Martha Trust

Mary House

Inspection Report

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Overall summary

Mary House provides accommodation with personal and nursing care for up to 12 people with learning and physical disabilities. At the time of the inspection there were 12 people living at Mary House. None of the people who were living at the service were able to speak with us but we did speak with some relatives.

We also 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.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were recognised, respected and promoted.

Relatives spoke positively about the staff and their kindness. One relative said, "There is a very positive, enthusiastic team spirit" and a "great sense of fun", which helped create a "warm and loving environment." Relatives felt there were "lots of positives" about the service although some felt there were some areas that could be improved, such as communication.

The service was not always safe and improvements were needed. The majority of risks associated with people's care and support had been identified and guidance about good practice was in place to reduce these risks and keep people safe. People were treated with dignity and respect. Staff understood the importance of supporting people to make their own decisions where possible. People received their medicines when they should and safely.

People's needs had been assessed. Relatives and staffs knowledge of people had been used to develop care plans. Care plans detailed people's known preferences, choices and independence skills. The service had recently introduced an "active support" programme, to encourage further development of interaction and independence skills. People had sufficient quantities of food and drink and any special dietary needs were catered for.

People were treated with kindness and respect. Relatives told us people's preferred name was always used by staff and this was recorded in their care plan.

People were encouraged to make their own day to day decisions about their care and support. Where people were unable to make complex decisions for themselves, such as whether to have hospital or dental treatment, the service had considered the person's capacity under the Mental Capacity Act 2005. Records showed a person's relatives and health care professionals had been involved in the best interest decision making process for that person. People had opportunities to undertake activities both within the service and in the local community.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law with the provider. The registered manager provided good leadership and support to the staff. Relatives had opportunities to feedback about the service provided, but some felt communication with management could be better. The senior management team had systems in place to monitor the quality of the service, so that people received care and support that met their needs.

We found there was a breach of Regulation 20 of the Health and Social Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service was not always safe and improvements were needed.

We found some risks associated with people's care and support had not been documented, but staff took a consistent approach and people remained safe. When accidents or incidents occurred action was taken to ensure people remained as safe as possible.

All but one relative told us they felt their family member was safe using the service. Action was being taken by the service and relative to address the other relatives concerns. Staff had a clear understanding of how to report safeguarding concerns within the home, in order to protect people who used the service. The safeguarding policy required review as it made reference to an incorrect local authority for reporting any safeguarding concerns.

Staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, in order to understand the legislation. They understood the importance of supporting people to make their own decisions and knew that best interest meetings would be held when people lacked that capacity, in order that decisions were made in people's best interests.

Staff treated people with dignity and respect. For example, they spoke quietly to people explaining what they were doing. People received their medicines when they should. The medicines policy was not up to date, it described medicines supplied in a monitored dosage system (a monitored dosage system is a medicine aid, such as a blister pack, pre-packaging all a person medicines) , which they no longer were, but staff followed a safe practice when administering people medicines.

Are services effective?

We found that the service was not always effective and improvements were needed.

People had their needs assessed before they moved into the service and then regularly once they had settled in. Relatives were involved in the initial assessments and care plans were developed from this information. There was little evidence of relative's involvement in care planning, but the service was taking steps to improve the involvement of relatives and record their agreement with the care plan content. Some changes in people's care and support although happening in practice had not been updated in the care plan. This

Summary of findings

left a risk that the person might not receive consistent care as staff did not have up to date written information about their care needs. A new "active support" programme had recently been implemented to aid people's involvement and independence.

Relatives told us that staff had the skills and experience to meet their needs. Staff were well supported by the registered manager and other senior staff within the organisation and they received training appropriate to their role.

People received adequate food and drinks. We saw that advice and guidance from health professionals regarding people's dietary needs was recorded in people's care plans.

Are services caring?

Relatives spoke positively about the staff and felt their family member's privacy and dignity was maintained. They said staff were respectful. Staff were kind and caring when supporting people. There were very good interactions between staff and people who lived at Mary House, although we heard an age inappropriate word of encouragement was used to some people, which we spoke to the registered manager about who agreed to talk to the staff member.

People were treated with dignity and their privacy was respected. People could be confident that their information was handled safely as there were systems in place to manage information appropriately and staff understood their responsibilities about confidentiality.

Relatives had opportunities to voice their views about their family member's care and support through review meetings. People's preferred names were recorded in their care plans and staff always used these names. People's communication skills were detailed in their care plans, in order that staff understood when people were making their needs known.

Are services responsive to people's needs?

People had their needs assessed and regularly reviewed. Relatives were involved in review meetings so were able to express their views on the service provided. In addition there were other systems in place to involve relatives in the service and the way it was run.

There were systems in place to support people when they were unable to make complex decisions, such as decisions about hospital or dental treatment, to ensure decisions were made in people's best interest.

Summary of findings

People participated in various activities although some relatives felt if these were better planned, people could participate in more activities. People went out regularly to take part in activities and attractions of their choice.

All but one relative did not have any complaints and felt confident in complaining. Action was being taken to address the other relatives concerns. There was a complaints procedure in place. However this required updating and it was not displayed within the service. This meant visitors might not know how to complain or how to contact the Care Quality Commission about any concerns.

Are services well-led?

The service held relative forums to exchange information and where relatives could raise concerns they might have about the service. People benefited from a service where there were systems in place to monitor and learn from complaints, accidents and incidents, so that risks to people of future occurrences were minimised. To enable people to receive a good quality service the service undertook regular audits to identify improvements and monitor action plans.

The service had a system in place to ensure there were sufficient numbers of staff on duty. The senior management team had undertaken a calculation to ascertain staffing levels although this was not based on people's needs. Staffing levels were monitored and had recently been reviewed and the service intended to increase staffing numbers.

Staff felt supported by the senior management team. They felt there was an open and supportive culture meaning they felt comfortable in taking any concerns forward. There were systems in place to monitor that staff had the necessary training and skills to meet the needs of people who used the service.

Summary of findings

What people who use the service and those that matter to them say

People who used the service were not able to communicate with us to express their views. We used SOFI to help us try and understand what it was like to live at Mary House.

We spoke with four relatives on the telephone following the inspection. Their feedback about the service was, on the whole, very positive. Relatives spoken with were satisfied with the care and support provided to their family member and spoke very positively about the compassion and caring attitude of care and nursing staff. They felt their family members were safe living at the service and that any risks were managed. Relatives felt they were involved in the care and support of their family members "to a point". They were all aware of and welcomed the new system being introduced to involve relatives further in care planning. Relatives all confirmed that they attended reviews and had opportunities to attend family forums where they could discuss any issues or concerns. They felt staff generally had the right skills and experience, but "some could do with a bit more training". Relatives agreed that people's privacy and dignity were respected. They felt confident in raising any concerns and told us that, when they had, these had been listened too. Relatives felt the service was "generally" well led, although some felt that communication could be better. Their comments included, "It's good - the best available", "It's very good, X (family member) is happy there and is healthy", "It's the best thing next to being at home", "They are always doing things and there are things going on in the home and they take them out", "Some things could be acted on better. They are not always proactive to sort out and get some things done. We have to point things out", "They are willing to listen and make changes", "The "active support" will help to improve life and there will be more inclusion", "We feel very lucky and grateful" and "They are prepared to be honest about mistakes they make and need improvements in some areas, such as laundry."

We also received feedback comments from two relatives by email. One was very positive and the other was not. One relative felt that, although there were a "lot of positive things", they were really not satisfied with aspects of the service, such as leadership, communication and activities. The management team had been working with them for a period of time to try and resolve issues. The other relative "could not praise this service highly enough". They were confident their family member was safe. They told us the service provided all the equipment necessary to keep their family member safe and comfortable. They said, "His condition is monitored very closely, giving us confidence that any medical complications will be dealt with appropriately and quickly." They told us, "Communication between staff, management and parents has always been very open and friendly in our experience." "From the beginning we have been encouraged to give feedback, positive or negative and to comment on whether staff can do things better or differently. We feel the home strives to be the very best it can." They spoke positively about the staff and their interactions with people who used the service. They said, "Great efforts have been made to create a "home from home" where everyone feels part of a large happy family. We are always made to feel very welcome."

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Detailed findings

Background to this inspection

At our last inspection in November 2013 we went back to look at shortfalls in the area of care and welfare of people who used services, which were identified at an inspection in December 2012 and again in April 2013. We found that the service had addressed the shortfalls and there were no further concerns.

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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. Our inspection team was made up of two inspectors, an expert by experience and their supporter. The expert by experience was a person who has personal experience of using this type of care service.

Before this inspection we reviewed information we held about the service and we asked the provider to send us some information.

We visited the service on 28 April 2014. During the inspection we spoke with the registered manager, the deputy manager, the director of care services and seven staff. We also looked at people's care plans and other records relating to the management of the service. As people were unable to tell us about their experiences of living at Mary House we spent time observing the care and support people received and their interactions with staff.

Following the visit we spoke with four people's relatives by telephone. We emailed eight relatives advising them of the inspection and asking them for their feedback in relation to the service provided.

We spoke with a health professional, who had recently visited the service to gain their feedback.

Are services safe?

Our findings

We looked at risk assessments and found that most risks associated with people's care and support had been identified and there was guidance in place to inform staff how to keep the person safe. For example, when moving and handling people and when people experienced epileptic seizures. We found that one person's care plan highlighted that they were at high risk of developing pressure sores, but we could not find any guidance in place to inform staff how to manage this safely. We spoke to staff and they told us that equipment was in place to reduce this risk and, during personal care routines, checks were made on the skin condition. We saw that risks associated with the use of the hydro pool had been assessed. We saw that for those people who were at risk of seizures this was not included in the risks identified. We discussed this with the staff who confirmed this was an omission and that this would be addressed in order to ensure a consistent approach was always taken. Staff were able to talk us through the safe procedure that would be adopted should this risk occur, in order to keep people safe. However the lack of documentation in relation to risk might lead to an inconsistent approach to people's needs, therefore leaving them at risk.

The above is a breach of Regulation 20 (1)(a) and the action we have asked the provider to take can be found at the back of this report.

Most relatives told us they felt their family member was safe living at Mary House. One relative said, "He (family member) is healthy and happy." We observed that the atmosphere during our inspection was happy, relaxed and calm. We saw that the service had a safeguarding policy and procedure in place to help keep people who used the service safe. This required updating as it made reference to an incorrect local authority for reporting any safeguarding concerns. Staff told us they had received training in safeguarding adults and records confirmed this. Staff demonstrated an understanding of their responsibilities in respect of safeguarding people from harm. They understood how to report any suspected abuse within the service, which followed the home's policy. However they were not clear about where they should report abuse outside of the service, but assured us they could access this information should they need to. This meant staff would be able to recognise signs of abuse or neglect and knew the procedures to report any allegations within the service, in order to keep people who used the service safe.

Each person had family members' involved in their care who supported them with their decision making. Relatives told us they felt people were "to a degree" or "to a point" involved in decision making about their day to day care and support. We saw that staff gave people time and encouraged them to be involved in decision making. For example, whether they wanted a drink or had eaten sufficient lunch. Care records included information about people's communication and ability to make decisions, to help staff adapt their approach in order to involve and encourage people to make their own decisions. For example, one care plan stated "talk to me slowly I communicate by using signs from adapted sign language, staff spend time getting to know what they mean." We saw that, where people did not have the mental capacity to consent to more complex decision making, such as hospital or dental treatment, the service had policies in place to enable staff to act in accordance with legal requirements. The registered manager told us that staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, in order to understand the legislation. Staff confirmed they had received MCA and DoLS training. In discussions staff felt the training had raised their awareness. They understood the importance of supporting people to make their own decisions and knew that best interest meetings would be held when people lacked that capacity, in order that decisions were made in people's best interests.

From our discussions with the registered manager and staff and our observations we found that some people displayed behaviours that meant they might self-harm or their behaviour might upset others. This was clearly recorded in people's care plans and there was detailed guidance for reducing the risks of this happening. Staff used equipment to restrict some people's involuntary movements which meant, for example, staff were then able to safely assist them with eating. These restrictions had been discussed and agreed with relatives and health professionals and were considered the least restrictive and in their best interest. We saw during lunch time that when a person displayed possible self-harming behaviour staff adopted a patient and calm approach explaining what they

Are services safe?

were doing and consistently used the same technique to reduce the risk of harm to the person. We looked at the care records and saw that the staff member had followed the recommended guidance for that person.

Staff had been proactive in seeking other ways of working with people around their behaviour and staff talked about "intensive interaction techniques" that some staff had been trained to use. However we found that this was not used consistently with people as so few staff were trained and there was no monitoring to determine whether the input that was provided, albeit intermittently, was having a positive effect. In discussion the registered manager advised they would review the use of the techniques with the health professional involved. Records showed that staff also sought input from other health professionals to ensure a range of investigations and examinations were undertaken to discount possible reasons for people's behaviour. For example, psychiatrist and referrals for a magnetic resonance imaging (MRI) scan and pain clinic appointments.

People benefited from effective systems in place to make sure accidents and incidents were acted upon, so people and staff were as safe as possible. Staff told us, and records confirmed, that when accidents and incidents occurred staff reported them and completed an accident/incident report. These contained information about what had happened, which was then logged onto a computer. This enabled the monitoring by staff of any action that was required to be taken to keep people safe and reduce the risk of further occurrence. For example, we saw that when a person was using the hydro pool (a hydro pool is a pool used for water exercise and other therapy treatments) they had swallowed water. The registered manager told us that the risk assessment had been updated and special equipment was now used to avoid this happening again when the person accessed the pool.

People received their medicines when they should and they were handled safely. The registered manager told us that the nurse on duty administered the medicines. There was a medicines policy and procedure in place to provide guidance for staff on the safe management of medicines.

The policy did not contain clear guidance about how to handle people's medicines safely. It had not been reviewed since 2011 and described medicines supplied in a monitored dosage system (a monitored dosage system is a medicine aid, such as a blister pack, pre-packaging all a person medicines) , which they no longer were. Although staff did not have clear guidance about how to handle people's medicines safely, they were able to demonstrate they knew how to handle medicines safely.

We observed a nurse and staff member testing a person's blood sugar and then administering their insulin. Later we saw they helped a person with their medicine, which was administered through their percutaneous endoscopic gastrostomy (PEG) feeding tube (a PEG feeding tube is a tube which goes directly into the stomach). On both occasions they explained what they were doing and made sure the person took their medicine safely.

We looked at people's medicine administration records (MAR) charts. Records showed that people received their prescribed medicines according to the prescriber's instructions. We saw that some entries on the MAR charts were handwritten and these had not always been signed or dated, which would be good practice. There was a clear audit trail of medicines arriving at the service. Records showed that medicines arriving into the home were checked against prescribing instructions. Quantities were checked and recorded to ensure there was sufficient for the four week period. There was also a system in place to audit the medicines being returned to the pharmacist and those taken out and returned when people had holidays or trips out. Some staff were trained and had had their competencies monitored in administering emergency medicines, such as medicines for epilepsy, so people could safely go out for activities.

We saw that all medicines were stored securely for the protection of people who used the service. Some prescribed creams were stored for staffs' convenience within people's bedrooms so there was easy access during personal care routines. Although there had been no assessment of this storage to make sure it was safe.

Are services effective?

(for example, treatment is effective)

Our findings

People had their needs assessed. Relatives told us they had been involved in an assessment of their family member's needs. One relative said, "We heard about Martha Trust and went and had a look and was impressed. We did the transition with the mental health team and let them know how things should be done." We saw that one person had moved into the service since the last inspection. Their needs had been assessed prior to admission and then a programme of transition had been put in place. The registered manager told us the transition period was set to suit the person as some people settled quicker than others. We saw that a series of short stays and overnight stays had been organised before the person moved in and then a review held after six weeks. In addition information was obtained from professionals where they were commissioning the person's care and support. This helped to give a comprehensive picture of the person and made sure they received effective care and support. One relative felt one of the positives about the service was that "the other care users are similar ages (in their twenties) as are a lot of the care staff." The registered manager gave an example of how the service was careful about whom they accepted, to ensure their needs could be met and they were compatible with other people who used the service.

Relatives had mixed views about whether they were involved in the planning of their family member's care and support. Some felt they were involved and others felt they were not. One relative said, "There could be more involvement." Another relative said, "To a point, although there are plans to involve us in the care plans, will that be routine? That's not known at present." We saw little evidence that relatives had been involved in the planning of people's care and support, other than providing information about needs and routines and personal histories to inform the care plan. The registered manager told us they had recently implemented a system that, when care plans were reviewed, a copy of the updated care plan was sent to the relatives for their agreement or comments. Final changes would then be made and relatives would sign a copy of the new care plan as evidence of their agreement with the content. Relatives told us they welcomed this new approach and were looking forward to having better input to the care plans. One relative who had seen their family member's care plan said, "All the information needed is in the care plan."

Most relatives felt staff did what they expected and their family member's care needs were met. We looked at three care plans. They were comprehensive and detailed people's specific choices and preferences relating to their care and support. For example, a preference for the same gender of staff, or the use of specific toiletries, such as bubbles in their bath. We found that people's needs were reassessed every six months when care plans were reviewed and updated regularly. A health care professional told us that any advice and guidance they had given the staff had been followed through into care planning and we saw this was usually the case. We saw that one person had been visited by a health care professional in March 2014 and they had given new guidance in relation to the preparation of the person's food and although we saw this was happening in practice, the care plan had not been updated. In another case we saw that the management of a health condition was regular doctor appointments and regular eye tests. We found no evidence of either but in discussions with staff, we heard about actions being taken including a best interest meeting in regard to eye tests for this person and that regular clinic visits happened for their condition, but not doctor's visits. The information in the care plan was not accurate although staff were ensuring that people's health needs were met. The above is a breach of Regulation 20 (1)(a) and the action we have asked the provider to take can be found at the back of this report.

The registered manager told us that a review meeting was held every six months involving people's relatives and, although notes lacked evidence of this involvement, all relatives confirmed they had attended review meetings.

We saw that care plans detailed how staff could encourage people to be as independent as possible. For example, we saw that one person could stretch their arm/leg out to aid putting on clothes. Staff told us the service was introducing an "active support" programme. Most staff had already received training for this programme. This required staff to review the way they worked with people setting simple, small, step goals for people to achieve and provide them with more opportunities to be involved in aspects of their daily lives. Staff described ways this had already informed their practice, such as one person hand over hand peeling vegetables, another passing cutlery to put away in a drawer and another brushing their hair. Relatives we spoke with welcomed this programme as they felt this was an area that could be improved.

Are services effective?

(for example, treatment is effective)

Relatives told us they felt staff "on the whole" had the skills and experience necessary to meet their family member's care and support needs. One relative said, "Most of them do and some need more training." Another relative said, "The staff are well trained in moving and handling techniques." One health care professional we spoke with felt that staff had the right caring and nursing skills and experience, but they felt staff skills could be improved around quality of life. Staff we spoke with told us they felt they received appropriate induction and on-going training in order for them to carry out their role and responsibilities. Records confirmed that staff had received training and, in addition, some staff had received specific training to meet people's identified needs, such as epilepsy, pain awareness and percutaneous endoscopic gastrostomy (PEG) feeding. We saw that the service had a training plan in place. Staff told us, and records confirmed, that they received observations of their practice, regular individual meetings with their line manager, team meetings and an annual appraisal, in order to support staff and ensure they deliver care and support safely and to an appropriate standard.

People had a diet to suit their individual dietary needs and preferences. A nutritional risk assessment had been undertaken for each person who used the service. We saw that detailed guidance was in place to ensure people received suitable and adequate food and drink. Food and fluid monitoring were in place to ensure people received adequate amounts of food and fluid. We saw an example where this was not happening for one person and staff had involved specialists in reviewing how best to tackle the risk of dehydration. Staff were introducing foods with a higher liquid content and we saw these were offered and eaten during lunch time. We saw that drinks were encouraged throughout the day and people with PEG feeds (a feeding tube directly into their stomach) received regular fluids. For those that because of medical conditions were not able to take fluids orally we saw that gel pads were used to help maintain good mouth care and resolve dryness of the mouth. We observed people having their lunch. We saw that staff accommodated people's preferences as to where and when they had their lunch. To ensure people received adequate food, some people had soft or pureed food and others had meal supplements. Staff were quietly supportively encouraging and assisting people with their meal and drinks on a one to one basis, so that people received the food and drink they required.

Are services caring?

Our findings

Most relatives commented positively on the care and support their family member received. Relatives told us that staff were kind and caring. Relatives felt that people had the privacy they needed and that the staff were respectful when they spoke to them. When we asked relatives about privacy and dignity one relative said, "They are very good at that. They always pull the curtains or close the blinds."

Relatives we spoke with felt the staff were compassionate and caring and understood the needs of their relative. Their comments included, "There are some very good staff", "The carers seem calm, nice and friendly people", "Generally the care side is very good", "We're very happy with the service", "They (people who used the service) are well cared for, staff are very good and caring", "The staff want the best for them" and "The staff engage with residents in a very positive, caring, and nurturing manner, in a way that demonstrates they clearly know each person very well individually. We are of the opinion that the staff see residents for who they are, not what they have. Great efforts are made to create a "home from home", where everyone feels part of a large, happy, family."

One health care professional told us they felt staff respected people's privacy and dignity and that the staff were caring.

People in the service were unable to tell us about their care and support and what it was like to live in Mary House due to their communication skills. We undertook two SOFI's during lunch observing interactions and involvement of staff with people they were supporting.

We found staff were encouraging and supportive of people's decisions about where and when to have their lunch. We saw that some people chose to come to the dining room to be with others, but had their meal later. People who were able to independently eat their meal were left to do so, although they were monitored and they were regularly encouraged or assisted to continue with their meal. However we saw that, at times, staff left the person they were feeding to assist another person without explaining to the individual what was happening and when they would return. People that required assisting with eating received one to one support. We saw that people who were assisted with eating and drinking were spoken to quietly during their meal, explaining which food was on the spoon, before people chose whether or not to eat it. We observed that, where a staff member thought a meal was not soft enough for a person they undertook to re-blend the food making it easier for the person to eat. We saw staff wiping the faces of people they were supporting throughout the meal to protect their dignity.

We saw that, when staff passed through the dining room, they acknowledged people who were having their lunch. One staff member stopped, gained eye contact with a person, and spoke with them whilst holding their hand as they did so. The atmosphere during lunch time was relaxed with people making happy noises and laughing.

We saw that personal care was managed discretely and we also saw people being taken down to the hydro pool for an activity. We observed that people and staff were dressed appropriately ensuring people's dignity was maintained. We did hear some age inappropriate words of encouragement to some young males. We made the registered manager aware of this who agreed to address this to improve practice.

The service had a policy giving guidance to staff on privacy, dignity and people's rights. Records showed that privacy, dignity and people's rights were covered during staff's induction. In discussions with staff they were able to demonstrate a good understanding and awareness of respecting people's privacy and dignity in their day to day work. For example, closing curtains and doors and allowing time alone where appropriate. Staff spoke positively about the new "active support" programme that was being implemented and how this was changing the way they worked with people with more emphasis on actively encouraging people to participate in their care and support.

Relatives had opportunities to voice their views on their family members care and support. We saw that people had regular reviews of their care and support and relatives were invited to take part. Records showed that people's preferred name was recorded in their care plan. Relatives confirmed, and we heard, people being addressed by this name. Most people living at the service had a communication passport, which described the body language, nonverbal noises, and facial expressions that they might use to indicate emotions. For example, pain,

Are services caring?

distress or anger. The triggers for some behaviours were also described to help staff recognise the signs and respond appropriately, so people received a consistent approach to their support.

People could be confident their information was handled confidentiality. The service had a policy on confidentiality. In discussions with staff they demonstrated they understood the need to keep information about people confidential. For example, not discussing other people whilst undertaking care and support to a person or having personal conversations with another member of staff. We heard from the registered manager how action had been taken recently when it was found there had been a possible breach in confidentiality, so people could be assured that any information about them was treated in confidence.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Relatives had mixed views about whether they received information from the service in a timely way. One relative told us, "Hospital letters and appointments are always scanned and sent to us by email, so we feel up to date and involved. X (family member) has a named nurse and she is very good at keeping in touch via phone calls or emails". Another relative talked about not receiving an appointment letter and one said, "We feel we don't know what is going on."

People and relatives had opportunities to express their views on the care and support provided. People had an initial assessment and their needs were reassessed every six months to determine the level of care and support each person required to meet their needs. From this care plans and risk assessments were updated. Relatives told us they were involved in review meetings when they were able to express their views on the service provided. In addition, families also had a family representative (this was a relative) that supported communication between the service and all families. One relative told us how this enabled "parents and staff to touch base." We heard mainly good evidence that relatives were welcomed in the service and most people had on-going links and contacts with their families. The service had recently installed a television that was touch screen and would enable people to Skype their relatives to help maintain their contact.

We saw that people's mental capacity to make decisions had been assessed on admission to the service. Following this, where important decisions were required, such as access to health care or the introduction of a restriction, best interest discussions had been held. These included relatives, health and/or social care professionals and staff. For those people who were fed through a tube directly into their stomach, the tube needed regular replacement. In an emergency it would need urgent replacement. It was not therefore practical for a best interest meeting to be held at the time this was required. In order to ensure that all appropriate people involved were in agreement with the tube change, this had been discussed and agreed at review meetings. Other examples of best interest decisions included behaviour management, which involved relatives, a social worker, the physiotherapist and staff. We saw that the least restrictive method of support had been assessed and consent given by those involved in the best interest decision making. Records showed that advice and guidance had been sought from the local authority.

People participated in a variety of activities although some relatives felt if activities were better planned people would participate in more activities. One relative said, "Hydro (hydro pool) is planned twice a week, but it is not happening. Usually they only get it once a week. We would like to see more outings." Another relative felt activities were detailed on the person's care plan, but they might not actually happen. They commented that watching a film did not involve any staff interaction and sometimes groups were run, but it was the staff doing the activity. Staff talked with us about the activities people might undertake. They told us information from relatives had been used to develop people's care plans so they detailed people's interests and what they liked to do. Daily report records showed that people were supported to go out into the community. For example, recent trips out had included the Rare Breeds Centre, a local garden centre, the town and walks to a nearby duck pond. In house activities had included using the hydro pool, aromatherapy, art group, spending time in the sensory room, watching films and playing and listening to music. Some staff told us that a lack of driver for the minibus had impacted on what opportunities people received, but that further drivers were being recruited and trained. This was confirmed by the registered manager. Staff had an awareness of those people who preferred time away from other people and liked to spend quiet time in their room. We saw this was scheduled into their activity programme.

Relatives told us they knew how to make a complaint and were confident to do so. Most relatives did not have any concerns and felt concerns they had raised had been listened to. One relative said, "They are generally very good and will look into things." We saw that there was a complaints procedure in place. However this required updating as the contact details of the Care Quality Commission were out of date and there was no reference to people's option of directing complaints to the local government ombudsman. The complaints procedure contained timescales so people were informed about how and when a complaint would be handled and responded

Are services responsive to people's needs?

(for example, to feedback?)

to by the service. At the time of the inspection visit there were no on-going complaints, although we saw that previous complaints had been investigated and people had received a response in line with the complaints procedure.

Are services well-led?

Our findings

There was a clear set of values detailed in the statement of purpose, which each relative had received a copy of, so people were clear about the type of service on offer and the standards they could expect from the service.

Relatives had opportunities to attend organisational relative forums twice a year and make their views about the care and support received known. One relative told us they found these "very useful, we would like more regular ones". At these meeting relatives would come together as a group with representatives of the organisation and discuss any concerns and share information. We saw from the minutes of the last meeting that relatives had raised concerns about the laundry service. We heard and staff confirmed that action had been taken to address the concerns. This had included each person who used the service having their own laundry day, which tied in with implementing "active support" and people being involved with their own laundry tasks.

Outside of these meetings most relatives felt that communication and accessibility with the management team could be better. One said, "Communication is the biggest downside. We rely on email and there can be problems receiving these." Another relative told us it "depended who was on duty about what updates we get". Some felt that they usually visited the service at weekends, but the registered manager was not available at weekends. Relatives found this frustrating and felt that small "concerns and niggles" could drag on rather than be "nipped in the bud".

There were systems in place to record, monitor and evaluate complaints, accidents and incidents. We saw that any accidents and incidents were recorded on a computer system and then periodically an overall analysis was undertaken by a health and safety consultant who monitored events for trends and learning. Individual accidents and incidents were recorded by staff on an accident form and then seen by the registered manager to investigate and take any appropriate action. We tracked an accident through the system and saw that an action plan had been recorded following the event and we heard how this had been implemented. Accident reports were also discussed at management meetings. We saw that actions taken had included working with partnership agencies to improve outcomes for people who used the service and staff. For example, when the service needed to access equipment for people. Staff told us that they sometimes received feedback about complaints or concerns raised and discussed improvements required that impacted on their practice.

Senior staff undertook regular audits to ensure people received a quality service. Audits identified areas where standards were met and also that required improvement. An action plan was put in place and monitored to ensure action was taken and shortfalls addressed. The registered manager told us audits included areas such as infection control, the environment and care plans. We looked at two infection control audits which showed improvements had been made and sustained. We saw that the staff learnt from previous inspections. Following an inspection where shortfalls were identified the service had drafted an action plan and although the service had since been found to be meeting regulations this action plan had remained in place and was still regularly monitored to ensure improvements were sustained.

We looked at some of the policies and procedures used to inform staff practice and ensure the service ran effectively. We found that the majority of these had not been reviewed for more than three years. The registered manager told us they were aware of this and the organisation had already started a review of policies and procedures with some awaiting approval from the organisations board. However, the review was slow which meant that staff might not have access to up to date guidance or legislation. For example, we saw that the safeguarding policy made reference to the incorrect local authority that would investigate a safeguarding alert.

The service had a system in place to ensure there were sufficient numbers of staff on duty. The senior management team had undertaken a calculation to ascertain staffing levels and we saw these were monitored and in the main the numbers of staff on the rota for last few weeks. Staff told us it was rare for agency staff to be used and that usually gaps in the rota were filled by existing staff that were familiar to people who used the service and their care and support needs. However on the odd occasion the calculated staffing levels had not been sustained and senior management team had not undertaken a dependency assessment based on people's needs in order to evidence that the reduced levels were safe for people that used the service. The registered manager told us they

Are services well-led?

felt they were safe as did staff, but staff felt the reduced levels might have impacted on people's opportunities to access outside activities. The registered manager told us the service had reviewed staffing levels recently and intended to raise them and were at the time of the inspection recruiting to help with the "active support" programme and they would develop and put a needs based staffing tool in place.

There was a system in place to monitor that the staff team's training requirements remained up to date and met the needs of people who used the service. Training targets were in place and training was monitored and discussed at regular organisation meetings. The service managed their own trained trainers, in addition to accessing on line training and outside training organisations. We heard how the management team had recently reviewed the staff's induction training programme and made changes so it was more service specific.

The registered manager told us that she led by example, was accessible to the staff and had an open door policy. Staff told us they had confidence in her leadership and felt comfortable in bringing concerns to her attention. We saw there was an established staffing structure in place including trained nurses, support staff and ancillary staff. Staff understood the lines of accountability and their roles and responsibilities. We spoke with staff who felt there was an open and supportive culture about the service. They found members of the management team and the organisation representatives were approachable and friendly. The service had a practice of recognising and complimenting examples of good work by staff, which were announced to other staff via their monthly newsletter. Staff felt confident in raising concerns and thought these were taken seriously and listened to. One staff member said, "The manager is very supportive. I love working here". Another said, "There is good support all round. We are a very good team here; we support each other, if needed we go to the nurse, or manager or higher up the chain, they will all support you. They are usually around and supportive including higher management."

The service had an emergency plan. We heard how this was at the time of the inspection being reviewed to make it more localised to the service. There was on call information in place and managers and nurses worked a rota system to help ensure staff had access the appropriate people at all times, in order for the service to run effectively for people.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. People were not protected against the risks of unsafe or inappropriate care as there was a lack of information or up to date information contained within care plans and risk assessments. Regulation 20(1)(a)