Shaw Healthcare Limited

The Martlets

Inspection report

Fairlands
East Preston
West Sussex
BN16 1HS

Tel: 01903788100
Website: www.shaw.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Martlets is registered to provide accommodation and nursing care for up to 80 people. The service supports people who have nursing needs, older people and those living with dementia. On the day of our inspection 71 people were living at the home.

The service had a registered manager in place. 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.

At our last inspection to the service in November 2015 we found two breaches of regulations. We found the service did not have sufficient staff to support people effectively and the registered person did not ensure the care and treatment of people was person centred. We asked the provider to take action and the provider sent us an action plan in December 2015 which told us what action they would be taking.

At this inspection we found that improvements had been made to safe staffing levels. However, further improvements were needed to ensure that staffing deployment would be based on changes in people's dependencies. The registered manager told us that staffing levels were in accordance with people's dependency levels. However not everyone's dependency levels had been assessed if their needs had changed so it was not possible to establish what the correct staffing levels should be. We have made a recommendation that the provider establish dependency levels of people who's needs had changed in order to ensure staffing levels remain safe.

At this inspection we found improvements to person-centred care had been made and the requirement was now met.

The arrangements for managing medicines (including obtaining, prescribing, recording, handling, storing, security and disposal) did not always keep people safe.

People told us they felt safe. Relatives told us they had no concerns about the safety of people. There were policies and procedures regarding the safeguarding of adults and staff knew what action to take if they thought anyone was at risk of harm. Risk assessments were in place to help keep people safe and these gave information for staff on the identified risk and guidance to mitigate the risks. Safe recruitment practices were followed and recruitment procedures ensured only those suitable to work in care were employed.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There were 29 people living at the home who were currently subject to DoLS. The registered manager understood when an application should be made and how to submit one. We found the provider to be meeting the requirements of DoLS. People were generally able to make day to day decisions for

themselves. The registered manager and staff were guided by the principles of the Mental Capacity Act 2005 (MCA) regarding best interests decisions should anyone be deemed to lack capacity.

Staff had undertaken training to ensure that they were able to meet people's needs. The provider supported staff to obtain recognised qualifications such as Qualifications and Credit Framework (QCF). or Health and Social Care Diplomas (These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard). All staff completed an induction before working unsupervised. Staff had completed mandatory training and were encouraged to undertake specialist training from accredited trainers. Staff received regular supervision and monitoring of staff performance was also undertaken through staff appraisals.

Each person had a plan of care which was person centred and provided staff with the information they needed to support people. However new care plan formats were being introduced and we discussed these with the registered manager as they were large documents which could make information difficult to find. People received enough to eat and drink. People spoke positively of the food and the choice they were offered. We were told, "The food is good, there is always a choice". People who were at risk of malnourishment were weighed on a monthly basis and referrals or advice were sought from suitable professionals where people were identified as being at risk.

Staff were knowledgeable about people's health needs and knew how to respond if they observed a change in their well-being. Staff were kept up to date about people in their care by attending regular handover meetings at the beginning of each shift. The home was supported by a range of health professionals.

People's privacy and dignity was respected and staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

The provider had a clear complaints procedure but people would benefit from further information when responses to complaints are provided.

The registered manager welcomed feedback on any aspect of the service. The staff team said communication between all staff at the home was good. However some staff felt they were not listened to by the provider's senior management.

The registered manager acted in accordance with the registration regulations and sent us notifications to inform us of any important events that took place in the home of which we needed to be aware.

The provider had a policy and procedure for quality assurance. The registered manager was visible and the operations manager visited the home regularly. The registered manager operated an open door policy for both staff and people using the service and their relatives. Weekly and monthly checks were carried out to help monitor the quality of the service provided, however these checks had not identified the shortfalls we found at the inspection. There were regular residents' meetings and people's feedback was sought on the quality of the service provided.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were placed at risk because medicines were not always managed safely.

Dependency needs of all people were not carried out so it was not clear if sufficient numbers of staff were always provided to meet people's needs.

There were policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Is the service effective?

Good

The service was effective.

Staff were trained in a number of relevant areas and received regular supervision.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet and specific dietary needs were catered for.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People told us they were treated well by staff and always treated with dignity and respect. Relatives said they were very happy with the care and support provided.

We observed care staff supporting people throughout our inspection. We saw people's privacy was respected. People and staff got on well together

Staff understood people's needs and provided support the way people preferred.

Is the service responsive?

Good

The service was responsive.

Each person had an individual plan of care and these gave staff the information they needed to provide support to people and there was a regular programme of activities for people.

The service had a complaints procedure and people knew what to do if they wished to raise a concern. However more information is needed when responses to complaints are provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were management systems in place to monitor the quality of the service. However these did not always identify shortfalls in the service provided.

Staff were not always confident in the providers senior management and felt they were not always listened to.

There was a registered manager in post who promoted an open culture. Staff told us they were well supported by the manager.

People and relatives told us the manager and staff were approachable and they could speak with them at any time.

The Martlets

Detailed findings

Background to this inspection

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

This inspection took place on 6 and 19 December 2016 and was unannounced. On the first day of the inspection an inspector, a pharmacist inspector, a specialist nurse advisor and an expert by experience conducted the inspection. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service. The expert by experience supporting us on this inspection had a background in dementia care. The second day of the inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. It asks what the service does well and what improvements it intends to make. We reviewed the PIR and checked the information that we held about the service and the service provider. This included the last inspection report and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

Some people at the home were living with dementia and were unable to share their experiences of life at The Martlets. We did, however, talk with people and obtain their views as much as possible. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with 14 people and five relatives. We talked with eight members of care staff, a senior carer, one agency nurse, the maintenance person, two domestic staff, the cook, the activities co-ordinator, the clinical lead nurse and the registered manager. We also received feedback from three health and social care professionals and a member of the local commissioning team from social services to gather information about the home.

We observed how staff interacted with people and how they supported them in the communal areas of the home. We looked at plans of care for eight people and also looked at risk assessments, incident records and medicines records. We looked at recruitment records for three members of staff. We also looked at staff training records and a range of records relating to the management of the service such as activities, menus, accidents and complaints as well as quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in November 2015, the provider was in breach of a Regulation associated with sufficient staffing deployed to meet people needs. At that time, there were not enough suitably qualified persons deployed to meet people's needs. We made a requirement for the service to improve. The provider sent us an action plan which told us that the registered manager had identified that the lunch time was busy and had deployed extra staff to meet people's needs at these times. At this inspection, we found that improvements had been made to ensure staff were responsive to people's needs throughout the day but that further improvement was needed to ensure changes in people's dependency was reflected in the staffing levels deployed.

On the days we visited there were a team leader and four staff working on the ground floor supporting 27 people. On the first floor there were a team leader and five members of staff supporting 29 people who were living with dementia. On the second floor there was one registered general nurse (RGN) and five members of staff supporting 15 people. At night there was a team leader who provided support across the ground and first floor with three care staff on the ground floor and three care staff on the first floor. On the second floor there was a RGN and two care staff. All night staff were awake throughout the night. The home's staffing rota showed that staffing levels were maintained at the same levels throughout the week and at weekends. Although the staffing levels currently deployed were the same as at the last visit to the service, the registered manager had altered how staff were deployed at key times such as meal times and this had improved the number of staff available to support people during this period.

The provider employed a total of 81 care staff, which included the registered manager, a unit manager, a clinical lead nurse and eight senior carers. In addition to care staff the provider employed a total of 23 staff including, domestic and laundry staff, kitchen staff, a maintenance person, two administrative assistants and activities co-ordinators. This meant that care and nursing staff could focus their time on providing care to people.

During our visit we used our SOFI tool to observe how people were supported by staff. At our last inspection there was an issue with staffing levels during the lunch time meal as staff were rushed when providing support to people to eat and others had to wait for long periods for support. The registered manager told us that at meal times more staff had been deployed to assist the care staff. These additional staff included the registered manager, domestic supervisors and the activities co-ordinator. Observations showed that staffing during meal times had improved and the registered manager told us they had utilised some domestic and activity staff to help out at meal times so the maximum numbers of staff were on the floor supporting people with their meals.

We spent time in the lounge areas on all floors. Staff told us, and our observations confirmed, that at least one member of staff was based in the lounge area to provide support to people, with other staff supporting people in their rooms or elsewhere on the floor. During our visit we observed call bells were answered in a reasonable time and people told us they did not have to wait long if they used the call system.

People told us staff were always busy. One person said, "I don't know how they cope, I don't think there are enough of them". Another said, "They (staff) are rushed off their feet; they do a brilliant job but they can only do so much in the time they have". A further person commented, "They are always cheerful even when they have so much to do". Relatives also told us staff were always very busy. One relative said, "If you come at weekends it's sometimes difficult to find staff, they are helping people in their rooms so there is no staff on the floor". One healthcare professional commented, "The layout of the home makes it difficult to find staff, there just doesn't seem to be enough of them".

Staff working on the ground floor told us people's needs were increasing but the staffing levels remained the same so the work was more stressful and they did not always have the time to do everything. Staff on the first floor said the staffing levels made it difficult to meet people's needs at all times as their care and support needs were high.

The registered manager told us staff at The Martlets were recruited to current dependency levels. Before a person moves into the home a baseline assessment was carried out to see if the home could meet the person's assessed needs. The registered manager told us if a person's needs changed the dependency needs of the person would be established by using a 48 hour diary where staff recorded the time spent providing care to each person so they could establish their dependency needs and allocate staff accordingly. However when needs had changed not everyone had their dependency needs re-assessed. This meant that staffing levels could not be relied on if everyone's dependency needs were not known. The registered manager said if there were any concerns regarding the dependency needs of individual people, they would use the 48 hour diary to see if their needs had changed. However, without up to date assessments, the tool would not be useful in identifying a change in dependency needs.

We observed that the current staffing levels did not place people at particular risk and found that improvements had been made to deployment of staff at key times, such as meal times. We observed that people's needs were attended to by staff in a timely way. However, staff told us that people's dependency levels had increased whilst staffing levels have remained the same. Staff, people and relatives told us they observed this increase in pressures for staff. This meant that staff were under increasing pressure and over time this could lead to difficulties in responding to people's needs. WE RECOMMEND that the provider carries out timely assessments when people's needs change to establish their dependency needs so that accurate and responsive staffing levels can be established to meet people's changing needs.

Medicines were not managed safely. People were registered with four GP practices and medicines were dispensed by a community pharmacy. Since our last inspection, a new computerised system, an Electronic Medicines Administration Record (EMAR) for recording and monitoring of medicines had been introduced by the provider. Staff checked that quantities and descriptions of medicines matched what was ordered against the EMAR system on delivery to the home; this was witnessed by a second member of staff. The community pharmacy provided training and a helpline on the EMAR system. Senior carers and a registered agency nurse had attended the training. However, staff yearly competency assessments in the administration of medicines by the home's management were overdue. This meant that staff administering medicines may not have the skills or competence required to carry out this task safely.

Medicines were not always administered on time. The EMAR system recorded the time of administration and we saw that some people's medicines were delayed in being administered. We were told that the EMAR system had helped to improve medicines' management. However this had not improved the time taken to administer medicines to people. Staff said that the morning medicines round could take up to three and a half hours to complete. This was due to the number of different medicines people were prescribed. The layout of the building also made it difficult for staff to get around with the medicines trolley quickly. We saw

evidence that a medicine prescribed for Parkinson's disease, due at 09.00 hrs, was given at varying times on different days, over a two and a half hour time span. Medicines prescribed to treat Parkinson's disease should be taken consistently at the same time each day to avoid symptoms of the disease occurring.

On the first day of the inspection, we observed medicines being administered during lunchtime on the middle floor of the home. We were told that this was sometimes delayed as staff administering medicines were also required to assist people with their lunch. The staff member administering medicines was interrupted on several occasions to assist people living in the home, to talk to a visiting GP and to answer the telephone. This practice was not in line with the home's medicines policy that stated that for safety purposes those administering medicines must not be disturbed unless there is an unavoidable emergency. This is to reduce the risk of medicines errors or omissions. One person was asked if they would like one or two soluble tablets for their pain. One tablet was requested, but due to distractions the nurse dissolved two tablets. However, the nurse openly told the person that there were two tablets and the person agreed to take them. The EMAR system recorded that the person usually only takes one tablet.

People's allergies were recorded and photographs were used to identify people which ensured the correct medicines were given to the appropriate person. However, some records did not include people's photographs which might have made it difficult for new or agency staff to administer medicines safely.

Patches to relieve people's pain were applied appropriately, but the area of the body was not recorded in the care notes. When pain patches are used, it is important that the area of the body they are affixed to is changed each week to ensure effective pain relief and avoid skin irritation. Failure to record this meant that this could not be monitored. Some patches for pain were to be applied weekly and were not checked regularly to ensure that they remained in place. This meant that some people may not be getting the amount of pain relief they need.

Dates for some medicines had expired and open bottles of liquids did not all have a date of opening recorded. This meant that some liquids which have a shortened shelf-life once opened may have been administered and this could mean people received medicines that were not effective.

Daily fridge temperatures were monitored; however records of one fridge did not include maximum and minimum temperatures. Therefore it was not certain if the fridge temperatures had remained within range and the medicines would be safe and effective.

Medicine safety alerts (national alerts requiring faulty products) were received by the registered manager. She told us that the pharmacy informed the home of drug recalls. There was a folder dated 2015 with information about medicine recalls and these detailed any action that had been taken. Any recalls issued in 2016 were on email, but there was no evidence to show that any action had been taken. This meant that there was a possibility that faulty products that had been recalled could have been missed.

Some medicines were administered on a 'when required' (PRN) basis. A service quality audit had been carried out in November 2016. In the medication audit section it said 'PRN protocols not completed correctly or in-date'. There was no evidence that any action had been taken to address this issue which meant that PRN medicines may not have always been administered and recorded in line with the providers policies and procedures.

The above evidence shows that the arrangements for managing medicines did not always keep people safe and is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People told us they felt safe at the home. People we spoke with said that they felt safe and would speak to staff if they were worried or unhappy about anything. One person told us, "In every way I feel safe here. Staff help me to move around and I feel supported by staff". Relatives had no concerns about their loved one's safety. One relative said, "Yes, I am confident that he has been safe here. Perhaps at the weekend staff numbers have been a bit thin but personally I've not had a problem and the home is usually clean".

Appropriate recruitment checks were carried out before staff commenced employment. Recruitment checks included completion of an application form and details of work/education history, proof of identification and eligibility to work in the UK. Disclosure and Baring Service (DBS) checks were also carried out. DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people. Staff did not start work at the home until all recruitment checks had been completed. At the time of the inspection, the service did not employ any nurse staff directly with the exception of a clinical lead nurse who has just started work at the home. Nursing staff were provided by an external agency and the registered manager told us they used the same agency and same staff so they had continuity of care for people. The clinical lead nurse said she was hoping to recruit permanent nursing staff in the future.

The service had policies and procedures regarding the safeguarding of people so staff had information about how to recognise possible abuse. A notice on display informed staff and people of who to contact should they have any concerns. All staff had completed training in safeguarding people and this was also included in the induction for newly appointed staff. Staff showed an understanding of safeguarding, were able to describe the different types of abuse, how they would recognise the signs and what to do if they were concerned about someone's safety. This meant people were protected by staff who knew what action to take if they suspected anyone was being mistreated.

Risk assessments were contained in people's plans of care. Where a risk had been identified there was information on how the risk could be reduced. These assessments gave staff the guidance they needed to help keep people safe. We saw risk assessments for the use of bedrails, the moving and handling of people and a Waterlow pressure ulcer assessment. There were also risk assessments regarding falls and for the use of equipment such as pressure mats which alerted staff when those at risk of falling got up in the night.

The registered manager told us about the contingency plans that were in place should the home be uninhabitable due to an unforeseen emergency such as total power failure, fire or flood. These plans included the arrangements for overnight accommodation and staff support to help ensure people were kept safe.

There was a maintenance log where staff or relatives could document any maintenance areas for attention such as light bulbs not working or electrical issues. The maintenance person recorded when these were attended to. The registered manager said there was a maintenance team employed by the provider and a maintenance person was on site Monday-Friday and someone on call at the weekends. On the first day of the inspection a programme of refurbishment was taking place, a number of carpets and flooring in the home were being replaced, however, this did not impact on people using the service. The home was found to be generally clean and was free from any odours. Staff, relatives and residents said the building was kept clean and well-maintained and any maintenance issues were dealt with swiftly.

Good

Is the service effective?

Our findings

People told us they were well supported by staff. People said staff were good and knew what they were doing. One person said, "They are very good, they all do their jobs well". Another told us, "The staff seem well qualified and they involve me in my care. The food's fine, plain but good; you order your meal the previous day and they are very good here at getting us drinks. If I ask, they will organise a visit from the chiropodist or the dentist and if I don't feel well, I ask to see the GP and they organise it". Relatives were happy with the care and support provided for their family members. One told us, "Medically, staff keep me informed and meals are adequate, they have choice". People were positive about the food provided. Comments included: "The food is nice – there's always choices," and, "On the whole, the food is good" and "They will do something else if you didn't fancy the meal on the day. We get enough to drink and if we ask for more they will always get it for you".

We looked at the training provided for staff. Mandatory training topics included: moving and handling, fire safety, safeguarding, infection control, food hygiene, health and safety, Control of Substances Hazardous to Health (COSHH), first aid and accidents and sudden illness. Additional training topics included: challenging behaviours, equality and diversity dementia, end of life care, diabetes, continence, person-centred care, data protection, catheterisation, Deprivation of Liberty Safeguards (DoLS) and training on the Mental Capacity Act 2005 (MCA). We asked staff about the training provided and generally staff were satisfied. One staff member told us, "The training is pretty good, if you ask for training they will arrange it for you".

New staff members completed an induction when they first started work. The registered manager said that care staff completed a four day induction and this included two days completing the provider's corporate induction with two days covering care practice and essential training. All new staff were expected to complete the Care Certificate, which is a nationally recognised standard of training for staff in health and social care settings.

The provider encouraged and supported staff to obtain further qualifications to help ensure the staff team had the skills to meet people's needs and support people effectively. The registered manager said that of the 71 care staff employed, 67 had achieved a minimum of level 2 National Vocational Qualifications or diploma in health and social care. The registered manager said this was something that the provider encouraged staff to do.

Staff received regular supervisions from their line manager every two months. The registered manager supervised senior staff who in turn provided supervision for other staff. Supervision records demonstrated a review of multiple areas/issues including: Review of work performance, future work targets agreed, training, support and development needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. Where appropriate, people's capacity to consent to care and treatment was assessed. These assessments showed whether people had capacity to make specific decisions about their care. Staff confirmed they had received training in the MCA and DoLS and this helped them to ensure they acted in accordance with the legal requirements. The registered manager and staff understood their responsibilities in this area. The registered manager told us that although people at The Martlets were frail and some were living with dementia, people were able to make day to day choices and decisions for themselves. The registered manager understood that if a person needed to make specific decisions, their capacity to make these decisions would need to be assessed.

In some people's care plans capacity assessments were in place and had been appropriately completed. It was also understood by the registered manager and staff that if the person was assessed as lacking capacity, decisions about their care and treatment would need to be made on their behalf and in their best interest. The registered manager told us that currently 29 applications for people under DoLS which applies to care homes had been made. Seven had so far been approved and the others were being dealt with on a priority basis. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Care plans had information about people's ability to make decisions about their care, treatment and support. We saw people had signed consent forms for staff to provide support to them and also for having their photographs used. We observed staff spoke with people and gained their consent before providing support or assistance.

People were consulted about their food preferences. Staff told us that menus and people's choices of food were regularly discussed during residents' meetings. We observed the lunch period on all three floors. Meals were served from a portable plug-in trolley with lidded compartments – it looked and smelt good, and was hot. On the 2nd floor the mealtime was well run and people who remained in bed were assisted with their food. On the 1st floor, 15 people were eating at the table in one lounge and in the other lounge seven people were sat at the table having their meal. Three people were eating their meal from an overlap table. On the ground floor, 17 people were served in the dining room and the rest chose to eat in their rooms. Meals were observed to be well presented. People were offered a choice of hot Cornish pasties, with peas and swede and chips or mashed potato. The alternative choice was egg and chips. We saw that three people chose to have a salad and seven chose to have an omelette as an alternative. This was followed by semolina or a choice of yogurts. All residents had drinks served with their meal. There was a choice of different squashes and/or water. This meant people were supported to have a balanced and nutritious diet.

People had chosen their meal the day before. However staff told us that if anyone changed their mind they could have a different choice and if the choices on offer were not to their liking, an alternative could be provided. The cook told us there were always extra portions sent up to each floor in case people changed their minds. Staff offered supported to people as required. We saw one person being assisted to eat by a family member. We also observed one person being very patiently supported to eat by a staff member. There was lots of gentle encouragement, and patience to ensure the person ate and drank sufficiently.

The cook advised us that she had been employed by the provider for seven years. She had an awareness of

special dietary needs and if needed would speak with dieticians and the nurses. She was knowledgeable about people's allergies, and had information about Coeliac disease and other dietary requirements people may have. We saw that a list of people's dietary needs, allergies and food preferences was displayed in the kitchen to ensure that the cook was aware of people's needs and choices when preparing the meals. People at risk of poor nutrition were regularly assessed and monitored using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify people who are malnourished, at risk of malnutrition or over weight. All people with special dietary needs were regularly assessed by external professionals, including the GP and dietician, to ensure their nutritional needs were being met. Food and fluid charts were in place to monitor how much people had eaten and drank on a daily basis however these were not always accurately completed by staff to clearly document that people received adequate nutrition and hydration. Although we did not see that this had impacted on people, the provider may wish to consider how this recording can be improved. .

Throughout the meal on all floors there were sufficient staff to provide support and encouragement. The atmosphere was relaxed and pleasant. Nobody was rushed. Following lunch people were asked where they wanted to go, either to the lounge or to their rooms. Carers assisted people appropriately and they were chatting to people and engaging them in conversation as they supported them.

People's health was monitored regularly and support was sought promptly when required. During the inspection we observed that one person was receiving a visit from a local GP. Each person had a health section in their care plan which contained information about the person and their health needs. This information helped to ensure people received consistent, effective support. People were registered with a GP and staff arranged regular health checks with GPs, specialist healthcare professionals, dentists and opticians and this helped people to stay healthy. A record of all healthcare appointments was kept and this included a record of any treatment or medicines prescribed, together with details of any follow up appointments.

Good

Is the service caring?

Our findings

People were happy with the care and support they received. People gave us positive feedback regarding the caring nature of staff and the home. Comments from people included: "Staff are all friendly and nice," "Staff are respectful and find time to have a chat" and, "The care here is good, all the staff are nice and friendly and everybody's pleasant". Relatives said the staff were kind and caring. One relative said, "I come in to help feed my husband at lunchtime and I believe the residents on floor one are all getting frailer and the staff are stretched looking after and caring for them. However they are always friendly. Polite and respectful and remain cheerful".

We saw that people were treated with kindness and compassion and staff related to people in a courteous and friendly manner, explaining what they were doing and giving reassurance if required.

Staff were able to tell us about the people they cared for, what they liked to do, whether they liked to join in activities and their preferences in respect of food. Staff showed an understanding of confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in the home's communication book which was a confidential document or discussed at staff handovers which were conducted in private.

Staff knocked on people's doors and waited for a response before entering. One staff member told us, "I always knock and wait for an answer before going into anyone's room". Another said, "I always make sure the door is closed and curtains are closed before offering any personal care, it's about protecting people's dignity". We observed staff took time to explain to people what they were doing and did not rush people; they allowed them time to take in the information and respected whatever decision they made. We observed respectful conversations between staff and people and there was also laughter and banter. People seemed to get on well together and some friendships had developed between residents.

We saw one person who was sitting in a chair in the lounge. This person needed a stand aid hoist to move into a wheel chair so they could see the GP in private. Staff explained to the person what they were going to do and why, they used a calm reassuring voice and explained what they were doing at each stage. The staff carried out this task with the minimum of fuss and engaged with the person throughout the process. This enabled the person to understand what was going on and why they were being moved.

On the floor where people living with dementia were cared for, staff responded calmly to people who were shouting out and tried to distract them and engaged them in conversation. They crouched down or sat next to people to meet them at eye level. They encouraged people and offered choices about what they might like to do and used distraction techniques to help people remain calm. We observed one person on the middle floor walking up and down the landing area and a staff member engaged positively with this person, they asked where they were going and if they needed any help. The person said, "I'm just having a look around". The staff member then told them, "That's OK but if you need any help just come and ask me".

There was a good rapport between staff and people and staff used people's preferred form of address and chatted and engaged with people showing kindness, patience and respect. Everyone was dressed appropriately for the time of year. On the first day of our visit the hairdresser was in attendance and we noted that some of the ladies had their hair done and were enjoying the experience.

Staff were seen to consult people before offering any support and this approach helped ensure people were supported in a way that respected their decisions, protected their rights and met their needs. Staff ensured people's privacy and dignity was respected. People who preferred to preserve their privacy were able to do so. Staff said they encouraged them every day. One staff member said, "We ask them what they want to wear, where they would like to sit. It's up to them, we ask them what they want. Some people choose to stay in their rooms while others like to go to the lounge. We give them choice, It's up to them."

People told us their privacy and dignity was always respected. We spoke with a member of care staff who told us about a person who had specific personal needs. This was met with maturity and were told that some compromises had been made to meet this person's needs.

Good

Is the service responsive?

Our findings

At the last inspection of the service we found that the registered person did not ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences. This was a breach of Regulations and we required the provider to improve. At this inspection we found that improvements had been made and this requirement was met.

People said staff were good and met their needs. People told us that they had their call bells in reach should they need any assistance. One person said, "You might have to wait a bit, but not long and you do feel like there's always someone around". People were generally positive about the activities on offer. However when we asked people what they would change about the service, the response in most cases was, "I would like to go out more". One person said, "I get fed up stuck in here, it's nice to go into the garden but I would like to go out into the community. Since I have been here no one from the home has ever taken me out. I have to rely on my relatives, but if they did not live close I don't know what I would do". One relative said, "They do involve residents in activities, like planting bulbs in the garden and arts and crafts". Relatives told us they were always made very welcome at almost any time and were offered refreshments when they visited.

We saw activities staff provided to people on the ground floor and saw people were involved in making Christmas decorations. There was a weekly activities plan, but we were told this could be changed at a moment's notice. On the second day of our visit, there was an outside entertainer who sang a range of Christmas songs. This was well supported by people from all three floors and people joined in with the songs they knew. One of the activities staff said some people had a short attention spans and if people lost interest, the staff were all very adaptable and would change things around to keep people engaged. The activities plan was displayed on the notice board and in the passenger lift. Activities planned for the week of our inspection included: Festive decoration making, Christmas movie night, bingo, visit from a school choir, reflexology, hairdresser, informative talks, and Christmas word search. There was also the Swan Café which was a weekly get together for people in the swan dining area where people sat and chatted, engaged in quizzes and had tea with a piece of cake. The activities co-ordinator told us this was popular with some people.

Although activities were provided for people on the ground and first floor, it was not apparent that residents who received care in bed received stimulation and /or therapeutic interventions. We spoke to the activities person who said, "At the moment I am on my own, I do try and get round to everyone, even if it's just to say 'hello'". On the second day of our visit, a new activities co-ordinator had started work and was slowly being introduced to people. A third activities person was due to start in the New Year. People told us there used to be a mini bus and people went out on outings to various places of interest when the weather allowed, but this was not happening now. The registered manager said that some people went out shopping with staff and others went out with family. She said the minibus was no longer available as they could not get staff to drive the vehicle. We discussed this issue with the registered manager who told us a mini bus from one of the provider's other homes could be used if a driver could be found.

Before anyone moved into The Martlets, the provider carried out an assessment of the person's care needs so they could be sure that they could provide the support the person needed. This assessment formed the basis of the initial care plan. The assessment included information about the person's social interests, medical history, care needs, continence, behaviour, nutrition, mobility, sleep patterns and skin integrity. The person concerned and their families were involved in this process.

All people had a plan of care that identified their assessed support needs. Each care plan was individual to meet their specific care needs. People had been consulted and they and their relatives were involved as much as possible in the planning of their care. Care plans contained information about the support people needed, what the person could do for themselves, the aims of the care plan and what interventions were needed by staff to meet the person's needs. For example, the care plan for one person detailed the care outcome was to ensure their personal hygiene was maintained and for the person to be well groomed as they took pride in their appearance. The care intervention for staff explained what the person could do for themselves, for example, 'Can wash hands and face themselves but requires staff support to wash rest of their body'. It went on to refer to the person's needs as, 'Can sometimes decline personal care, usually before bed but will accept care in the mornings'. Staff said care plans gave them the information they needed to give people appropriate care and support and enabled staff to understand how the person wanted to be supported. Staff could then respond positively and provide the support needed in the way people preferred. Care notes evidenced multi-disciplinary team working with GPs, community psychiatric nurses, dementia crisis team and admission avoidance nurses. This enabled the registered manager and staff to get the right support and advice to respond to peoples changing needs.

The registered manager told us that she was in the process of changing care plans to a new corporate care plan so all of the provider's homes used the same care plan format. The registered manager showed us a blank copy of the new care plan. This was a large document with over 200 pages with an index at the front of the care plan to assist in locating information . However the proposed new file was somewhat unwieldy and may make the document less accessible and information more difficult to find. Staff also told us they felt the care plans were too big and would make the document less user friendly. We gave this feedback to the registered manager as they move forward with changing the care plans.

Daily records compiled by staff detailed the support people had received throughout the day. Care plans were reviewed every month to help ensure they were kept up to date and reflected each individual's current needs. Reviews contained an evaluation of how the plan was working for the person concerned and detailed any changes that needed to be made. We saw changes had been made to people's plans of care as required.

During our visit we monitored the time taken for staff to answer people's call bells. We observed that staff responded to any calls for assistance with call bells being answered within a reasonable time. The registered manager told us that she could obtain a print out for call bell response times if there were any issued raised.

Staff told us they were kept up to date about people's well-being and about changes in their care needs by attending the handover meeting held at the beginning of each shift. A handover was carried out on each floor and this was recorded by the nurses and senior care staff on duty. The handover included information about any appointments and updated staff on any additional issues or changes. The handover gave staff information on any care or treatment needs for people. We spoke to a senior carer and she told us that due to changes in shift patterns, they received a handover at the start of the day and the information was then passed to staff as they came on duty. However, when staff were administering medicines, there were times when the handover to oncoming staff was given late. The registered manager told us she was working with

the new clinical lead to make handovers more informative for staff.

The service routinely listened and learned from people's experiences, concerns and complaints. People were encouraged to discuss any concerns they had with the registered manager or any member of staff. The registered manager said that normal day to day issues were dealt with straight away. Formal complaints had to be recorded and reported to the provider's head office. They then decided the appropriate person to deal with the complaint and ensured that it was investigated by an appropriate person. A copy of the provider's complaints procedure was displayed on notice boards at the home. The registered manager told us that people and relatives were given a copy when they moved into The Martlets. Staff told us they would support anyone to make a complaint or raise a concern if they so wished.

All complaints were recorded on the computer. This gave information about the nature of the complaint, the action taken and the outcome of the complaint. We looked in the complaints log and found that two recent complaints had been dealt with appropriately. However when replying to people about their complaint a copy of the complaints procedure was not always included in the response. This meant that if people were not satisfied with the outcome of their complaint they may not know how to take the matter further. The registered manager said in future she would ensure a copy of the providers complaint procedure was included so that people who made a complaint would know what they should do if they were unhappy with any responses they received. The registered manager said any complaints were discussed at staff meetings (if appropriate) so that the provider, registered manager and staff could learn from these and try to ensure they did not happen again.

Requires Improvement

Is the service well-led?

Our findings

The provider had a policy and procedure for quality assurance. The quality assurance procedures that were carried out helped the provider and registered manager to ensure the service they provided was of a good standard. They also helped to identify areas where the service could be improved. The registered manager ensured that weekly and monthly checks were carried out to monitor the quality of service provision. Checks and audits that took place included food hygiene, health and safety, care plan monitoring, medicines, audits of weight charts, falls, infection control, complaints and staff files. However these audits had not identified some of the shortfalls we found during the inspection such as the lack of up to date competency assessment for staff who administer medicines, the fact that some people were not getting their medicines on time, the incomplete recording on food, fluid and turning charts and the lack of dependency assessments for people whose needs may have changed. Although some aspects of the service had improved since our November 2015 inspection, the service was still requiring improvement in a number of areas and remains "Requires Improvement" overall.

The provider employed an operations manager who visited the home on a regular basis. This was described as a business meeting and a form was completed by the area manager. This form included information such as any appraisals due, care issues, safeguarding issues and any incidents or investigations which had taken place. We looked at the operations manager's last two reports and although they identified some issues, they did not give any information on what action was required and did not provide any feedback that actions had been taken as a result of previous visits. However the provider told us that actions are set and reviewed the following month at the monthly business meetings, however we did not see this in the copies of the reports we looked at..

Records were kept secure, however not all records relating to people's care and support were completed. For example, for some people food and fluid charts were incomplete as were turning and repositioning charts for people who remained in bed. Therefore it was not clear whether care had been delivered in line with people's needs and their plans of care.

We spoke to some staff who said, although the management at the home was good, they were not confident about the management at head office. Some staff told us they felt that the senior leadership did not seek or act upon their feedback in a meaningful way. When asked what staff morale was like, the response from some of the staff was "pretty low". However this was not the view expressed by all the staff we spoke with and did not impact upon their caring and friendly demeanour when supporting people.

The provider had recently appointed a clinical lead nurse and the registered manager told us this appointment was long overdue. The registered manager who was not a nurse said this would help her to identify areas for improvement. We spoke with the clinical lead nurse who told us they understood that there were a number of issues and care practices that would benefit from their input. The clinical lead had already identified some of the areas we found during the inspection but had not yet had time to embed in practice any procedures to make and sustain improvements.

People said the registered manager was good and they could talk with them at any time. People said they felt the home was well-run. Comments included: "The manager is very nice" and "She is very approachable, but everyone can approach any member of staff" and "I feel the Home is well managed". Relatives told us the registered manager was approachable. One relative said, "I do see the manager about and she is a very approachable person. There seems to be reasonably good management. The best thing for my relatives is that they are very safe, but also have the freedom of movement around the floor, not sitting in a chair all day".

The registered manager was visible, spent time on the floor and people said they would go to her if they had any concerns about their care. Communication between people, families and staff was encouraged in an open way. The registered manager told us they operated an open door policy and welcomed feedback on how they could improve the service provided.

Staff said the registered manager and senior staff at the home were good and they knew they could speak with them at any time. Staff confirmed they met with the registered manager or their line managers on a regular basis. This helped the senior staff to monitor how staff were performing so they could ensure the home was meeting people's needs. The team leaders, senior staff and registered manager said they regularly worked alongside staff so were able to observe their practice and monitor their attitudes, values and behaviour. This enabled them to identify any areas that may need to be improved and gave them the opportunity to praise and encourage good working practices.

The registered manager acted in accordance with CQC registration requirements. We were sent notifications as required to inform us of any important events that took place in the home.

The registered manager said questionnaires were sent out annually but responses were low. We saw from the outcome of the last survey that those responses were positive with people generally feeling satisfied with their care and believing that they were treated by the staff with dignity and respect. The registered manager said that in the New Year she intended to send out questionnaires to people and relatives at varying points throughout the year. She hoped that this would help her monitor feedback better and to gain more responses.

The registered manager told us that regular staff meetings were held and staff confirmed this. However these were normally only attended by staff who were on duty and this did not allow staff to be fully involved due to their care duties. The registered manager said in the New Year she was planning to hold staff meetings for each floor with cover being provided so that all staff on the floor could attend.

The registered manager held regular meetings with relatives and residents but these were not well attended. Minutes of all these meetings were kept and we saw that generally the same people attended each meeting. The registered manager said she was looking at ways to get more people involved so that meeting were more meaningful to everyone at the home.

The registered manager told us she kept her own skills and knowledge up to date by attending any training on offer from the provider. She said she regularly monitored professional websites to keep up to date. She also attended regular management meetings where managers from the provider's other homes got together to discuss practice issues and share their knowledge.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The arrangements for managing medicines did not always keep people safe. Regulation 12(1)(2)(g)