did not obtain a clear answer on this and we did not see staff doing this during our visit, even though there were times this could have taken place.

During the inspection we found that people's confidential records were not stored securely. These were in an unlocked cupboard and unlocked filing cabinet. Some people's Medication Administration Records (MARs) were on a shelf in an open staff area. In the evening on the first day we visited one person's record remained on the coffee table in the communal room where people had gathered following dinner. We raised this issue of confidentiality with the registered manager who later sent us an action plan which stated that this issue had been resolved.

When we visited the home we found that there were a number of safety checks taking place to ensure the environment and the building was safe to use. This included testing of electrical items used in the home, and the specialist equipment used by people at the home. We looked at fire safety; we could see there was a fire plan. Evacuation and test drills had taken place and various fire safety equipment, had been tested. Staff had also had training on how to use the fire extinguishers.

During our visit we found an issue with the emergency fire exit door upstairs which opened out onto a long outside staircase. This could pose a risk to people who were not considered safe to leave the home alone. When we opened this door the alarm to alert staff this door was open was not working.

The service was also not testing for the virus Legionella. This is a water born virus and can cause people to become unwell. We raised these issues with the registered manager, they later sent us an action plan detailing a Legionella test had been scheduled.

The service had an emergency contingency plan in place. This listed information for staff in charge to access in the event of an emergency, which could affect the running of the home. There was some good practical information in this plan such as various utility suppliers and emergency call out telephone numbers. The plan also included a list of senior staff, with their telephone numbers, to contact. However, there was no practical plan in place if the service suddenly experienced a reduction of staff. There was a statement that staff were prepared to work longer shifts, but it did not state who these are with their contact numbers. There was no recorded review of the plan to check that it was still current and staff availability had not changed.

We found there were enough staff on duty to meet people's needs. We looked at the last four weeks

'worked on' rotas and found these numbers of staff were consistently working on shift. The people and relatives we spoke with did not tell us there were any issues with staff presence and availability.

When we visited the home we looked at the recruitment practices for staff at the home. We looked at three staff recruitment files. All these staff had a Disclosure and Baring Service (DBS) record in place, before they started working at the home. Two files had two forms confirming staff identifies, but one staff record only had one. All staff did not have full employment histories. Staff's application forms asked for their last ten years of employment history, all had not provided this. A full employment safety check and two recorded proof of staff identities are all important additional safety checks. All these safety checks are to ensure people are as safe as possible in the presence of the care staff.

At the inspection we looked at whether people's medicines were stored and administered safely. We looked at people's Medication Administration Records (MAR's) and found these were accurately completed. These records gave important information to staff in a succinct way to promote staff's understanding of people's health needs. When people were administered their medicines, a senior member of staff double checked individuals' medicines had been given correctly. We completed an audit of medicines and found the correct amount had been administered.

Despite this we found that people's medical creams were not stored correctly. These were in an open part of one of the lounges at the home and in people's bathrooms and bedrooms. These products all needed to be stored below 25 degrees. If stored above this temperature this medicine may not be effective. Some people's en-suites were very warm when we entered them. Staff were not monitoring these temperatures in these rooms. Staff were however monitoring the temperatures of the medicine cabinets in the home. We looked at these records and saw often these temperatures where getting close to the maximum recommended levels. On one occasion it went beyond this figure.

During our visit we inspected the communal areas and found these rooms looked hygienic and clean. However, when we went into two people's rooms they were not clean. One person had dark oily marks on the wall near their bed. These rooms were dusty in some areas of the room. People's en-suites were generally not clean. One person's toilet was stained. The shower curtain poles were rusty, a shower was constantly dripping, the light cords were sticky and stained, and the toilet brushes were sitting in water in some of these rooms. There was chipped paintwork on some of the walls and bannister rails. These were all hygiene and potential infection control issues. We raised this with the registered manager, who later sent us a plan stating one room had been 'deep cleaned' but this did not address the other hygiene issues and how this would be managed in the future.

The people we spoke with said they felt safe. One person said, "I feel safe here and the manager is ok." We asked a small group of people who lived at the home if they felt they could talk to staff if they were worried about something. One person said, "No worries." The rest of the group repeated this. A person's relative told us, "I do think [name of person] is safe, yes. The staff cater to [name of person's] needs."

Requires Improvement

Is the service effective?

Our findings

We inspected Marlin Lodge in July 2015 and found that the home provided effective care to people. In this inspection in November 2017 we found some areas where improvements were required.

During our visit we looked at three people's assessments and care records. We could see that these people had had full assessments of their care needs. The staff we spoke with were able to give us information about people's care and health needs. Staff told us what they had to do to ensure certain people's needs were effectively met.

We looked at the training programme delivered to staff and we could see staff had up to date training in key areas. For example, first aid, managing challenging behaviour, health and safety, medicines administration, epilepsy, and dementia awareness.

We were told by staff that they were asked questions in their supervisions about important areas to their work and asked to give a summary of a particular individual's needs. However, we looked at this section of staff's supervisions. On some occasions the registered manager made comments that the individual member of staff has a 'reasonable' knowledge or needed to improve their understanding in certain areas. What questions were asked, their responses, were not recorded. Therefore we could not conclude if this was a robust way to check staff knowledge in these areas. We also noted that when staff were asked to improve their knowledge this had not been checked or revisited at the next supervision. There was no evidence to say staff then had refresher training in these areas. We also saw some members of staff test scoring for certain subjects. Sometimes these were 60 per cent or lower. There was no evidence to say if the training was revisited and what the new score was.

The registered manager was routinely observing staff practice when staff administered people their medicines and these observations were recorded. However, the registered manager was not routinely observing staff competency, following a robust competency frame work, and recording these observations with outcomes. These would be important checks to enable the registered manager to be confident about staff practice and the effectiveness of the training delivered.

Alternatively we saw that staff completed an induction to their roles and some members of staff were tested after this induction to ensure they had understood their induction and initial training. However, during our visit we did observe poor staff practice when assisting people who had sensory impairment issues and how staff spoke and engaged with people. In these situations staff practice could be improved upon. We raised this with the registered manager who sent us an action plan identifying this issue.

People were supported to have enough to eat and drink. There were efforts made to promote a healthy diet. Information was displayed around the dining room about how this could be achieved. However, during our visit and at meal times this was not referred to. The main evening meal was pizza chips and baked beans and the alternative was a frozen pie. Carrots were offered to one person as an alternative to baked beans,

because they did not like them. There were no other healthy alternatives on the menu that day. When people requested 'unhealthy' foods at their weekly 'residents meetings' it was documented that staff advised these meals were not healthy. However there was no record if healthier alternatives or ways to make something slightly more healthier were discussed and planned.

Alternatively we spoke to one member of staff who was a key worker for one person at the home. They told us how they supported this person to lose sufficient weight that they were no longer obese and they were no longer at risk of a diet related condition. We saw other records where people had gradually lost weight. One person told us how staff supported them to lose weight. A member of staff told us how they supported people to grow vegetables last summer, and we saw some photos showing this. We therefore concluded that the staff and the registered manager were supporting people to eat healthily, but there were elements of this practice which could be improved upon. Such as having a healthier alternative on the menu.

When we visited the home we observed the meal time experience. The meal time did appear rushed. Most people were going out in the evening to attend a club. We thought that this meal was rushed to enable people to leave on time for the club. However, people sat about for some time post the meal waiting to go. Staff did not utilise the meal time as a social opportunity and to see how people's days had been. One person was eating their meal while they watched TV. They took some time to finish their meal; during eating their meal their food looked cold and staff did not ask if their food was to their liking and warm enough. One person told us, "Sometimes I'm asked to sit in the lounge because there isn't enough space for me in the dining room." There were no audits or engagement with people about their meal time 'experiences'.

At our visit we observed one person who was being supported to eat their food. This person had complex needs with eating and drinking and was at risk of choking. We saw this person being supported to eat certain meals. We noted that this support was at the person's own pace. At times, however, one member of staff was not observing the person eat but watched parts of the TV programme, which was playing in the lounge. We saw that staff did not always support and encourage this person to sit upright post eating to prevent the risk of choking.

We spoke with the registered manager about how the staff supported people to access services to maintain their health. We were shown and looked at a sample of records which evidenced that health professionals were contacted and referrals made, when issues developed with people's health needs.

The registered manager and provider had made arrangements this summer for the garden to be more accessible for people with different mobility needs. The provider had ensured that there was a specialist swing to enable one person who uses a wheelchair to use the swing.

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 so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with three members of staff who all had a good understanding about what mental capacity meant. These members of staff were able to give examples of how they asked people about elements of daily living and how they respected the wishes and choices that they made. Staff were also aware of the processes that must be followed if a person does not have capacity to make a particular decision. However, we noted that people signed a consent form giving consent to certain elements of the care they received. Part of this was agreeing to CCTV cameras in some areas of the home. This consent form did not evidence that this had been explained to people in a way they could individually understand. We spoke to the manager about this who told us that this is verbally explained to people before they sign this form.

Some people had been placed under a DoLS by the local authority due to the risks they faced if they left the home alone. People moved freely about and outside the home and were not unlawfully restricted. We concluded that the staff and management of the home were compliant with MCA, but improvements were required about how they sometimes evidenced this.

Requires Improvement

Is the service caring?

Our findings

At our last inspection of the Marlin Lodge in July 2015 we found that people were supported in a caring way. In this inspection in November 2017 we found some areas where improvements were required.

During our two day visit at Marlin Lodge we observed that staff and the registered manager consistently spoke to people in a direct way. Sometimes this 'directness' sounded dictatorial, unfriendly, and treated people in an infantilised way. The registered manager asked one person, "Have you washed your hands?" This was said in front of people in a direct way with no change or softening of tone to their voice. This person then lowered their head and said, "No" and walked off to wash them. A member of staff called for a person who was in another room, by just stating their name, they did not go and find the person. They said in a loud voice, "Name of person." A person asked if someone was doing the washing up, the registered manager said, "No you need to." No attempt was made to soften what was said in these situations, how it was said and the body language used by staff was not considered. These were not kind or respectful interactions.

At times staff made direct statements to people whilst they were standing up in front of them. Sometimes staff did this with their arms folded. There were only two occasions when we saw two members of staff talking to people at their eye level and in a gentle way. However, these conversations were also generally task orientated. There was no chatting to people. At no point did the inspection team believe these members of staff were meaning to be unkind, but we equally believed that this consistent tone was not conducive to a friendly and caring atmosphere.

We observed staff talking over people, discussing work related issues. Staff did this when people were eating or watching TV in the lounge. One member of staff was supporting a person who was visually impaired to eat their food, whilst answering the registered manager who was in the nearby kitchen about what hot drink they wanted and if they wanted sugar in their drink.

We later saw one member of staff talk to another person who had requested something quietly. Across the other side of the room, the other member of staff while they were supporting another person said, "What does she want?" The other member of staff answered, "She wants her [item of personal clothing] adjusted." Another person had become distressed about something and left the room abruptly. Later this person apologised. The registered manager said, "[Name of person] is a good girl, one is at least apologising." A member of staff was supporting a person to walk they said, "Good girl you are doing well."

We concluded that these were not respectful interactions, people were not being treated in a caring way, people's dignity and the fact they are adults was not always being promoted by staff.

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

During our visit the staff we spoke with told us how they promoted people's dignity and privacy when they

supported them with their personal care tasks. One member of staff said that if a person indicates that they want to say something sensitive; they will take them to a private room to discuss it.

When we visited Marlin Lodge we saw some staff responding to people's needs quickly, taking practical action to ensure their care needs were met and they felt supported. For example one person said they wanted to use the bathroom, at the moment they were due to go out, a member of staff quickly responded. This person missed their transport and they apologised, the member of staff spoke at their level and said, "You don't need to apologise." They went on to reassure them that they were still going out. However, we saw a person who was very tired, who had recently been unwell. We saw one member of staff saying to another, "She doesn't look well I'm worried." No further action was taken. No plan was devised. Eventually the registered manager suggested the person should be supported to their own bed, as they were sleeping very heavily in the lounge.

We spoke with the registered manager about these issues. They said that staff need to raise their voices sometimes as some people have a hearing difficulty and some people need clear instruction. We advised the registered manager of our observations and explained this can still be achieved in a kind and caring way. The registered manager later sent us an action plan which included person centred care training for staff.

There was no advocacy information around the home to support people to access advocacy support. This was not addressed in people's weekly one to one reviews we looked at. Two people asked us twice about issues relating to their money and one person asked us if they could possibly work. On two occasions this was said in the presence of staff, but staff did not suggest speaking with an external body, or make real plans with the person to make this happen to address their concerns.

The people we spoke with either spoke positively about the staff or passively. The registered manager suggested we spoke with one person and introduced them to us, they said, "It's a lovely place." Another person said, "Yeah, staff are alright."

When we looked at people's records and spoke with some members of staff we saw examples of the service promoting people's independence with daily domestic living tasks and routines. We saw that key workers set goals for people to aim at and try and achieve. We also noted there were occasions when these goals, which were often of a domestic nature, had been achieved. However, the support people received in this way, did not consider wider areas of independent life.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the Marlin Lodge in July 2015 we found that the staff and the management of the home were responsive to people's needs. At this inspection in November 2017 we found some areas where improvements were required.

During our visit we were looking at one person's care record and they asked to see it. They told us, "I like looking at my pictures." We asked another person if they go through their folders and care records with staff they said, "No, have I got a folder?"

When we visited the home we looked at a sample of three people's records. We found evidence which suggested that people were involved in the planning of their care. We saw examples of some personal information relevant to people as individuals. Elements of people's care records and care plans were in pictorial form. The staff we spoke with and the registered manager told us that they talked through with people their care plans. We also noted that people had signed to say they agreed to elements of their care. People also had one to one sessions with their 'key workers'. We looked at these records and we could see they were written from the person's, perspective. They also had details about the goals that the person wanted to aim for and it was evidenced if these goals had been achieved.

We concluded that it was likely people were involved in the planning of their care. However, this did fall short of person centred holistic planning. For example, we saw recorded in some people's records that they liked music but it did not say what type of music they liked. One person's record stated that they liked animals but it did not say what animals they liked. These people's records did not explore how these interests were going to be maintained and promoted by staff and the management of the home.

Staff set goals with people and reviewed if these had been achieved. People's records gave background information about people's histories, and basic information about the people who were important to them. When we spoke with the manager and a person's key worker they told us some of the interests and aspirations individuals had. However, the staff had either not taken action or considered ways to try and achieve these whilst involving the person in the process. During our visit two people separately asked us about the interests and goals they had, and asked us how they could achieve these. On two occasions we spoke with the person in front of their key workers and made some basic suggestions, these had not been considered. In both occasions the key workers said, "We could look into that." However, they had not considered with the person, ways to really achieve their aspirations.

We could see that there were social events taking place. Most people went to day opportunities at a day service five days a week. This was arranged and funded by social services. In people's records we could see that people went on holidays each year. This summer a group of people went to Portugal. There were some activities scheduled for the evening which included entertainment options. One night was bingo and another was a foot spar experience. However, some people told us that they were not able to do the activities they wanted to do outside of the home, because they did not have enough money. One person

said, "I can only go to the cinema once a month because I don't have enough money." A member of staff told us how one person liked football, but when their relative could no longer afford the season ticket, they no longer went. We concluded that the service was not responding to these social needs or considering other creative ways to try and achieve them and advocate on the person's behalf.

People told us that they had to be in their rooms by 22:00 pm. One person said, "By 10pm at night we have to be in our rooms." A member of staff told us, "The guys have to be in their rooms by 10pm. In the main house the residents start going to bed at 8pm and most are in their rooms by 9pm. They all have their own TV in their rooms." We asked what would happen if people wanted to be out of their rooms after ten. After some consideration the member of staff said, "Now there is waking night staff, it would be ok."

On a Sunday a member of staff took people to a Christian church group that people had elected to go to. One person's record confirmed they belonged to a particular Christian faith. The registered manager told us that the leader of this group had refused to visit the person at the home. Their relative confirmed this. However, the staff we spoke with and the registered manager had not advocated on this person's behalf to enable them to access this spiritual and cultural support. We asked the member of staff which Christian denomination the church was that they took people to each week, they could not tell us.

A member of staff told us they contacted a local organisation to enable a person to receive support with their hobby. They also told us that this person wanted to work in a particular industry. This member of staff said how they approached some companies, who had declined to help. This member of staff said, "They always say its health and safety." However, this member of staff had not taken other steps and worked with the person to try and achieve this interest to work or in this particular industry in a different way. There were no plans to try to overcome this issue.

One person had decided not to go to the day service one day we were visiting the home. They spent time in their room. One member of staff suggested watching a film in the lounge, which the person started to do, they later became upset and left the room suddenly. The member of staff did not take this opportunity to chat or engage with this person. There was only another person in the home at that time, and they were fast asleep. We also noted that staff did not chat or engage with people in a social way. We observed that there were opportunities throughout our visit where this could have happened, but it did not.

We concluded that although some activities and entertainment was taking place, and staff were meeting to talk to people individually on a regular basis. Staff and the registered manager were not maximising social opportunities and being person centred with people. There were some positive elements to staff responding to people's social needs, but it was not sufficient to meet the characteristics of 'Good' in this element of the support people received.

During our visit we saw that there were some people who had particular communication needs. One person told us that they could use sign language to communicate with people, due to their own hearing needs. We did not see staff using this form of communication during our visit. We asked a senior member of staff if staff could support this person to communicate in this way, they said, "No, staff cannot sign, only one person here (who lived at the service) can sign."

Another person had a visual impairment. Staff were observed talking to other people when they were supporting this person and sat close to them. A further person was struggling to use a knife and fork when eating their food, they faced some communication challenges. A member of staff went up to them, taking the knife and folk out of their hands, they gave them a spoon, and said, "That will be better for you." This member of staff did not attempt to explain to this person that the spoon would be better. They did not even

get to their eye level and to speak with them. Staff told us that they did not have any training on communication techniques, or training about how to support people with a hearing or visual loss.

The service had not considered different forms of technology to support people to communicate or to access information that people found interesting or connected to their aspirations.

The people we spoke with told us that they knew how to make a complaint if they wanted to. One person said, "I would talk to the manager, and that is the manager." A relative said, "I have not had a reason to complain, but if I did, I would speak with the manager."

The registered manager showed us a complaint that a person had made about a recent holiday the home had arranged. The registered manager was present on this holiday. This person felt there had been a lack of activities. We could see recorded that the registered manager and this person's key worker met with the person and discussed this with them. The record showed that the registered manager reflected back to the person the activities they had taken part in. However, we found issues with how a potential safeguarding event was managed and how this meeting was recorded. We therefore could not be confident this complaint was managed in a way which was open and transparent. Also, no course of action was agreed to prevent this complaint happening again.

When we looked at three people's records we could see that a member of staff had spoken with the person about their end of life wishes. We looked at this information. It contained important details about what type of funeral they wanted, who they wanted to be at the funeral, and any individual requests about how they wanted to be laid to rest. However, one person's record said they would like music played and hymns, but it did not state what music or hymns were to be played. All of these people's plans did not consider other relevant issues. For example, where they would want to be cared for and by whom. Did they not want to be admitted to hospital during this time. Suitable provision had not been made to fully explore and know people's wishes about this element of their life, especially if they were unable to express this themselves at that time.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the Marlin Lodge in July 2015 we found that the home was well managed. At this inspection in November 2017 we found some areas where improvements were required.

When we visited the home we identified some issues with the culture of the service. The approach of staff towards the people they supported was not always kind, caring, and respectful. The interactions staff had with people were task focused. Conversations were often to relay an action often of a domestic nature. There was a directness of tone and body language which was not conducive to a friendly caring atmosphere. The registered manager was responsive to these issues but the culture and how staff interacted with people had not been reviewed or tested by the registered manager and provider before.

We observed that some staff despite working at the home for some time needed guidance from the registered manager when supporting people. Staff did not always take the initiative when supporting people with daily needs and with their goals, interests, and aspirations. The registered manager told us that they were trying to support staff to be more confident in their work, and directed us to an awards scheme where a member of staff had been identified as employee of the month for showing 'initiative' in their work. However, it had not been considered if this element of the culture was having an impact on how staff promoted people's opportunities, interests, and how they wanted to live their lives. Nor if there were other ways to promote staff competency in their work. Or that areas of staff competency needed reviewing and monitoring to support staff to improve in their work. We observed that when we spoke with staff near the registered manager that staff often looked at the registered manager for confirmation when speaking with us.

When we spoke with staff they spoke positively about valuing working at the home and supporting the people they supported to lead, "Quality lives." However, this was not consistently evidenced when we observed staff practice and when we spoke with people about their goals.

During the inspection we observed how the registered manager had dealt with an allegation. We also looked at the records of a complaint the registered manager had also dealt with. It was not evidenced that these were dealt with in a fully open and transparent way.

The registered manager was completing audits to monitor the quality of the care that was provided. However, some of these audits were not effective as they did not identify all the issues which we found. For example the culture and sometimes practice of staff. The way staff competency was being monitored and recorded. Staff employment checks. The way people's creams and medicines were being stored. The potential infection control and hygiene issues of the home. Whether people's care and social needs were always being clearly recorded and in detail. If people's goals, aspirations, and social needs were being met in a person centred way. If people's records were being stored correctly. The way complaints and concerns were investigated. The condition of some people's bedrooms and some communal parts of the home had not been identified as an issue that required improvements to be made.

The provider was not completing any quality monitoring checks to ensure a high standard of care was consistently being delivered. A robust quality audit could have identified the issues which we found during our inspection to enable the registered manager to address these issues sooner.

These shortfalls represent a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place who understood what important information they must send us by law. However, the last rating of the home was not being clearly displayed at the home. We advised the registered manager to access our website for the guidance about how to display the rating in the near future.

People were having meetings with their key workers and as a group with other people who lived at the home. People were asked their views about the care and support they received. However, when people expressed frustrations with the home these were not acted upon. One person said on two occasions, "I can't wait to get out of this place." A person said in a loud voice, "I hate you, I hate this place." Staff did not speak with these people about what they had said to see if something could be improved upon or changed. People were also not being asked about what general improvements they would like to see at the home. People were therefore not being involved in the development of the home.

There were no strong links with the local community. People at the home accessed local groups and services but the local community was not involved in the service. We saw there had been an event this summer which relatives were invited to, but there were no events which involved the wider community or other services and organisations.

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 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and Respect. The provider had not ensured that appropriate action to ensure people are always treated with dignity and respect. Regulation 10 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This also included the management of the service. Regulation 17 (1) and (2) (a) (b) (c)