# Progress Housing

# Marlow

## 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? | **Requires improvement** |

## Overall summary

The inspection took place on 11 May 2015 and was unannounced.

Marlow is a care home that is registered to accommodate up to 15 people with a learning and/or physical disability and associated complex health needs. It is situated close to the town centre of Worthing. At the time of our inspection there were 14 people living at the service. Marlow provides accommodation for up to 11 people who require close supervision and support, in the main part of the building. Upstairs there are two flats, each occupied by two people. Each flat has a separate kitchen, with dining area, and sitting room. People who live in the flats are encouraged to be as independent as possible.

Marlow is a modern, purpose-built home. Gardens are accessible to people and flower beds have been raised so that people, where they wish and are able, can help with gardening. There are large communal areas including a dining area, lounge and kitchen. There is a separate, small, quiet lounge situated at the front of the property.

The service has a manager who is in the process of registering with the Care Quality Commission.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was no robust system in place to measure the quality of care delivered, nor were there regular audits undertaken for all aspects of the service. An audit had been undertaken recently, but there was no action plan in place to identify what actions needed to be taken, by whom and within any specific timeframe. The manager had not informed CQC of the outcome of Deprivation of Liberty Safeguards (DoLS) which is a requirement of registration. Staff were not formally asked for their views about the service.

People were asked what they thought about the service and residents' meetings were held. Relatives were also asked for their feedback. Staff felt well supported and worked as a team to meet people's needs. The culture of the service was inclusive and person-centred.

People were safe and protected from avoidable harm. Potential risks to people had been identified and assessed. Where accidents or incidents had occurred, these were reported by staff and used to reassess people's risks, to prevent such events from reoccurring. Premises and equipment were managed safely. There were sufficient staff on duty to meet people's needs safely. New staff had all necessary checks undertaken before they started work. Medicines were ordered, administered, stored and disposed of safely.

Staff knew people well and had the knowledge and skills they needed to deliver people's care effectively. New staff were encouraged to undertake qualifications in health and social care. Essential training was delivered and staff could access on-line training. Staff received regular face to face supervisions with their supervisors and a yearly appraisal. Staff communicated with people in a way that was appropriate to them. Staff understood the requirements of the Mental Capacity Act (2005) and put this into practice.

People could choose what they wanted to eat and drink and were supported by staff as needed. Specialist diets were catered for and people were weighed regularly to ensure they maintained good health. People were supported through access to healthcare services and specialists.

Staff cared for people in a positive and sensitive way and encouraged people to be as independent as they could be. There was good communication between staff at handover meetings.

People's needs were met in a responsive way and care plans provided staff with detailed information about how their needs should be met. People had weekly planners which showed the activities they had planned across the week, some of which were group activities and others individual to them. People had their own rooms which were personalised in line with their preferences. There was a complaints policy in place, although no written complaints had been received during the year.

We found a 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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

People were protected from avoidable harm and staff knew what action to take if they suspected abuse was happening. Risks were identified and assessed appropriately.

There were sufficient numbers of staff on duty to care for people safely. The service undertook checks of new staff when they were recruited.

Medicines were managed safely.

**Good**

**Is the service effective?**
The service was effective.

Staff were encouraged to take a qualification in health and social care and they received all essential training. Staff had regular supervision meetings with their supervisors.

Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had sufficient to eat and drink and to maintain a healthy lifestyle, with access to healthcare professionals.

**Good**

**Is the service caring?**
The service was caring.

People received care from staff who knew them well and understood how they wished to be cared for. They were encouraged to be as independent as possible.

Relatives were able to visit without undue restriction.

**Good**

**Is the service responsive?**
The service was responsive.

People had weekly planners and were involved in choosing what they wanted to do. Their rooms were decorated in line with their personal preferences and taste.

Staff put the needs of residents first.

There was a complaints policy in place. No written complaints had been received within the last year.

**Good**

**Is the service well-led?**
Some aspects of the service were not well led.

**Requires improvement**

# Summary of findings

The provider did not have a robust quality assurance system in place to measure or audit the service. Staff had not been asked for formal feedback.

Staff worked as a team and in an inclusive way. They felt supported by the management.

# Marlow

**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.

The inspection took place on 11 May 2015 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the 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.

We observed care and spoke with people, relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records including four care records, three staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection we spoke with one person using the service and one relative. Due to the nature of people's complex needs, we were not always able to ask direct questions. We did, however, meet with people and were able to obtain their views as much as possible. We spoke with the manager, a registered manager from one of the provider's other locations, the proprietor and three care staff.

Good

# Is the service safe?

## Our findings

People were protected from avoidable harm. A relative felt that their family member was safe and told us, "He is safe from abuse, he is safe from infection. If anything happened, I feel confident the staff would report it". Staff had received training in safeguarding adults at risk and the new manager had arranged for this training to be refreshed for all staff. The training plan confirmed this. Staff confirmed that they had undertaken safeguarding training and were able to describe the different types of abuse and provided examples that might indicate abuse was taking place. Staff knew how to report any incidents and one person said they would, "Report it to the leader or management, but if they were involved, I would go straight to CQC".

Risks to individuals and the service were managed so that people were protected and their freedom was supported and respected. Risk assessments had been drawn up for people which identified the area of potential risk, the action to be taken by staff and steps to be taken in the management of future risks. Staff had signed people's risk assessments to show they had read and understood them. There were detailed risk assessments in place for people in areas such as eating and drinking, medicines, wheelchair transfers and the use of bedrails. Accidents and incidents were reported promptly and, where these had occurred, had informed and updated people's risk assessments.

Premises and equipment were managed to keep people safe. There was overhead tracking so that people could be moved and hoisted safely, for example, between their bedroom and their ensuite bathroom. We observed that staff moved people safely when using wheelchairs and associated equipment and checked that brakes were applied when needed. Staff reminded people about any obstacles that might be in the way of their wheelchairs. One person was in the corridor in their wheelchair and another person let them know they were coming up behind. At a handover meeting, the manager shared advice with staff on the correct way that a new sling should be used for one person. Everyone had their own individual slings which provided more flexibility for people in that they could have baths or showers whenever they wanted. Some people, who were at risk of seizures, wore protective helmets to keep them safe. Staff checked that people had their lap belts securely fastened when moving them in their wheelchairs.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. Some people required 1:1 support during waking hours. When staffing levels were reduced at night, some people who were at risk of becoming ill, had video or other monitoring equipment switched on in their rooms. Their permission was sought for this, or if they lacked capacity to make this decision, then their relatives had given their consent. Staff also checked on people regularly during the night to make sure they were safe. A relative told us that she liked to make sure staff knew, "How he [family member] likes his bed to be tucked in". Agency staff were not used, but, if there was a need to supplement staff, then the provider could use staff from their other locations which were close by.

The service followed safe recruitment practices. Staff files showed that new staff had completed an application form and provided a full employment history. Two references had been received, a photo ID obtained and statutory checks undertaken to make sure they were safe to work with adults at risk.

Medicines were ordered, administered, stored and disposed of safely. All staff were trained in the administration of medicines. We observed medicines being administered at lunchtime. The staff member washed his hands and wore protective gloves, which he changed between administering each person's medicines. He said to one person, "Buddy, can you swallow it down for me?" and when the person did so, he added, "Good man". Whilst medicines were not administered covertly, one person liked to have their tablet on top of something sweet as it helped them to swallow. Care staff told us they put the tablet on top of yogurt or something similar, but always explained to the person what they had done, that it was their tablet, so the person knew they were taking it. MAR (Medication Administration Record) charts had been completed and signed off by staff appropriately. We found there were two gaps on one shift where the same staff member had not signed to say that two people had received their medicines. The manager identified the member of staff, checked with them and confirmed that the medicines had in fact been administered, but the staff member had forgotten to sign the MAR. Some people were on PRN medicines (medicines to be taken as needed) for pain relief. Staff told us they monitored behaviour to identify when people experienced pain. When PRN medicines were administered, staff had completed the appropriate PRN form to show the reason for administering

Good

# Is the service safe?

the medicine. There was guidance for staff about when PRN should be administered and this was reviewed in February 2015, so that staff were up to date on this guidance.

We asked staff what would happen if people refused to take their medicine. They gave us an example of one person who sometimes did not take their medicine. The staff member said that they were advised there was a 1½ to 2 hour window where the particular medicine could be given, so they would go back later or try another member of staff, in case the person just preferred another member of staff to administer it. If the person still refused, they contacted the GP surgery or rang 111 for further advice. At the handover meeting, we observed staff showed a very high level of understanding of different medicines and what they were for.

Good

# Is the service effective?

## Our findings

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. New staff were encouraged to undertake a level 3 qualification in health and social care, then to progress to level 5, if they wished. There was an induction programme where new staff received training and shadowed more experienced staff to learn the job. Staff said they had time to read risk assessments and care plans. When we asked staff about how they received information on people, they all responded, "care plan". Staff received essential training in moving and handling, health and safety, first aid, food hygiene, infection control, fire evacuation arrangements and mental capacity. The staff training plan confirmed training that staff had completed and training that was due. Staff told us they felt confident in their roles and one person explained they had undertaken moving and handling training and shadowed a person being hoisted as part of their induction. The manager told us that staff could access the local authority's training on-line. Where staff training was required to meet people's particular needs, such as epilepsy, then this was arranged. Spot checks were also undertaken to ensure staff put what they had learned into practice when delivering people's care.

Staff had face to face supervision meetings with their supervisor every other month and a yearly appraisal and records confirmed this. One member of staff told us that they had, "Just had one on the 5th. We discuss needs of residents, improvements we can make and concerns of staff". Staff would discuss people they cared for, training and any other issues that were either work related or of a personal nature. Actions were then identified which were followed up at the next supervision meeting.

Staff had skills to communicate with people effectively. We observed one person put their hand to their head with a tissue and looked to be a little anxious. A member of staff responded immediately, crouched down in front of the person and gently tried to guide her hand away from her face. The person put her hand back to her head. This occurred during a musical session in the lounge. The staff member had a tambourine and played it to the person. The person then took her hand away and started to laugh, becoming fully engaged with the session again. The staff member went back and sat nearby joining in with the session.

Staff understood the relevant requirements of the Mental Capacity Act (MCA) 2005 and put what they had learned into practice. One member of staff told us, "It's about people's rights, respecting their human rights. Knowing our limitations [as staff] and respect". They added that in training they were made aware how people with a learning disability could be vulnerable and it was important to give them choices. Another member of staff told us, "It's about doing the right thing for the resident. Not trespassing over their rights and choices". Deprivation of Liberty Safeguards (DoLS) applications had been made to local authorities for everyone living at the service. 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. Three authorisations had been granted, but the majority had not been processed due to the backlog of applications received by local authorities. CQC had not been notified that three DoLS authorisations had been granted, which is a requirement of the provider's registration. We informed the manager about this and she said she would ensure that any future decisions relating to DoLS were notified to CQC. The manager subsequently sent the three appropriate notifications to CQC.

People were supported to have sufficient to eat, drink and maintain a balanced diet. We observed people having drinks with biscuits during the morning and drinks were freely available at lunchtime and throughout the day. Some people had specially adapted cups to enable them to drink easily. At lunch, staff joined people at the dining table, which made for an inclusive atmosphere. Staff responded to people's requests and food choices and moved around to support and talk with people. Staff encouraged people to eat and praised them when they did. The way the table was organised meant that everyone was able to sit together and be involved in the meal. Although people had different dietary needs, everyone ate at the same time. We observed that one person was encouraged to eat quiche and salad, but communicated with staff that he did not wish to. The staff member asked if he would prefer a sandwich and the person indicated he preferred this alternative. The person's behaviour implied that he was happy with the sandwich, but then staff realised the person

Good

# Is the service effective?

was not eating. The staff member asked him if he wanted mayonnaise and the person indicated 'yes'. The staff member added the mayonnaise to the sandwich filling and the person readily ate the sandwich and appeared to enjoy it.

Staff were patient with people and supported them to choose the food they wanted to eat and assisted them where necessary. Some people had plate surrounds and adapted cutlery so they could eat independently. We observed one member of staff supporting a person to eat their lunch. They did this in a gentle manner and gave the person time and space to eat. The manager then came into the dining area. One person, who had been reluctant to start eating, shouted her name to gain her attention. The person then ate a big mouthful of food to show they were eating well. It was a light-hearted interaction and the manager praised them. Overall lunch was a lively, fun affair which people seemed to enjoy.

Specialist diets were catered for. One person was on a Halal diet which staff knew about and catered for; their food was stored separately in the kitchen. Staff explained how another person required a gluten free diet and the food products she required. People were weighed by staff who monitored their weight to ensure this was maintained within healthy limits. Where there had been concerns over one person's diet, the dietician had been contacted and the person was re-assessed. Menus were planned over a four weekly cycle, with the main meal served in the evening, as many people were out during the day. There was a range of alternative food choices on offer to people. People could access the kitchen and were encouraged to be involved in the preparation of food and drinks, supported by staff.

People were supported to maintain good health and had access to healthcare services and support. Records showed that people visited their GP and dentist and were supported to keep hospital appointments. Some people had hospital passports in place. The aim of the hospital passport is to assist people with a learning disability to provide hospital staff with important information about them and their health when they are admitted to hospital. Staff followed advice from a physiotherapist for one person and we observed them helping to deliver a physio programme that had been put in place. A chiropodist visited the service on a regular basis.

Good

# Is the service caring?

## Our findings

Positive, caring relationships had been developed between people and staff. A relative said that staff always kept her informed when her son became unwell. She said, "They ring every time. Support workers let me know and keep me informed. They do it because they know it's the right thing to do, meaning they care, not because they're told. I really count some of them as my best friends". This relative confirmed that staff treated her son with respect and dignity and said, "They respect his privacy; they're always shutting the door". A member of staff said, "[Named person] likes to be alone in her bedroom. We close the door just so we can hear. She is very independent, so privacy is very important to her. She doesn't like to always be tailed behind". (This person received 1:1 support.)

People's likes and dislikes were ascertained and recorded. One person liked, 'music, spending time on own, walk on the seafront, holidays, going out for coffee and cake and foot massages.' They disliked, 'loud noise, being watched, shopping, personal space being invaded, curry and new faces'. From our observations, it was clear that staff knew people's preferences. A relative told us, "I know they take him out, as when we go out, he points to M&S and we go to the café upstairs and he sits in a particular spot. If we walk past the pier, the ice-cream man says, "Here for your usual?"."

Staff were caring and kind and supported friendships. A relative referred to her son and said, "He likes to socialise. When he is in bed listening to music, [named another person] will sit beside him for half an hour. Staff encourage the friendship, they let them be". Relatives and friends were able to visit without undue restriction. A relative explained, "I visit when I want and am made welcome. They [staff] just ask that I ring the bell when I first arrive. I can make a cup of tea and they give me meals".

We observed that staff knew people well and understood how they wished to be cared for. They provided examples of how well they knew people. One staff member said, "[Named person] needs control over his own space" and "[Named another person] needs you to be involved in what he is doing, even if just a cup of tea". Staff explained the importance of getting to know people well, as many were non-verbal and the importance of understanding body language. People were encouraged to be independent and staff promoted this. One person could walk for a short distance and staff encouraged them to do so, but took along a wheelchair so the person could rest if needed. When staff did transfers, they encouraged people to do as much as possible. We observed one person transfer from an adapted dining chair to a wheelchair. The staff member encouraged them to put their hands out to the staff member. The person then stood themselves up and transferred safely to the wheelchair. Another person was supported to walk using a frame. The member of staff stood back advised them of any obstacle that might impede progress, but let the person walk by themselves. Staff shared information about people at handover meetings between shifts. The handover meeting was undertaken in a room with the doors closed, so people's confidentiality was respected.

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to their needs. One member of staff told us, "We prioritise the residents' needs first". Another staff member said, "It's all about the resident. What makes the resident happy. To protect and make them happy". Care plans provided staff with comprehensive information about people and how their needs should be met. For example, one care record provided information about the person's health condition, behaviour, cognition, psychological and emotional wellbeing, social and interpersonal skills, communication, mobility, nutrition, continence, skin, breathing, pain, medicines and other aspects, including their life story. Care plans had been signed by staff to show that they had read and understood them. Care plans were reviewed at least annually, or more often, if needed.

People had weekly planners which showed the different activities that they would be involved in throughout the week; pictures and photos were utilised to aid communication. People could be involved in organised activities such as physical fitness, Bingo and a PAT (Pets as Therapy) dog came to visit on a regular basis. A music session was in progress during our inspection with a trombonist and electric guitar player. One person stood with the musician playing maracas and the majority of people and staff played along with different percussion instruments. Some people were singing and others moving in time to the music. People also undertook activities on an individual basis. For example, one person enjoyed horse riding at a local country centre. We saw that one person had their activities on a weekly planner on the wall so they could see what activities they were doing for the week. Activities were depicted and laminated and affixed with reusable tape, so they could be moved easily. At a staff handover meeting, staff discussed who would be providing a baking session with people and who was going to do the baking.

The service had a policy which stated that male staff did not provide personal care to female residents, but otherwise people could choose who delivered their care. A relative said that one member of care staff was great with her son and was the best at administering post-seizure medication. Staff told us that if people responded negatively to staff, then another member of staff would become involved. We observed one incident of this happening during the lunchtime period, when one member of staff was swapped for another.

In the flats upstairs, staff explained that it was very important that people knew the person who was caring for them. People had allocated keyworkers who co-ordinated all aspects of their care. There were also assistant keyworkers. This meant that if the keyworker was off on holiday or away, the person would still be supported by someone who was familiar to them. A member of staff said, "We present staff to them [people] and see their reaction" as they checked to see if staff the people did not know could work with them. The staff member said that if people were not happy with staff, they could display challenging behaviour.

People had their own rooms which were very individual and personalised. People had personal items and photographs on display. Some people had been supported to make photo collages of their friends and family. Another person liked glittery objects in bottles that they could shake and they had been supported to make these in craft sessions. Some people had sensory projectors in their rooms. A relative showed us the pictures that her son had painted which were hung up in the corridors of the home. There were photos of people who lived at the service around the dining room which provided a homely touch. There was a mirror on display with everyone's birthdays noted – people and staff. – which added an inclusive feel.

The service routinely listened and learned from people's experience, concerns and complaints. There was information on display at the entrance to the service, including CQC leaflets on who to contact. The provider had a complaints policy in place which stated, 'All complaints are dealt with as quickly as possible. Complaints will be investigated thoroughly and fairly by a senior member of staff. Written complaints given to the manager will be responded to within two working days'. It went on to say that if the complainant was still not satisfied, then they were advised to contact the local authority's director of social services. No written complaints had been received during the year. A relative told us that she felt confident her concerns would be listened to and that she was happy to communicate with staff. She told us, "If I have pointed anything out, it is put right the next day or very soon after".

Requires improvement

# Is the service well-led?

## Our findings

The manager had only been in post at the service for four weeks and was in the process of registering with CQC. Whilst some attempt had been made in the past to measure the quality of the service delivered, there was no robust system in place to drive continuous improvement. Audits had been undertaken in January and April 2014 and areas such as staffing, training, care plans, mealtimes and food, housekeeping, laundry, medicines administration and storage had been checked. Regular audits had not been undertaken. An audit had been carried out earlier in the month by the provider, which had identified some areas for improvement, such as care plan updates and staff training. Some action had already been taken, however, there was no clear action plan in place to show who was responsible for any actions to be taken or dates by which actions should be completed. There was no analysis of accidents or incidents, measurement of trends or patterns, to ensure that similar occurrences were recognised and prevented in the future. The manager had not informed CQC of DoLS authorisations or outcomes for people, where these had been received from local authorities. Staff had not been formally asked for their feedback about the service.

These matters were a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in developing the service. They were asked for their views about the service and service user surveys had been completed. Where people were unable to complete these surveys independently, they had been supported by their keyworker to express their views. All responses received were positive. The manager told us that she planned to hold residents' meetings every month. Records showed that residents' meetings were held in January and April this year. Items such as menus and activities that people wanted to do, were discussed, but no action points had been identified. The registered manager at another of the provider's locations said she would share their residents' meeting template with the new manager.

Relatives had been asked for their feedback through a service survey in December 2014. One relative commented on the standard of care and stated, 'Could not be better' and another relative said, 'Gives me peace of mind knowing [named family member] is so well looked after'.

There was a whistleblowing policy in place and staff knew how to raise a concern anonymously if they needed to. Staff said they would be comfortable to discuss any concerns they had with the manager. Staff felt well supported. A member of staff explained that when they started they were told if there was anything, any concerns, they could come and discuss them. They added, it was "Open, they told me when I started, if anything, you can come. [Named staff] is approachable".

There was an inclusive atmosphere at Marlow, with staff and people joining in activities, such as lunch and music, together. Staff worked as a team and supported each other to meet people's needs. They did not wait to be asked, but helped if they saw another member of staff needed a hand. Staff we spoke with were clear that residents' needs came first. They told us about the importance of independence for people, for example, helping them to walk, even if just a little. Staff seemed to have a personal sense of responsibility for the care of the people they looked after and a pride in the service. We observed the manager and her interaction with people. People felt comfortable with her and called her name. They sought physical interaction with her. It was clear that people had got to know the manager well in the short time she had been at the service.

The culture of the service was one of inclusion and a personalised, person-centred approach was evident. A member of staff told us, "It's quite different here [to other homes they had worked in], homely, more interactive and people express themselves". It was about, "knowing the person, get to know them properly, not just personal care". Another member of staff said, "Building the experience for the guys. Best for the guys for the position they're in. Really best experience they can have through the day – a good life".

Staff knew and understood what was expected of them. Some members of staff had additional key responsibilities. For example, one person checked the contents of the first aid box on a monthly basis and another undertook a medicines audit every month. Other areas of responsibilities were: Control of Substances Hazardous to Health (COSHH) cupboard, food shopping, fire alarm testing, fire drill, people's weights and equipment checks. Staff meetings were held monthly and notes confirmed this. Staff were also able to communicate through a communications book which was updated on a daily basis and at handover meetings.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met: The registered person did not have systems or processes to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (a) |