Martha Trust

Mary House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out on 12 and 20 July 2018 and was unannounced. At the last inspection, the service was rated 'Good.' At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Mary House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation and personal care for up to 13 people living with a learning disability. There were 13 people living at the service at the time of our inspection.

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

People continued to be supported to have choice and control over aspects of their lives, and staff supported people in the least restrictive way possible. People were able to maintain contact with those people that were important to them and were able to participate in a range of activities.

People were safe and positive risk taking was encouraged. Risk assessment and risk management practices were robust. As far as possible, people were protected from harm and abuse. Staff knew how to recognise the signs of abuse and what they should do if they thought someone was a risk. People were supported to eat and drink enough, and specialist dietary needs were met. People were able to access the healthcare they needed to remain well and their medicines were safely managed.

People experienced care that met their needs, and were supported by kind, caring staff. People had their privacy and dignity respected, and staff knew what to do to make sure people's independence was promoted. People experienced person centred care and had their care needs regularly assessed, with all of the relevant people involved.

Staff were supported with training, supervision and appraisals to make sure they had the skills they needed to provide good quality care. Specialist training had been arranged where needed, for example, supporting people with behaviour that may cause themselves or others anxiety.

People were asked for their consent before any care was given and staff made sure they always acted in people's best interests. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be deprived of their liberty for their own safety or unable to make informed choices about

their care.

The registered manager had notified the CQC of events that were reportable. The rating of 'Good' was displayed at the service and on the provider's website. The service has met all the fundamental standards and the registered manager and staff have maintained a good service. Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? the service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

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.

This comprehensive inspection took place on 12 and 20 July 2018 and was unannounced. We visited the service on 12 July and telephoned relatives on 20 July 2018. The inspection was carried out by two inspectors.

This scheduled inspection was bought forward because of safeguarding concerns which had been raised with CQC and the local authority. This meant we did not request a Provider Information Return (PIR) before the inspection. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the last inspection report and other information including any notifications. Notifications are information we receive when a significant event happens, like a death or a serious injury.

We met and spent time with most of the people living in the home. Due to the nature of people's complex needs, people were not able to tell us about their experiences, so we also observed the care and support that people received. We spoke with five members of staff, a registered nurse, a visiting health care professional, the deputy and registered manager and the director of operations for the provider. After the inspection visit we contacted three relatives by telephone and a member of the local authority safeguarding team. We sampled various records including two care plans, medicine records, quality audits, two staff recruitment files and training records for all staff. We observed how people were supported and how staff interacted with people.

Good

Is the service safe?

Our findings

People continued to experience safe care. Relatives we spoke with all told us they felt their family member was safe living at Mary House. One relative said their family member was, "Totally safe there". When talking about safety, another relative said "I don't concern myself. I'm not thinking, oh, I've got to go and see what they're doing".

Staff had regular training in safeguarding people from abuse, and knew how to recognise the signs of someone at risk of or possibly experiencing abuse. However, a safeguarding concern which staff had identified had not been reported to the registered manager and local authority on the day the concern was noted. As soon as this mistake was identified, staff and the registered manager took the right action, and the incident was properly reported and investigated. There was no impact for the person from the delay in reporting the concerns.

The provider, registered manager and staff recognised their mistake and used this as an opportunity for learning. They were given support and advice by the local authority safeguarding team about what to do to prevent this situation happening again. Staff were given further training and support, and safeguarding procedures were reviewed to make sure they were up to date. A member of staff told us, "I am confident about raising a safeguarding, we all are aware of whistle blowing procedures and I wouldn't hesitate to raise a safeguarding if I saw any form of abuse".

Other incidents and accidents were recorded and reviewed. For example, medicine errors had been identified and reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. This meant it had been disclosed to the individual or their next of kin, an apology offered and an action plan discussed to prevent a reoccurrence. This ensured as far as possible lessons had been learnt. Individual risk assessments had been implemented, reviewed and updated to give enough guidance and support for staff to help them provide safe care.

Risks to people's safety were well assessed and properly managed. Staff knew what they needed to do to make sure people remained safe and described how they would identify risk and take appropriate action to minimise it. This included supporting people who may have behaviours that could cause themselves or others anxiety, or managing a complex heath need which could put people's safety at risk, such as epilepsy. A visiting health care professional described how staff were able to complete dynamic risk assessments as people's health needs changed through the day. This enabled people to join in with a particular activity which could be potentially challenging in a safe way.

People continued to be supported by enough well-trained staff to meet their care needs in a safe way. When people needed the support of more staff for a particular activity, such as hydrotherapy, they were always made available. Recruitment practices remained good, and the relevant checks were made before staff began work.

People's medicines continued to be safely managed. Each person had an individualised medicine

administration record (MAR). MAR charts are a document which records when people received their medicines. This included a photograph of the person with a list of their known allergies, any swallowing difficulties and how they took their medicines. MAR charts showed medicines were administered appropriately and on time. There was clear advice for staff on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol and anti-convulsion (seizure) medicines. Registered nurses and senior care staff had received appropriate training in administering medicines.

The home remained clean, and there were regular audits to make sure cleanliness levels were maintained. Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or apron when needed. The building and equipment was properly maintained and regular checks of the environment were carried out to make sure people were safe, such as checks of the fire safety equipment and electrical systems.

Good

Is the service effective?

Our findings

People continued to experience effective care. Their choices and needs were regularly assessed and met. As far as possible people and their relatives were involved in care plan reviews, which were completed regularly. This made sure people's needs were regularly reviewed, so their treatment and support was delivered in line with their preferences, current guidance and best practice. People's protected characteristics were considered when care was provided and staff made sure that people's complex needs were not seen as a barrier for people to achieve effective outcomes in their care. People were supported to use technology, such as a computer tablet, or specialist computer software to make their preference known, and to support them to be as independent as possible when making choices.

People were supported by staff who received suitable training to enable them to meet people's needs, as well as regular supervision and appraisal. One member of staff said the training is "Good, we get training on challenging behaviour" which enabled them to support people without having to restrain them. Staff had regular opportunities to talk about the people they supported and reflect on their practice. The registered manager made sure staff had completed additional training in caring for people with a complex learning disability or complex physical disability. This included training in emotional intelligence. These subjects focused on emotional awareness and how this might contribute to developing deeper relationships with people based on mutual respect. Staff had completed other specialist training called Positive Behaviour Support (PBS). This enabled staff to support people who may from time to time experience behaviours that could cause themselves or others anxiety. Other mandatory training included moving and handling, infection prevention and control and food hygiene.

People continued to be well supported to eat and drink enough. Food was homemade and nutritious and staff and the chef knew what people's preferences were. Some people had difficulty swallowing and were at risk of choking. This meant they ate a diet that was soft or pureed, to help reduce the risk of them choking. Guidelines regarding the consistency of food for people with swallowing difficulties were available and staff made sure they knew each person's nutritional guidelines well. Some people were unable to eat food with their mouth, so had a percutaneous endoscopic gastrostomy (PEG) in place. This is where a tube is passed into a person's stomach through the abdominal wall, and provides nutrition directly into the intestines, bypassing the mouth. Staff knew how to support people with this way of feeding. Everyone was supported with their nutritional intake and staff knew what to do to make sure people had enough to eat and drink, while remaining safe.

Staff had a good understanding of how to involve people, where they were able, in decision making and made sure they asked people for their consent before providing care and support. Staff understood the Mental Capacity Act and how it related to the people they support. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in

their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that DoLS applications had been made for those people that lacked capacity. Where a DoLS had been granted, staff made sure they met the conditions of the DoLS.

People had their capacity to make decisions about their day to day life, regularly evaluated and reviewed. When best interest decisions were made on behalf of a person, they were decision specific and detailed how the person was involved in the decision making if possible, as well as others who knew them well, such as a relative or health care professional. People were supported with more complex heath care decisions and staff made sure they acted in people's best interests.

People continued to be supported to work with healthcare professionals so they maintained good health. Everyone was registered with a doctor and had access to the community learning disability team, occupational and physiotherapists. Staff and the registered manager made sure people had regular heath checks and medicines reviews. People's health needs were monitored by staff who took prompt action if people became unwell or their health needs changed. For example, one person became unwell during the inspection. The person was supported in a prompt way, by staff who quickly recognised the sudden change in the person's health. The person received the right healthcare support quickly, and was soon back to their usual self.

The building was purpose built and suitable for people's needs. Everyone had access to all areas including the garden, however they moved around. Everyone had their own room and each person had been helped to decide how they wanted it to be decorated. There were plenty of personal belongings, photographs and mementos to help make things feel like home. There was enough specialist equipment to help people bath and shower and rooms had been adapted so people who used a wheelchair or other mobility equipment could get around as easily as possible. People had specialist seating which provided postural support so they were able to relax and rest in comfort.

Good

Is the service caring?

Our findings

People continued to be treated in a kind and caring way. Staff were compassionate and treated people with dignity. There was a calm and relaxed feeling in the home and staff knew people and their preferences well. For example, we saw one person who communicated through their behaviour that they were distressed. Staff knew this was what the person was communicating, and responded quickly and in a dignified and respectful way. The person was supported in a caring way by staff and their distress resolved quickly because of this.

A relative told us staff were, "Very good. Very approachable" and have a "Good focus" on people, and that living in the home enabled their family member to, "Do the things she would found really difficult to do" such as hydrotherapy and being with a group of their peers. One member of staff described the home as "Very family orientated, friendly and run well" and they "love" working in the home as people were "at the centre of what we do."

A visiting health care professional (HCP) said, "Staff know their clients really well", which enabled people to take part in a complex activity. The HCP went onto say, "I never get an 'I don't know' from staff" and staff gave a very detailed and clear handover to make sure people enjoyed an activity as much as possible. "The staff care about each other too. There's always been a nice happy atmosphere when I come", and "there's a nice feeling about the place."

People's dignity and privacy was respected and staff knew how people preferred to live their lives. Each person's room was their own and staff did not enter without the person's permission. People's confidentiality was protected and records were kept securely, so they could not be accessed by people who were not authorised to do so.

People, their relatives and staff where appropriate, were involved in care plan reviews, and in helping people as much as possible to make their preferences known. One relative described how staff needed time to get to know their family member and saw that staff had done this. They said, "Staff all seem to know what they are doing" and, "When you see them with (name) there is definitely a relationship", "It's a family atmosphere" and "We are very pleased with them (staff) and very happy for (name).

Most people had lived at the home for some time and staff and the registered manager had used this experience to enable them to understand people's preferences and to support people to be as independent as possible.

People were given control and choice in their own lives. People were at the centre of everything in the home and staff made sure people were involved in aspects of daily life where possible. Staff communicated with people in their preferred way, to make sure this happened. This included using objects of reference and pictures where appropriate. Staff also understood people's body language very well and what a person was communicating with their actions if they were unable to communicate verbally.

People's friends and relatives were encouraged to visit whenever they liked and social gatherings and parties were common. People were supported to stay in contact with relatives using social media and video calling.

Good

Is the service responsive?

Our findings

People continued to experience care that was person centred and focused on them as an individual. People had regular reviews of their care needs and care plans and risk assessments were amended when necessary. The relevant people were involved in each person's care reviews. Staff were responsive to people's individual needs and responded well to requests from people when they needed support. Staff enabled people to be as independent as they could. People were supported with their religious and spiritual needs and had been supported to attend a place of worship of their choice, when and if they wanted to.

People were supported to follow their interests and staff took time to find out what people might enjoy doing. For example, one person was supported to go 'banger racing', as staff thought this might be something the person would enjoy. However, the person found the noise and dust uncomfortable, and they decided they did not want to go again. People were supported to do other activates such as watching football on the home's 'big screen' and going out for coffee. People and staff had joined together and formed a choir which they had named the 'Mayhem' choir. This enabled people and staff to join together and take part in an activity which they all found enjoyable.

From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People were supported with their specific communication needs. Staff understood how to use pictures and objects of reference where appropriate. Some people also used Makaton to communicate. Makaton is a language programme which uses signs and symbols to help people to communicate. Staff and the registered manager had recognised this was a communication area they could further develop and had introduced a 'sign of the week', to help them learn more signs so they could develop their communication skills.

People were being supported with other associative technology to help them use a computer to communicate. A new IT suite was planned, to enable people to further develop this way of communicating. The registered manager hoped this would also enable people to become more active in expressing their choices and making decisions.

The provider had a complaints policy and complaints continued to be managed appropriately. A relative told us, "If I have any problems I go straight to" the registered manager and, "He gets on it straight away. He says 'if you don't complain, we can't rectify it. We need you to come and tell us or we can't change it". If any concerns or complaints were raised, they were listened to and the registered manager aimed to use them as a learning tool.

Although no-one was being supported with end of life care at the time of the inspection, staff had considered what might happen in the future as people age, or if they suddenly became unwell. They had

talked with people's relatives or their representatives to find out what their funeral preferences might be. Staff expected people to be able to live in the home for the rest of their life and training for end of life care was being considered. One RN said, "I hope to be able to introduce end of life care training and teach in house to all staff."

Good

Is the service well-led?

Our findings

The service continued to be well-led and there was a registered manager in post. Responsibilities were clear, and there was a clear staffing structure in place for the day to day management of the service. A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The service continued to be well managed by the provider, long standing registered manager and staff team.

Relatives and staff gave positive feedback about the culture and values of the service and described how the registered manager had made a positive impact on improving the way the service was run. A relative told us the registered manager was, "Very open and accessible. Always available if you need to chat" and they, "Have been great since he's been there things have improved because of his openness". The same relative said they were happy with the way the registered manager had dealt with a significant incident and said, "They were very professional" and made sure staff were given extra training. They want on to say, "It was fine. These things happen" and "He's approachable and gets things done"

The provider, registered manager and staff promoted a culture that was person centred and supportive. The registered manager described how they wanted to develop a strong 'thinking' culture in the home, to enable staff to provide, "Excellent personal care, being open minded, person centred and not tasked focused". Staff aimed to deliver high quality care, and this was at the centre of their work. One member of staff told us the home was relaxed with "No pressure" and "No set schedules for care delivery. It's tailored for each person". They described how the home was very well run, with good communication between staff and managers and that everyone worked well as a team. The provider was moving towards electronic care plans and medicines management. The aim was to free up staff time so they were more available to spend time with people who use the service, as well as simplifying the quality monitoring processes.

There continued to be a suitable quality monitoring system in place which included health and safety checks, medicines audits and standards of cleanliness. Any areas identified for improvement were addressed. Other managers within the organisation monitored quality assurance checks and provided support to the service if it were needed. Senior managers also regularly visited the home, to meet people, review their care and to make sure quality standards were maintained. People, and their relatives, where appropriate, continued to be asked for their opinion about the quality of service during regular meetings and in surveys.