Martha Trust

Mary House

Inspection report

Mary House
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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?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

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

At the last inspection on 28 April 2014 we asked the provider to take action to make improvements in records. After that inspection we received information about concerns relating to the home. We carried out this unannounced inspection on 19 and 23 of December 2014 to check that improvements had been made, to follow up

Summary of findings

on the concerns received and to determine a rating for the home. At this inspection we found insufficient progress had been made in relation to records and we also identified a number of additional concerns. This is reflected in the enforcement actions we have taken which can be seen at the back of this report.

A registered manager was in post but was on temporary leave at the time of inspection. In the interim, the director of care services for the organisation had taken on the role of manager and the deputy manager had also taken on additional duties. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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.

People's safety was compromised in a number of ways. Minimum staff levels were provided most days. However, a number of people received additional funding for one to one support and these hours were rarely provided. There were a lack of protocols for the management of topical creams and this increased the risks of creams being applied inappropriately. The systems for monitoring cleanliness were inadequate and did not protect people from the risk of infection. Care plans did not fully reflect people's complex needs and incident and accident records were not always evaluated to consider if risk assessments were sufficiently detailed to support staff in reducing the number of incidents.

A number of people had equipment that was ill fitting and no longer met their needs. This included wheelchairs, standing frame and walking frames. Whilst progress had being made in recent weeks to arrange for some people's equipment needs to be reassessed, this was a slow process and the home had not been proactive in pushing this forward. There was a lack of timely referral to healthcare professionals to assist staff in meeting people's complex needs, for example in relation to oral hygiene and maintaining oral skills. Due to the turnover in the staff team significant gaps were seen in relation to staff training. There was limited evidence that sufficient staff had appropriate specialist training to meet people's complex needs.

People's relatives told us that they had no problem raising concerns with the management of the home. However, they said that actions taken to address matters were not always sustained. There were no systems in place to document actions taken in respect of informal complaints. Activity programmes were not varied and there was limited evidence that people were offered meaningful occupation.

The systems to monitor the quality of the home were not effective. When shortfalls were identified there was minimal evidence that the shortfalls were followed up to ensure matters were addressed.

We observed practices that showed that people's dignity was not always respected. However, we also observed very positive interactions, for example a staff member giving lots reassurance to a person whilst they were assisted with their mobility. A visiting therapist told us staff were, "Wonderful, I can't praise them enough. It's spacious and staff are attentive and kind." One relative told us, "Staff are dedicated, we have no concerns about the care given." Relatives told us that if their relative was unwell staff were in touch regularly to give them an update.

We found a number of breaches of the regulations. This includes a continuous breach in relation to records we found at our last inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing levels were inadequate to meet people's needs.

Systems in place to ensure the cleanliness of the home were not effective and this presented a risk of cross infection.

A lack of protocols for the safe use of topical creams meant that people were at risk of having creams applied inappropriately.

Risk assessments did not always reflect people's changing needs or take account of incidents and accidents.

Is the service effective?

Inadequate

The service was not effective.

There were significant gaps in staff training records and it was not possible to determine if staff were appropriately trained to meet people's complex needs.

The management of oral hygiene was not always effective.

People did not always receive care and support in line with their assessed needs. Whilst the manager had received training on the Mental Capacity Act care staff had yet to complete this training. Staff were clear about when restraint should and should not be used.

Is the service caring?

Requires improvement

The service was not consistently caring.

At times care was task orientated and this meant that people's needs and preferences were not always considered. People were not always treated in a way that showed them respect.

At other times it was evident that staff knew people well and how they liked to be supported.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not suitably developed to meet people's complex needs. Reviews of plans were not detailed and did not always reflect changes to people's care and support. A number of people had equipment that no longer met their needs

A lack of staffing meant that people did not always have opportunities to engage in meaningful hobbies or activities related to their interests.

Summary of findings

Comments received during the inspection demonstrated that not all complaints or concerns were documented and that when improvements were made they were not sustained.

Is the service well-led?

Inadequate

The service was not well-led.

Although there were systems to assess the quality of the service provided, these were not effective. Where shortfalls in audits were identified they were not followed up to ensure they had been addressed.

The management style was not inclusive and staff did not feel valued or feel that their views were heard.

Records were not recorded sufficiently detailed to enable management to have confidence that the home was well run.

Mary House

Detailed findings

Background to this inspection

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

On 1 April 2015 the Care Act 2014 came into force. To accommodate the introduction of this new Legislation there is a short transition period. Therefore within this inspection report two sets of Regulations are referred to. These are, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All new inspections will only be completed against the new Regulations - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out an unannounced inspection of the service on 28 April 2014. That inspection was part of a testing phase of our new approach to regulating adult social care. A breach of legal requirements was found. After that inspection we received information about concerns at the home. This unannounced inspection took place on 19 and 23 December 2014 to check that the home now met legal requirements and to follow up on the concerns received. We found that the home remained in breach of requirements and further breaches were identified.

On the first day of our inspection the inspection team consisted of two inspectors. On the second day the team consisted of three inspectors.

Before our inspection, we reviewed the information we held about the home. This included notifications of incidents and accidents that the provider is required to send us by law. Following the inspection we contacted the commissioners (social services) of the service and local healthcare professionals to obtain their views about the care provided.

We spoke with the chief executive officer, the director of care services, the deputy manager, six relatives and six staff. We also spoke with a physiotherapist employed to work part time in the home and a visiting complimentary therapist. We observed care and support in communal areas and also looked at the kitchens and people's bedrooms and ensuites. We reviewed a range of records about people's care and how the home was managed. These included the care plans for five people, the staff training records, people's medicine's records and the quality assurance audits that were available. People were not able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Whilst all of the relatives told us they felt their relatives were safe, they raised concerns about care and support in a way that led us to question this. Before this inspection a relative had informed us that they did not feel their relative was safe in the home. One relative told us they made assumptions that their relative was safe but did not know for sure. They relied on clear communication between the home and them as their relatives could not tell them of their experiences. We were told that there was good communication when people were ill. However, only one relative said that there was good communication overall. Staffing levels were not appropriate to meet people's assessed needs. This had an impact on the care and support people received and the guidance staff received to carry out their roles within the home. This had the potential to leave people unsafe.

The provider had a tool in place to determine staffing levels based on the needs of people. The home had assessed that they needed six care staff on duty throughout each day to meet the assessed needs of people. In addition, 141one to one hours support per week were funded to meet the needs of six people. (One to one hours are specific hours where the placing authority has assessed a person needs dedicated staff support. These hours are funded in addition to the core staff hours in each home). We looked at rotas over a three week period. A minimum of six staff worked every morning shift with the exception of one day when there were five. Over the three week period there were 11afternoons where there were only five staff and three afternoons where there were four staff. There was limited evidence that additional staff were on duty at times to meet one to one hours but it was confirmed that this was not always happening. All staff told us that they had difficulty providing one to one hours and we saw people were not provided with the one to one hours they were funded to receive. One staff member said they were very busy, so time with people was, "Very variable." A relative told us, that their relative was funded to receive one to one hours and that they regularly came to the home and found them on their own.

We were told that two staff were on long term sick, two on maternity leave and two were on temporary leave. These hours were covered with staff working overtime and by bank staff. There were also vacancies for a domestic assistant, a part time kitchen supervisor and a gardener. This meant that care staff also had to assist with cleaning and cooking tasks leaving less time to spend with people on the floor. Although the organisation was working hard to recruit to all vacancies there were still vacancies for 3.83 whole time equivalent support workers.

Whilst the organisation was working hard to recruit additional staff, it was evident that people were not as active as they could have been had they received their allocated one to one hours. Staff levels in the afternoon on the first day of inspection had an impact on the care and support that was provided to people. After lunch, three people spent time on floor activities. Whilst a staff member was supporting a person with an activity on the floor, another person was self-propelling their wheelchair in reverse. A few times the person came close to one of the people on the floor and the staff member intervened to move them away. However, on one occasion the staff member did not see the person propel their wheelchair and the wheels went over the mat. We intervened to ensure that the person on the floor was unharmed. A staff member told us, "We don't get a break. There is not enough time to manage to support people properly."

All of the above was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were a number of areas that could potentially lead to a risk of cross infection. Carpets throughout the home needed hoovering and carpets within the communal lounges were stained with food debris. Within shared bathrooms we found the risk of communal use of bars of soap and creams as these were not always named. In two rooms the lids had been left off creams and the contents had spread to other items. There was conflicting information given about the frequency of cleaning of mop heads and the infection control policy did not provide clarity. The wheels of the laundry trolley were not clean, the chassis immediately above had the appearance of dried-on dust. As the trolley was wheeled throughout the home this increased the risk of spreading infection. Folders for people's food and fluid records were kept in a container on a sideboard in the dining room. Several had food debris stuck to them and staff were seen to use the documents. Microorganisms can grow on uncleaned surfaces and if touched, in some circumstances, can be spread. The home was not clean and this left people at risk of infection.

Inadequate

Is the service safe?

On the first day of our inspection there was animal waste in one of the internal patio areas. At lunch time this had not been removed so we pointed it out to one of the staff. The staff member told us that a dog had been in the home before our inspection started. The animal waste was still there at the end of the day.

We were told that there had been no domestic supervisor for a two week period. Staff had taken on the role of cleaning the home until a new supervisor started in post. Whilst a supervisor had been appointed a start date had yet to be agreed. In the interim, there were no cleaning schedules in place to show what areas had been cleaned each day. Whilst we were told that staff were clear about the areas that needed cleaning, there was no written evidence that this happened, the home was not clean and there was no one with responsibility for making sure that it happened. This placed people at risk of infection.

We found that the registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Oral medicines were stored appropriately and there were systems in place to manage these medicines safely. Stock checks were completed when medicines were delivered to the home to ensure people received their medicines as prescribed. We observed medicines were administered safely.

However, there were no clear procedures in place to ensure that people's prescribed creams were only used for them. For example, in relation to one cream, the name of the person it had originally been prescribed for had been crossed out and another person's name was written on the top. We found one cream in a person's drawer that clearly had the name of another person. Staff told us they were informed at handover about which creams were to be used for people and where they were to be applied. However, staff were reliant on this information being passed on verbally and this could lead to the risk of creams being applied inappropriately. For example, one person had six prescribed creams. The use of creams was not recorded in their care plan and there were no protocols in place about their application. On the medicine administration records (MAR) chart only one prescribed cream had been signed as having been applied. In their drawer there were eight creams. Two prescribed creams had no name on the containers and the label on a third container was partly washed away. The labels on some creams stated, 'apply as directed' and on others 'apply to the affected area.'

The medicine administration records (MAR) charts showed that some staff signed for the administration of prescribed creams but others did not. A wide range of additional unprescribed creams were in use but not signed for. This meant that it was not possible to determine if creams had been applied and there was a potential for staff to apply more frequently that necessary. Over-use of ointments, can result in too much medicine being absorbed into the body and this could lead to thinning or weakening of the skin.

A number of people were prescribed medicines on an 'as required' basis for example for pain relief. However, there were no protocols in place to determine when they should be given. Care plans for some people clearly stated that pain could lead to seizures or that they were a side effect of constipation so staff should be clear to review regularly. As people were unable to tell staff that they were in pain it was essential that staff knew people well and knew signs that might indicate this. Given the turnover in the staff team and use of agency nursing staff, the lack of protocols would not aid this.

We found that the registered person did not protect service users against the risks associated with the unsafe use and management of medicines. All of the above issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not clear if all incidents of bruising were documented or investigated by the home. There was an undated handwritten piece of paper in the diary. We were told this had been left by a night staff member. This detailed that a bruise had been seen on one person's right arm. There was an entry in the person's records but it was unclear if this was the same incident. No body chart had been completed. We were told that incident records were only used to document more serious issues and that minor issues like bruising were not documented. This was

Is the service safe?

confirmed by a nurse. We looked at the computer records for incident reporting and noted that there was some evidence that bruising was recorded by staff but there was no reference to this incident.

On the computer records there were no dates of incidents. However, there were more detailed records that stated the nature of the incident, how they had occurred and what actions were taken as a result. We saw ten records and only two referred to the need to review risk assessments. Risk assessments in care plans included details of any perceived risks and guided staff to the relevant care plans for advice on how to reduce the risks of accidents and incidents. However, as it was not clear if risk assessments were consistently reviewed and updated following incidents, it was not possible to determine if staff had the most up to date guidance on how to manage risk.

One risk assessment related to the risk of choking at mealtimes and the need to ensure that nurses were trained to respond and take appropriate action. The deputy manager confirmed that the newest three nurses had not received first aid training that was specific to the complex needs of people. The majority of care staff had only received basic first aid training. This could leave people in this service vulnerable if choking occurred.

Within people's care plans there was advice for staff to ensure that they were moved into a different position throughout the day as a way of reducing the possibility of pressure damage occurring. However, within one care plan although the person was considered 'high risk' in terms of pressure damage there was no information about re-positioning or the type of equipment in use. We saw that some people were moved to different positions during the day but it was not possible to determine if people were moved in line with their needs.

There was limited evidence of a multidisciplinary approach in the management of epilepsy. One person's emergency guidelines were dated 2013 and had been signed by their consultant. There was no evidence that they had been reviewed since then. Epilepsy guidelines for another person were dated 2010. There was no evidence that they had been reviewed or that they had been drawn up by a professional with suitable qualifications to do so. In relation to a third person, although their guidelines had recently been reviewed there was no evidence that they had been drawn up by a professional with suitable qualifications to do so.

The issues in relation to the lack of risk assessments were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A staff member knew which people had epilepsy and knew that different types of seizures required a different response from staff. They were aware that there were guidelines in place and said that the key was to make sure the person was safe, there were emergency bells close at hand and the nurses were quick to respond. They also talked of the importance of documenting everything.

Within staff recruitment records there was evidence that staff had completed an application form, references were obtained and forms of identification were present. Criminal records checks had taken place. Records were kept of interview questions. One record was very detailed, one was not signed and one contained large gaps so it was not possible to determine if a thorough assessment of the staff member had been carried out. For example, there was no response to a question about the main principals of caring for people with disabilities/learning disability.

The home had updated the safeguarding policy and procedure to inform staff to refer to the local safeguarding guidelines for reporting of such matters. The policy gave information about where the guidelines could be located. Staff told us that they had received training on the subject. They were clear that if they suspected or witnessed abuse they would report it to the manager.

Inadequate

Is the service effective?

Our findings

One relative told us, "My (relative) loves' their food and we have no concerns about the food. It's homemade and all done from scratch." Another relative told us that when their relative refused a meal an alternative was cooked for them. Although we observed areas of care that were effective we also found areas of practice that were not.

On the first day of our inspection there was a Christmas buffet at lunchtime which was joined by some people's relatives. Staff worked hard to make this festive occasion special and there was a warm and relaxed atmosphere. However, one person was supported by three different staff during their meal. One staff member gave the food and cut it up, another recut the food into smaller pieces and a third gave the person a large handled spoon. It was noted that this was not in line with the person's care plan which stated that their personal preference was that they didn't like food cut up too small.

We observed breakfast on our second day of inspection. A nurse had to intervene to prevent a staff member giving a person a type of food they were allergic to. Despite this, once the meal started the staff member was attentive to the person's needs and remained with the person until the meal was completed. There was evidence in minutes of nurse's meetings that there was another near miss where a staff member almost gave a person a drink when they were 'nil by mouth.' Whilst harm had not occurred there was a potential to cause significant harm if these incidents had not been witnessed by staff who knew people well.

One person's care plan included detailed advice and support in relation to mealtimes, how the person was to be supported and specific risks surrounding mealtimes. Staff were clear about the support required. We were told that there was a list of the food items that the person was either allergic to or didn't like within the person's care plan and on the fridges. There was a list on the fridge but this had not been reviewed since June 2013. This meant that people were reliant on staff knowing them well and this could have placed the person at risk of harm.

We found that the registered person did not protect people against the risks of inadequate nutrition and dehydration. These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of people required specialist diets and staff were clear about what they could and couldn't have on their menus. One person had thickeners added to their drinks and another person also had thickeners occasionally. Staff were clear about when this was to be provided.

Two relatives told us that they had concerns about the management of oral hygiene. One relative had made arrangements for their relative to have professional treatment and this is now provided on an ongoing basis. We asked one relative if it was difficult to provide oral hygiene for their relative. They said that they did not find it difficult but could appreciate that staff might think so. We asked if they had provided training for staff and they said, "No," but that they would be happy to do so. We asked a staff member if they found the provision of oral hygiene for this person difficult. They said that it, "Can be hard but staff attempt as best they can." We asked if the steps to ensuring good oral hygiene for this person were broken down in their care plan and they said, "No." Staff did not have guidance on how to support this person effectively and therefore did not support them well.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The organisation's policy was that staff would attend four supervision meetings each year one of which would be an annual appraisal of performance. Records showed that staff were not receiving supervision in line with the home's policy. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Records showed that approximately three quarters of the staff team were due to receive their annual appraisal. A staff member told us that they attended a supervision meeting every six months and that they found it, "Very useful." Staff supervision dates were not available at the time of inspection. Following our inspection we requested details of supervision dates. Three of the nursing staff had not attended a supervision meeting for over a year and three months. At least half the staff team had not attended a supervision meeting for over six months. The provider

had not given staff suitable opportunities to express concerns and consider their training and therefore staff may not have had the training necessary to deliver care effectively.

At the time of inspection the staff training plan was not up to date but we were told that this task would be completed over the Christmas period and a copy would be sent to us. In January we contacted the provider to request an updated copy. Records were provided but did not include details of all the staff team. We requested further information. We had been told that moving and handling training had been held in November 2014 but the staff due to attend training in November were still showing as requiring training in January so we were not sure that we had the most up to date records. Records showed that almost all of the staff team required training in fire drills, basic fire safety and needed to look at a health and safety DVD. Three quarters of the staff team required training in safeguarding, basic food hygiene, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Half of the staff team required training in active support. Twelve staff required training in infection control. We were told that training had been booked for infection control and safeguarding in January and for fire training over two days in February 2015. However, due to concerns we had about infection control, safeguarding and care delivery, we were not assured that staff had the knowledge and skills to meet people's needs effectively.

We were not confident that staff had the specialist skills needed to meet the needs of people with profound multiple learning disabilities. Records showed that only five staff had received external training to use the hydro pool. One of these staff was a flexi worker. A staff member told us, "Training was not helpful. I didn't feel none the wiser". Some people required their nutrition to be fed to them via a tube into their stomach. This is known as having a percutaneous endoscopic gastrostomy (PEG). We were told that training for this was, "On the job." Only one of the eight nurses, and two bank nurses had received formal training in this. Whilst we observed a nurse giving a person their medicines via their PEG and had no concerns about the procedure used, a lack of formal training in this area could leave people at risk. We were unable to determine how many of the staff team had received training on epilepsy. Training on epilepsy should be provided by a specialist in epilepsy and as people had complex epilepsy it was even more important that this was provided. A lack of specialist training could increase the risk that people could be treated inappropriately. Only fifteen of the care staff team had completed a health related qualification.

There was a two week induction period for new staff. A staff member told us that they spent two weeks shadowing more experienced staff. They said, "I learnt a lot in two weeks." They said that they had completed all the basic training and said that senior staff had been very supportive. This person's staff file contained an induction but it had not been completed within two weeks. The provider told us that induction was not working as well as they would have liked. Following the initial in-house induction, support staff completed a more in-depth induction pack that they held responsibility for until it was completed. We asked to see one but there were none available in the home. We were told that the organisation had not found the induction procedure met their needs as it was too complex, so they were reverting to the previous procedure which was linked to Skills for Care but this had not yet happened.

The registered manager had attended training on the MCA and how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. Approximately three quarters of the staff team had not received training on MCA or DoLS. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Two staff said they had completed this training by e-learning (computer based training). One said that it wasn't easy as they had no one to discuss it with. They said they would like more training on the subject. If staff do not have a clear understanding of both MCA and DoLS then people could potentially be at risk of being deprived of their liberty unlawfully.

We found that the registered person failed to ensure that there were suitable arrangements in place to ensure that staff were suitably trained or supervised for the work performed. These issues were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative had made an application for one person for an urgent DoLS and this had been granted. However, this had run out and a standard application had been submitted.

Inadequate

Is the service effective?

The care plan was clear about the use of restraint and when it was permitted to be used for this person and there was a risk assessment in place. Staff were clear about when restraint should and should not be used.

Staff were clear about the steps to be taken before they used restraint for one person. They were also clear that there were times when another person was restrained and the steps that needed to be followed before restraint was used. This showed that people were protected from the use of restraint when it was unnecessary and that it was only ever used as a last resort.

Requires improvement

Is the service caring?

Our findings

A visiting therapist told us staff were, "Wonderful, I can't praise them enough. It's spacious and staff are attentive and kind." We observed a staff member explaining to one person what they were doing at each stage of moving them from one position to another. They gave reassurance throughout the move and they spoke in a caring and friendly manner. A relative told us, "Staff are dedicated, we have no concerns about the care given." Whilst relatives spoke positively about staff's caring approach we also observed practices that led us to believe that care was sometimes task led and attention was not always given to the individual. For example, staff did not always explain to people what they were going to do. On occasions staff approached people from behind and moved their wheelchairs without telling them what they were doing or where they were going. On the first day of our inspection we observed two staff supporting people to eat. Both staff were attentive to the task and paced the meal well but did not interact with people throughout the process. A relative told us, "My relative is always well presented, although sometimes when we come in we have seen them wearing other people's clothes."

On the first morning of our inspection we observed an activity for approximately 15 minutes. External entertainers provided a pantomime. People sat in a semicircle and, staff sat behind people. However by the end of the observation time some staff had begun to move forward to sit with people. It was evident through facial expressions that one person clearly enjoyed the performance. However, it was not apparent if the performance was enjoyed by others and there was very limited support offered by staff to help people engage with the performers.

We noted that whilst people were watching a film, a staff member came into the room took the brake off the person's wheelchair and proceeded to take them to the dining room. Once they were moving they started to speak with the person to explain what they were doing. Whilst the person showed no reaction to the situation, there was no recognition that they might have been enjoying the film. It was also noted that the person was then left in the dining room for quite a while before staff support was provided so there was no necessity to have moved them when they did.

Three staff told us that due to staff shortages they often felt rushed and didn't have enough time to give to people. One staff member said that they had now moved to a system that if people were asleep they left them. They said, "We used to wake them up." Another said, "It's now more about the task than spending time with people. It would be nice to have a little more time to do pamper baths rather than functional baths."

A staff member told us that one person who received nutrition via a tube also received food tasters daily. The food tasters were considered maintenance of oral skills as opposed to having any nutritional value. However, this had stopped because staff that had been trained to provide the 'tasters' had left. We were told that the 'tasters' had stopped two months before our inspection. A referral had been made to the local speech and language team (SALT) a few days before our inspection and the person's relatives had been informed the day of our inspection. The relative told us that had they known the tasters had stopped they would have made a referral to the SALT team earlier.

A staff member told us they had seven people to support at mealtimes and, "There are not enough staff to support all so we can't do one to one. We have to get up and feed another person at the same time so it's awkward." We did not observe this practice during our inspection. On the second day of our inspection we saw that one person was sat on a sling in their wheelchair. The name on the sling was that of another person.

We found that the registered person failed to ensure that people's independence and dignity was promoted and that they were always treated with respect. These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives gave a mixed response to a question about their involvement in their son/daughter's care plan. They told us that they attended reviews where they were updated on people's needs but they had no ongoing involvement in care planning throughout the year. Within one care plan there was a comment that the parents should feel free to include whatever they wanted about their relative's life history. We asked the relative about this but they said that they had not seen the care plan. However, in another care plan we noted that the relatives had written a detailed life history about the person. All relatives told us that they would like more involvement with care planning.

Requires improvement

Is the service caring?

During our inspection we spoke with an independent complimentary therapist who had provided treatment in the home to a number of people for several years. They said that staff were, “Attentive and kind and that they knew people well.”

We did however observe practices that demonstrated that staff were caring, and ensured that people’s dignity was respected. For example, when a person’s top needed changing, the staff member politely asked permission to take them to their room to do this. A staff member told us when supporting people with personal care they, “Always make sure doors and curtains are shut. I put a towel across people until their clothes are on.”

We observed one person assisting a staff member with hoovering, The person was pulling the vacuum along with the flexible pipe over their shoulder while the staff member offered encouragement. Staff thanked the person for helping them to move the vacuum cleaner from one room to another. The person was smiling and clearly enjoyed the engagement.

A staff member told us, “We know people really well and make sure they look well presented. We have girly days.” Another said, “We always ask what they want to wear. We get options out and know that certain people might look at one and not the other.” Another said, “Everyone is different. One person likes to get up late.” “When people are unhappy they let us know.”

Inadequate

Is the service responsive?

Our findings

A relative told us that staff, "Know my (relative) well and know their moods, their likes and dislikes." All relatives said that the home kept in touch if their relatives were unwell or if there was a problem. Bedrooms were personalised to each person's tastes. On the first day of our inspection, as well as the pantomime there was a special Christmas buffet at lunch time and a film in the afternoon. In addition a number of people received reflexology treatments. A couple of people used the home's hydro pool. On the second day of our inspection there was a film and hand pampering. Although we received some positive comments about the activities provided we found that staff were not always responsive to people's needs.

People's education and recreational needs had not been fully assessed. One staff member told us, "Activities need to be more planned." A relative told us, "There is too much watching TV, with staff sitting around." Following the pantomime on the first day of our inspection, in between personal care tasks or formal activities, we saw that people were placed in front of the TV. On the afternoon of our inspection the activity was to watch a film, therefore people had spent several hours sitting in front of the TV. One person was taken out of their wheelchair to spend time in their walker. However, they were then left for 15 minutes in a standing position before a carer supported them to walk round the building.

There were opportunities within the home to use the art room, sensory room and the hydro pool. (A hydro pool is a pool used for water exercise and other therapy treatments). We were told that if there were not enough staff, the sessions were cancelled.

One person's activity plan stated, walk to the seafront one day, walk in the garden another day and walk in the community another day. There was no information about the purpose of activities and records of activities did not include the person's level of participation or if they had enjoyed the activity. A staff member told us that one person's activities on the second day of our inspection were to use their walker and to spend time on their mat. However, the person was meant to be in receipt of one to one support throughout the day. Records did not demonstrate what one to one support or activity was provided whilst the person was on the mat.

Approximately half of the staff team had received training on 'active support'. (Active support is a way of providing assistance to people that focuses on making sure that they are engaged and participating in all areas of their life). The implementation of this approach was still in its infancy, we saw limited evidence that it was used and record keeping relating to this was minimal.

There was no system in place to ensure that staff had read care plans. Guidance was provided in care plans to staff about how each person wished to be supported and this included their preferred routines. However, we asked care staff if, during their induction period they read care plans. Staff said that they tried to read as many as possible. Care staff wrote the daily records each day and nursing staff had responsibility for writing and reviewing care plans. Staff said that they were told of changes in people's needs on a daily basis at the handover. However, that meant they were reliant on staff verbally passing on information and they were not regularly reading care plans, including risk assessments. This could leave people at risk of harm if staff forget to pass on changes that have occurred to a person's needs.

One person's care plan had been updated on 26 November 14. This included that the person went horse riding. However, the person's relative said that this was no longer the case. Records said to ensure that staff used the correct sling when supporting the person but there was no information about what size sling to use.

This above paragraphs were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A relative told us, "We still play a big part in our relative's life, we go to every medical appointment and dental appointment." Another relative told us that they had been excluded from some health appointments and equipment provided had as a result had not been effective, for example specialist shoes. Other relatives told us that they took it upon themselves to make healthcare appointments for their relatives and that they informed the home of the outcome.

Four people had wheelchairs and/or a variety of equipment that were ill fitting and had not been formally reviewed for a number of years. A number of people had equipment that had been of benefit to them but could not be used as it no longer met their needs. A reassessment of needs had not

Is the service responsive?

been carried out. A relative felt that they had been 'fighting the system' for new equipment on their own and that the home had provided minimal support to them. There was limited evidence in people's notes that the home had been proactive in trying to arrange appointments or move things along. However, it was evident that since the new physiotherapist had been appointed progress had been made with trying to secure assessments and suitable equipment. Due to time constraints, (the physiotherapist was only employed 4-6 hours each week) this was moving slowly. The physiotherapist told us that they were dealing with the more urgent issues first, for example, trying to determine the cause of one person's pain.

The protocol for use of a walker for one person was dated 2010 and said that the guidelines were under development. However, when we spoke with the relative and the physiotherapist, both confirmed that the equipment was not in use as a full reassessment needed to be carried out. Whilst there was information about how to support this person with various aspects of moving and handling, there was no information about how to transfer the person into their wheelchair As the person's wheelchair no longer met their needs we were told that it was not possible to position them correctly in their wheelchair. It was therefore even more important to have clear guidance on how to achieve the best possible position to prevent pressure damage until the person had a new wheelchair.

It was noted that one person wore leg and ankle splints that were worn and not effective in their function. This equipment was not referred to in their care plan. Whilst staff were clear that long socks were to be worn under the equipment the person's socks had not been pulled over the top of the equipment. This had the potential to cause pressure damage.

The above three paragraphs were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A staff member told us that if a relative raised concerns with them they would pass the concerns on to a nurse. A visiting professional told us, "I focus on the wellbeing of the people, if I had concerns I wouldn't hesitate to raise them." Relatives told us that they had raised a number of concerns with the home. For example, one person told us that toiletries were switched around and they were constantly buying more. They said, "Clothes go missing. Another relative told us, "We accept that clothes will get ruined."

They said that this was due to the way drinks were given to their relative. They said that in the past they had given a talk to staff on how to give drinks and had been asked to do this again. Another relative said, "I'm fed up telling staff." There was no system in place to record these type of concerns and it was therefore not possible to determine what actions had been taken to address them. No formal complaints had been recorded but there was an action plan following concerns raised by one relative, to ensure that matters did not occur again.

There was a comments and suggestions box easily visible near the entrance to the home. The complaint policy was displayed in the entrance lobby. At our last inspection the policy required updating as the Contact details of the Care Quality Commission (CQC) were out of date and there was no reference to people's option of directing complaints to the local government ombudsman. At this inspection the CQC details had been updated. However, there was no reference to the local ombudsman and the document directed people to the CQC if they were unhappy with the outcome of their complaint. CQC has no remit to investigate individual complaints about social or health care services. Following our inspection an updated complaints policy and procedure was sent to us.

We found that the registered person failed to ensure that there was an effective complaint procedure in place. The above two paragraphs were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within the care plans there was detailed information about how best to communicate with people and each person had a communication passport. Staff who knew people well were able to tell us how they could identify signs or indications from people who could not communicate verbally that could indicate they were unhappy or in pain. A staff member told us that when one person was distressed they gave them floor time as it was noted that that was when they were most relaxed. This was evident on both days of our inspection.

One relative said, "Communication is a problem, we need to turn the wheels a bit at times." However another relative

Inadequate

Is the service responsive?

told us that when they went on holiday they had been able to skype (video call) their relative in the home. They had been grateful to have this facility and felt reassured that their relative was happy.

Inadequate

Is the service well-led?

Our findings

We received mixed messages about the management of the home. Two staff told us that there had been a lack of leadership and that managers did not address issues between members of staff and often left them to sort things out for themselves. One of the staff told us that managers were not on the floor enough. They said, "There is no communication. There is a lack of reality about what goes on. It's very hierarchical and no one interacts with others, not on the same level." An example of this was seen in two different house meeting minutes where staff were told, 'If a member of staff has an issue with something then they are to speak to (manager) about it and not complain to other staff members. If that person is not willing to speak to (manager) then please keep the issue to themselves.' There was no recognition that a staff member may not be able to speak with the manager and that there are other members of the management team that staff could speak to if they had concerns. However we also received positive comments about management. A staff member told us that the manager, "Really fights for people and gets involved. She is really helpful and knows what's going on." Another staff member said, "Managers are on the floor. They are open to ideas."

At the time of our inspection the registered manager was on temporary leave. During this time the organisation's director of care services had taken on this role and she was assisted in this task by the deputy manager.

There were a range of measures in place to ensure staff, relatives and trustees were kept up to date on the running of the home. Board meetings, clinical governance meetings, nurses meetings and house meetings were held monthly. Records provided in relation to the board and clinical governance meetings were agenda or action points. Whilst it was clear who had responsibility for addressing matters raised, it was not always possible to determine if all actions had been followed up.

Records for the house meetings did not show the names or numbers of staff that attended the meetings. They demonstrated that a wide range of topics had been discussed and that staff had been kept up to date on a range of matters. Whilst a staff member told us they could have their say at meetings, minutes read like a list of instructions and there was limited evidence that staff views had been sought.

Minutes of monthly nurse's meetings showed that nurses were kept up to date on matters of importance and were given advice on how to support staff. Records detailed some of the problems highlighted by staff in the course of their work such as the view that six staff were not enough in the mornings. Staff were reminded to ensure one to one hours were provided where possible. There was a statement that, 'Some residents can be showered after breakfast using one to one hours.' However, it should be noted that bathing is classed as an essential function of everyday living and should not rely on additional staff to provide as an activity.

Family forum meetings were held twice a year as an opportunity to hear views of families and to keep them updated about developments with the organisation. Minutes showed that families were given opportunities to share their views about the home. Recurrent themes like laundry, staff name badges, wanting to know more about activities and involvement with care plans did not appear to have progressed. Whilst there was evidence that relatives were kept up to date on a range of matters, three relatives felt that the same issues came up again and again. One relative said, nothing changes, we raise problems, we are told, 'leave it with me', it improves for a while but it is not sustained". Another relative told us they had concerns about the state of the garden. They said that a lot of money had been spent on it but it had then been left to get into a state. We were told that the gardener had left unexpectedly and that they were trying to recruit to this vacancy.

One of the directors had carried out an audit of one of the key domains 'caring' in November 2014. Whilst a number of findings were positive, it was noted that they had rated the area as 'inadequate.' The deadline for addressing the shortfalls raised were either February or April 2015. Shortfalls included consideration for communication training and staff to be more aware of people's sensory impairments when communicating with them. At this inspection there was no evidence that work was underway to ensure that communication was improving.

A number of audits had been carried out to monitor the quality of the home. These showed that in relation to some areas progress had been achieved. However, the systems were not effective as they did not pick up the range of shortfalls identified within this report. When issues were identified it was not always possible to see who had responsibility for addressing shortfalls and by when. There

was progress noted between the two infection control audits but then an increase in shortfalls were identified at a recent targeted audit of one person's bedroom/bathroom. This audit had been carried out three days before our inspection. The home's audit stated that there was no communal use of creams. However, in other bedrooms we found evidence of possible communal use of creams. Within one shared bathroom we found four deodorants in a drawer, only one of which was named, there was a razor that was uncovered and a toothbrush uncovered.

We were told by two staff that there were no cleaning schedules in place and that care staff had taken on additional cleaning tasks in the absence of a domestic cleaner. However, the recent targeted infection control audit for one bedroom stated, 'cleaning schedule in place, however awaiting a new cleaner to commence role.' We saw no evidence of a cleaning schedule.

There was no evidence that care plans were audited on a regular basis. There was one in-house care file audit which had been started in September 2014 but this had not been completed. A laundry audit carried out in May 2014 showed that there were no guidelines in place for the washing machine and tumble drier. This was still the case. The management of laundry was a consistent issue at the relative forum meetings. Although notes of house meetings indicated that there had been improvements in this area, it was noted in the most recent minutes that one person's jumper had been ruined in the tumble drier and that staff were offered training in this area if it was needed. Staff told us different temperatures at which soiled clothes should be washed. One staff member said 95℃ and another said 75℃.

In relation to other audits for example, medicines and waste management, it was not evident that follow up audits had been carried out to address shortfalls identified had been addressed.

First aid kits were poorly stocked and not effective in an emergency. There were four first aid boxes in one of the laundry rooms. One contained eye pads and two contained bandages. All items were out of date and one box contained a number of miscellaneous plastic objects. These matters had not been identified as part of the home's monitoring systems.

The provider arranged for an external analysis of all accidents and incidents that occurred in the home. Risk analysis reports were provided for 2011 and 2013. Within the report there was a statement that all incidents had been included in the analysis, whether considered trivial or not. However, as reported under the 'safe' domain, not all incidents of bruising were included within the computer records. We were therefore unsure about the accuracy of the findings. The 2013 analysis stated that several incident reports did not include dates and times of incidents. It was noted that the time of incidents was now recorded but the date was not recorded. No data had been included relating to the location of incidents. This was now recorded. The number of incidents between 2012 and 2013 had significantly reduced. However, if all accidents and incidents regardless of the severity had been recorded, the outcome may have been different. The analysis was clear about particular days and times when accidents/incidents were most likely to occur.

The issues relating to auditing, meetings and incident and evaluations of accidents and incidents show that the systems for monitoring the quality of care delivery were not effective and were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Within people's care plans there was advice for staff to ensure that people were moved into a different position throughout the day as a way of reducing the possibility of pressure damage occurring. During our inspection people were moved throughout the day, but this was not always recorded in daily records. Care plans also stated to turn people regularly at night. One person's care plan said that the person's skin was, "Prone to irritation and can lead to compromised pressure areas," They had been assessed as high risk in terms of the risk of pressure damage and staff were to change the person's position every two hours. Whilst night records showed that people were checked regularly, there was no written evidence that people were repositioned and there were no monitoring tools in place by the home to ensure that this happened.

Within care plans there was advice from the home's physiotherapist to ensure that passive exercises were carried out with people and in some cases this was to be twice a day. However, there was no written evidence that this was done or no monitoring tools to ensure that they happened.

Within one person's care plan there was information about the management of diabetes. However, it was noted that the protocol had last been reviewed in 2012, related

Is the service well-led?

documentation was held in more than one place, and some aspects could be confusing for an agency nurse. For example, records showed information about the rotation of injection sites. When a staff member was asked why the abdomen was not used as an injection site they did not know. Another staff member told us that this was the person's personal preference. This information had not been documented in the care plan and the person would not have been able to tell an agency nurse. Staff told us that they checked the injection site for tissue damaged areas every time they gave an injection, however they said, and we confirmed, that this was not in the person's care plan.

There were a wide range of records held in the home that staff would need to refer to on a daily basis and within these records there was some duplication. For example, there were daily handover sheets, daily records that were completed by care staff and clinical records that were completed by nurses. There was information that was kept within MAR charts that was not in care plans about how to support people with nutrition. These records were not dated or signed. The storing of information in so many places presented risks that an agency staff member might not have the most up to date information if they did not read the correct record.

We were told that food and fluid charts were completed after each meal. However on the second day of our inspection we looked at food and fluid records for three people in the afternoon but these had not been completed for the morning. A staff member told us, "Food and fluid charts are useless". Some people fill in regularly after each meal but you get people that don't fill in. Drinks charts are hardly ever filled in. It looks like people haven't been offered a drink. No one is managing this." It was therefore not possible to determine if people had received appropriate hydration on the day of our inspection.

We found that the registered person failed to ensure that records used for the management of the regulated activity were accurately maintained. These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The organisation's mission was to, 'Offer friendship and encouragement to the people we support, enabling them to achieve their goals.' It stated, 'We show compassion to everyone at Martha including each other.' 'We are always supportive and encouraging.' 'We treat everyone with respect and dignity.' There was a poster displayed detailing the organisation's mission and there was evidence that the organisation was working to ensure that the mission was made known to staff and families. A staff member told us the aim of the service was to, "To make sure the guys are happy, healthy and well looked after." Whilst the organisation was working hard to promote their mission statement, the evidence in this report shows that there were shortfalls in how they were supporting and encouraging people and that people were not always treated with respect and dignity.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 12(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person did not protect service users against the risks of inadequate nutrition and dehydration.** **Regulation 14**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not ensure service user's independence and dignity was promoted and that they were always treated with respect.** **Regulation 10**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered provider failed to ensure that there was an effective complaint procedure in place.** **Regulation 16**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not always ensure that records used for the management of the regulated activity were accurately maintained. Regulation 17 (2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person failed to ensure that there were suitable arrangements in place to ensure that staff were suitably trained or supervised for the work performed. Regulation 18(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. Regulation 12 (2)(h)

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not always take proper steps to ensure that service users were at risk of receiving care that was inappropriate. Regulation 9(1)(a)(b)(i)(ii)(iii)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have an effective system in place to regularly monitor the quality of care provided. Regulation 10(1)(a)(b)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered person did not have suitable arrangements to ensure the availability of equipment provided promoted the independence and comfort of service users and met their assessed needs. Regulation 16 (2)(3)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Enforcement actions

The registered person did not always ensure that there were sufficient staff to support services user's assessed needs. Regulation 22

The enforcement action we took:
Warning notice