Marmora Limited

# Marmora Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 27 September 2017 and was unannounced.

Marmora was last inspected on 13 May 2015 and was given an overall rating of 'Good'.

Marmora provides accommodation and personal care for up to 27 older people who may have varying levels of dementia related needs. There were 25 people using the service at the time of this inspection.

The service did not have a registered manager. A new manager had been appointed and commenced employment on 2 May 2017, they had submitted an application to the Commission for registration and this was being processed.

A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run.

Prior to this inspection we received information of concern from various sources about the quality and safety of care provided at Marmora. We shared this information with the local authority safeguarding team. The outcome of their visits found that elements of the concerns were substantiated.

Our findings and feedback from the local authority and other healthcare professionals indicated failures around staffing significantly contributed to the number of safeguard concerns linked to poor practice, numbers and skills mix of staff.

We found a number of breaches 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 the report.

There had been a lack of oversight of the service by the provider to ensure the care the service delivered was of good quality, safe and continued to improve.

We found serious shortfalls in medication management and people were not always receiving their prescribed medication which placed their health and welfare at risk.

Thorough risk assessments had not been carried out routinely to identify and mitigate risks in relation to people's support needs, fire safety and infection control. Necessary health and safety precautions had not been taken within the home to protect people from harm.

An effective system was not in place to ensure there were sufficient numbers of staff on duty to support people and meet their individual care needs. There were not enough staff to provide adequate supervision,

nutritional support, stimulation and meaningful engagement/activity.

People's care was not co-ordinated or managed to ensure their specific needs were being met. People were not always supported to ensure that they had enough food and drinks to support their health needs. Records were incomplete and not assessed, we could not be assured that people had been given enough to eat and drink. Where people of low weight turned down food, or had a low appetite, this was not always being effectively managed. This put people at risk of losing, or not maintaining their weight.

People were supported to see, when needed, health and social care professionals.

Care records provided insufficient guidance for staff in providing safe care and in supporting people's wellbeing. We found improvements were needed in staff's understanding of dementia care to enable them to support people in providing care that was effective and person centred. This included staff's knowledge in managing high levels of anxiety and associated behaviour and supporting people to have access to meaningful stimulus, tailored to their level of dementia.

Training for staff was not managed effectively. There were shortfalls in mandatory training and staff had not received training in subject areas relevant to people's needs. The provider had made arrangements to develop staff training and development. However where we identified shortfalls in staff's knowledge of supporting people with dementia, medication, nutrition, fire safety, risk and providing a clean and safe environment, this showed further work was needed. This is to ensure that staff put into practice what they have learned, and where required given access to further training. The skills and knowledge gained will need to be monitored and embedded in practice to support continuous improvement.

Safe recruitment practices ensured the suitability of newly appointed staff coming to work in the service. Safeguarding incidents were not always recognised as safeguarding and therefore were not always reported to the local safeguarding authority or the Care Quality Commission (CQC).

Staff had good relationships with people who used the service and their relatives. The majority of staff's interactions with people were caring, respectful, supported people's dignity and carried out in a respectful manner. However improvements were needed to ensure all interactions were carried out this way.

The quality assurance systems were not robust enough to independently identify and address shortfalls as part of driving continuous improvement and embedding them in practice. In addition there was no analysis or consideration of the impact on the quality of care linked to the numbers and/or deployment of staff in the service. Improvements were needed to ensure people were provided with safe, clean and hygienic environment.

The new manager had identified shortfalls and areas for improvement and had started to make changes to the running of the service. It was not possible for them to fully demonstrate the impact of these changes because of the short time they had been implemented for. Further work was needed to ensure that they were fully embedded and sustained. Feedback we had received regarding the manager, described them as supportive, but our inspection found they needed to be more proactive in instigating changes and developing workable system's in a more timely manner.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

People were not protected from the unsafe management of medicines and people were not always receiving their medicines as prescribed.

Staffing levels were not sufficient to meet people's needs.

Fire safety and infection control was not adequately managed.

Not all risks to people had been identified and mitigated.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Training and development was not sufficient in some areas to assist staff in the delivery of safe and effective care and support. We found shortfalls in staff's knowledge of supporting people with dementia.

Not all people were being effectively monitored and supported by staff to ensure they were given enough to eat and drink.

The Mental Capacity Act (2005) principles were not always followed to ensure best interest decision assessments carried out and recorded.

People were supported to access healthcare services and receive ongoing healthcare support.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring

People's dignity was not always respected.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care plans lacked detail to inform staff on the type and level of care people needed to meet their individual and diverse needs and people were not always supported in a consistent and planned way.

There was a lack of general activity to ensure people's wellbeing. Improvements were needed to ensure all people had access to stimulating occupation/activities, linked to latest research, which met their individual needs.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Improvement was needed to ensure that quality monitoring systems were robust and effective to ensure that the quality and safety of care was consistently assessed, monitored, reviewed and improved.

Improvement was needed to embed a positive culture which fully reflected the best interests of people.

# Marmora Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 27 September 2017 and was unannounced. It was a comprehensive inspection carried out by two inspectors.

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, what the service does well and improvements they plan to make. We reviewed the information in the PIR along with information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority, health professionals and members of the public.

We met and spoke with 15 people using the service, one relative, four care staff, the cook, the manager, the registered provider and four visiting healthcare professionals.

We reviewed four peoples care records, four staff recruitment and personnel files, training records and records relating to the quality and safety monitoring of the service.

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.

Inadequate

# Is the service safe?

## Our findings

There were areas of unsafe practice that placed people at risk.

Prior to our inspection we had received information from various sources about poor management of medicines. We shared this information with the local authority safeguarding team and their visits found that people were not always receiving their prescribed medicines and they were concerned about the length of time it was taking for staff to complete the medication round.

At this inspection we found people's medicines were still not being managed safely and people were being placed at risk to their health and wellbeing. On two consecutive nights 15 people had not received their prescribed medicines. Staff working those nights did not have the right skills, experience or competence to administer medicines. The night carer leading the shift, although had completed training in administering medication, had expressed concern about their competence to do this and so the senior on the day shift stayed on to administer the medication. However this temporary arrangement was not communicated and managed over the next two nights and people did not receive their medicines as prescribed.

Some people were prescribed medicines on an 'as and when required' (PRN) basis. Not everybody on PRN medication had a protocol in place. Where people had PRN protocols they were not sufficiently detailed to guide staff on the purpose of the medicine and when it should be given to ensure it was taken appropriately and safely. For example one person was prescribed a variable dose of tablets; one or two, up to four times a day, 4-8 tablets. There was no guidance on the minimum time between doses, offering the medicine when needed and not just during medication rounds, keeping a record of how many tablets were being taken each time and the need for keeping it under review to inform the GP if it they were working or not.

There was no system in place that would ensure specific medicines such as weekly pain relief patches were applied correctly. Most patches need to be applied to rotated sites to prevent the potential risk of skin irritation and to ensure maximum absorption. We found for one person their patch was applied twice to the same area and three times within a month to a same alternate area. The patches are a Controlled Drug usually prescribed to treat severe pain and have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal set out in the Misuse of Drugs act Regulations 2001 (as amended). The system for booking in and recording controlled drugs was unsafe. A stock that had been delivered, although stored securely, had not been checked in by two staff and recorded in the controlled drug register to reduce risk of error.

At the time of our inspection there were contractors in the building laying new stair covering. There were tools, cables, rolls of lino and exposed floorboards on the landing posing potential trip hazards. One person with moderate dementia needs and using a walking stick, was upstairs alone. They put their hand through the inspectors arm for support pointing to the exposed floor boards. There was no awareness of the potential risks to people's safety posed from contractors in the service working outside people's bedrooms. A risk assessment had not been carried out and there were no strategies in place to minimise the risks which would include staff supervision.

Health professionals were left unaccompanied to give people their flu vaccination. They had to go and seek out a staff member to assist them in identifying the correct people to receive a vaccination. There were no best interest decision or risk assessments in place that took account of individuals understanding of the purpose for it, informed consent, any contraindications they may have to a flu vaccine or monitoring for any reactions.

Risk assessments did not provide staff with sufficient guidance to effectively manage people's behaviours that challenged others. There was a lack of information about triggers for people's behaviours or control measures to minimise the potential for occurrence. There was no information about ways of managing people's behaviours to diffuse situations or de-escalate incidents. We observed that people's behaviours had a negative impact on others and at times put others at risk; staff did not know how to diffuse the incidents to keep people safe. There was also a lack of risk assessments related to health needs emergencies. For example there was no clear guidance for staff on how to recognise signs and symptoms of a high or low blood sugar for people with diabetes and what actions to take. Staff said if they had any concerns they would contact a community nurse.

The provider did not have available a suitable and sufficient fire risk assessment of the premises as required by the Regulatory Reform (Fire Safety) Order 2005 to help identify risks that can be removed or reduced and to decide the nature and extent of general fire precautions that needed to be taken. We found some fire doors were not closing properly.

A laundry cupboard with sliding wooden doors was located on the corridor/stairway that would be used as an escape route to the nearest fire exit. Inside were laundry and bedding (a source of fuel) and a dusty water heater (a source of ignition) and therefore a potential fire risk. We recommend advice is sought from a trained fire safety expert as to whether the cupboard poses a safety risk or hazard and any fire resistant measures that need to be taken to either reduce or remove the risk.

Standard and individual emergency evacuation plans were not sufficiently detailed and reviewed. They did not include assisted means of escape and evacuation strategies with escape time and travel distances. People using the service should be able to escape to a place of safety, either unaided or with assistance, but without the help of the fire and rescue service. However, some people with disabilities may need help from staff who need to be designated for the purpose. Evacuation plans did not detail the level and type of assistance each individual needed which may include if accommodated on the first or second floor, an evacuation chair. Not all staff were trained in fire safety, evacuation procedures or the use of fire safety equipment.

Prior to this inspection we received information of concern from various sources about the cleanliness of the home and infection control measures not being observed. During this inspection we found that in the main the home was clean however we observed poor hygiene practice which had the potential to expose people to the risk of infection. Staff were seen carrying dirty laundry that was not bagged from a bedroom through the dining room to the laundry, a night urine bag had been removed and left unsecure dripping urine onto the floor, no bin in the sluice room for dirty paper towels, wet mops were left in buckets and not placed appropriately to air dry, a bed rail covering was stained and dirty and we observed dirty bowls and denture pots. Staff demonstrated a lack of understanding of standard infection prevention and control precautions. They wore gloves throughout mealtimes and said they were for infection prevention but at the same time they were touching other surfaces such as chairs and doors. One member of staff came into the dining room wearing gloves and took a person in their wheelchair out to the toilet. Gloves are not a substitute for good hand hygiene and their use at mealtimes compromised people's dignity.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe Care and Treatment

Prior to this inspection we received information of concern from various sources about insufficient levels of staffing to effectively meet the needs of people using the service.

During this inspection there were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. People told us there were not enough staff at the busy times of the day. Visiting health professionals told us that in their view the service was running on minimal staff and this impacted on the quality and safety of the care being provided to people. They said that staff were not always available to assist them when they visited. The manager told us that following a period of instability the service was now fully staffed. However staff spoken with felt they needed an additional staff member particularly at key times of the day when everybody needed assistance such as getting up, going to bed and particularly meal times.

At the time of our inspection there were one senior and three care staff working a twelve hour shift, 8.00am to 08.00pm. Staffs lunch breaks impacted on the availability of staff to support people at lunchtimes or staff took their breaks late. An apprentice assisted people to eat, gave out drinks and monitored communal areas. The senior care staff told us that they had little time on shift to support the care staff because they were administering medicines at key times of the day. This left three staff to attend to the daily care of the residents, two deployed to the first floor and one working alone on the second floor.

Staff told us that they also undertook ancillary tasks additional to their caring role. The cook worked only three evenings a week and alternate weekends. When the cook was not on duty care staff covered which impacted on their ability to give effective care and support to people.

We observed staff were constantly busy and spent little time with people who needed more support or monitoring to keep them safe. Call bells were constantly ringing. Staff carried out checks on people in their bedrooms as required by the care plan but these were quick with little interaction between the member of staff and the person. Staff did not have the time to give people the social interaction they needed, as they were required to immediately return to assist others in the communal areas. One person who was blind and had poor cognitive skills remained in bed throughout the two days of our inspection. They needed supervision when seated out in a chair. The manager told us that they had enough staff to supervise and interact with this person whilst they sat in a chair for periods of 20 to 30 minutes throughout the day. This did not happen.

Shifts appeared to be disorganised with a lack of co-ordination. Fluid intake was not always being recorded by the care staff and there was no oversight to ensure people were having sufficient to drink to meet their needs or take necessary action when they were not. Senior staff told us that they had little time to oversee monitoring records to ensure they were completed. There was not enough staff to support people at meal times. One person told us while waiting for assistance to eat, "It is the same every day, you are kept waiting, it is getting past a joke perhaps you could help me?" On the second day one person who chose to eat their meals away from the dining room was left without support for 25 minutes; they had not eaten their food, staff were busy either serving in the dining room or taking meals to people in their rooms. Their care plan stated that they needed staff to prompt and encourage them to eat, but this did not happen until we brought the situation to the attention of staff.

The provider had not considered ways of avoiding disruptions during medication administration to ensure medicines were administered safely and on time. We observed a morning medication round being disrupted

because although there was an administrator in the office the senior administering the medicines was also answering the phone, opening the front door and responding to staff or people using the service. This meant people were getting their medicines late and could impact on the safety of people requiring time specific medication. There was no organisation of roles and responsibilities; on one occasion we saw the senior giving out drinks to people whilst on the phone, on other occasions we saw the administrator pouring out drinks for people and assisting someone to walk with a walking frame.

The manager had recently started to use tools such as the Residential Forum and Barthel Index to determine dependency levels and calculate staffing numbers. These tools are not effective because they do not take into account peoples dementia related needs, engagement and wellbeing, personalised care nor the impact of the layout of the building which is spread over three floors.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Staffing

The provider had a safe and robust system in place for the recruitment and selection of new staff. Required checks were undertaken and references sought to ensure that staff were suitable to work with vulnerable people. This helped to ensure that staff were appropriate to carry out their role. All staff received online training in relation to safeguarding vulnerable adults and there was a poster in the home. However we found policies and procedures were not always followed to address incidents of potential risk of harm to identify how and when they occurred. Whilst the provider told us in their PIR that they worked collaboratively and shared information to safeguard and protect the welfare of people using the service, we found that relevant information was not always reported to the local safeguarding authority or the Care Quality Commission (CQC). The local authority during their visits had identified situations of unidentified injury such as bruising or extensive skin tears that should have been alerted to them as a safeguarding concern. The manager did not recognise or understand the wider aspects of safeguarding people from risk and report concerns outside of the organisation to the professionals responsible for leading on investigations. The medicine related safety incident identified at this inspection had not been reported to the CQC as legally required or reported to the local authority as a safeguarding concern.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Requires Improvement

# Is the service effective?

## Our findings

We found the provider had not ensured staff training was effective and covered the right areas to meet people's diverse needs and ensure their healthcare conditions were fully understood and recognised by staff. This was demonstrated by shortfalls in staff practice and approach, which at times, affected peoples care.

All new staff had commenced the Care Certificate. The Care Certificate identifies a set of care standards and introductory skills that health and social care workers should consistently adhere to and includes assessments of competence. Staff told us that they undertook training in core subjects such as health and safety, safeguarding, Mental Capacity Act and pressure ulcer prevention provided by an on-line, E-learning facility. Whilst this method provides a good introductory basis for subjects it needs to be followed up by further training to develop staff knowledge and understanding. Not all staff had received training in food handling hygiene although they were preparing food.

A health care professional commented that staff needed more training around dementia, they told us, "Staff do not know how to interact with people who are expressing their anxieties and needs vocally, they do not know how to effectively use diversion strategies and so their anxiety continues to increase." Staff did not know about best practice and did not take into account how dementia impacted on an individuals' day to day living, their behaviour and their ability to express themselves or understand. At lunchtime we observed a person with dementia related needs continually shouting out and saying they wanted to be moved. Staff did not respond and kept telling them to wait. The situation escalated needlessly and as the noise level rose it impacted on others which resulted in another person telling them to "shut up". A healthcare professional, staff and people using the service told us that this happened regularly.

The service cared for people with various long term conditions and end of life but staff had not received training specific to these subject areas to enable them to meet those people's needs more effectively. The providers Statement of Purpose (SoP) stated, 'All care staff within the home will be appropriately qualified to deliver the highest standards of care' and 'A continued staff development program is implemented to ensure standards are maintained'. Staff told us they did not have a personalised development plan which reflected areas linked to the needs of people they cared for. Improvements were needed to develop staff skills and abilities. The manager told us that this was being addressed and the provider had recently recruited a training manager to oversee the training and development of staff across the providers' two homes.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

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 capacity to take particular decisions, any made on their behalf must be in their best interests and as least as restrictive as

possible.

We checked whether the service was working within the principles of the MCA. Our observations showed that the service was inconsistent in its approach and did not always work within these principles. One person told us how staff respected that they could make their own decisions and acted on their requests. They said that they did not feel restricted in any way and chose to stay in their room. We observed a staff member approach a person with a paper clothes protector, "Can I put one of these on you? We don't want to spoil that lovely top." However where people were living with dementia there was no assessment and best interest decision recorded for the administration of a flu vaccination. Staff did not accompany the nurse to introduce them to each individual and provide an explanation and information to people about the flu vaccination to enable them to make an informed decision, and give consent.

People who were less dependent told us that they had access to drinks and snacks throughout the day. One person told us, "I've got biscuits here and I have a cup of tea two or three times a day brought to me, I only have to ask for one." Whilst we were with them a cup of tea was brought in.

However for people who were more dependent, assessed at risk of dehydration, poor skin integrity or susceptible to urine infections staff needed to be more effective in prompting and encouraging them to drink. Although hot and cold drinks were regularly available they were not readily accessible to people cared for in bed and people living with dementia were not independently taking them. At 10.45am there were nine people seated in the lounge, drinks were not in easy reach and people were not actively supported to drink. People were reliant on staff and had to ask for a drink to be poured and given to them. When the tea trolley came round, two people with their eyes closed were not woken and offered a hot drink and when they were awake later they were not asked if they would like one.

Fluid intake monitoring charts for another person cared for in bed and totally reliant on staff showed fluids were not offered regularly and when they were only sips were taken. Blanket statements of 'good diet and fluid taken' were recorded in their daily report records which did not accurately reflect the monitoring charts. Food charts for this person showed gaps indicating that meals were not eaten.

The manager told us in their PIR that the home was working closely with the Community Dietetics team and their Food First approach to treating poor dietary intake and unintential weight loss using every day nourishing foods and drinks. People's weights were being monitored; whilst some care plans reflected actions to be taken by staff to prevent further weight loss the service had no system to support people to independently access food. For example for the duration of our inspection there were no finger foods, additional snacks or fresh fruit readily available for people to eat if they were hungry. Where nutritional supplementary drinks had been provided to people they were not always supported to drink them. A nutritional supplementary drink left in the morning for one individual was still on their table at lunchtime, untouched. They told us, "I don't really like it". Staff had not returned to monitor their intake and an alternative flavour or different enriched calorie drink was not offered.

Staff were not adequately deployed to the dining room to ensure that people received their meals. We observed that some people had to wait for their meals and therefore they were cold and no longer appetising. We observed a staff member take a meal upstairs to a person's bedroom and then bring it straight back down. They told us that the meal was cold and they had brought it down to reheat. The cook assured us that the meals were checked before they left the kitchen. The meal had got cold because the staff member was delayed assisting someone else. People left to eat independently had little interaction with staff which did not encourage or promote practical help to eat more either independently or with support. As a result some ate very little of what they were served and staff did not always explore this further.

Where people required access to healthcare professionals and on-going healthcare support, this was provided. This included visits from community nurses, GPs, occupational therapists, speech and language therapists and dieticians. One person told us that they had seen the nurse yesterday and they were getting some new medication to help them.

Requires Improvement

# Is the service caring?

## Our findings

We found there was inconsistency in the caring approach of the service which was mostly due to staff's limited time and lack of understanding.

One person described staff as, "Good and two or three are outstanding." They told us how staff made them feel valued. They demonstrated how staff would blow them a kiss when they left their bedroom and how it made them feel, "Lovely." Another person told us how the staff made them feel wanted, "They [staff] do work hard, I get on very well with them, they are pretty good to me" and "When they come in in the morning they blow me a kiss, that I do like, I am fond of them." We observed another staff member go up and gently rub a persons back and enquire if they were okay, "You look a little lost" and then they engaged the person in conversation.

A relative told us that the staff were "very good" and they "have always made me feel welcome, it is a very friendly home." We observed another relative made to feel welcome and their conversation with staff showed that the staff member knew about the family and important events.

Whilst people who were more independent told us they were happy with the level of care they received our observations of people who needed more support from staff were not as positive. For example a staff member showed a person the biscuit tin, the individual naturally put out their hand to reach into the tin. The staff member, wearing blue gloves, pulled back the biscuit tin and picked them out a biscuit with their gloved hand and handed it to them without any exchange of words. Care was task focused and did very little to promote people's independence and choice, staff did not have time to sit and talk with individuals for any meaningful period of time. Improvement was needed to ensure people who were more dependent with dementia related needs had caring, meaningful and supportive relationships where they also felt valued.

People's dignity was not consistently respected and promoted. For example staff put blue plastic gloves on to serve people their meals, we found one person in their bedroom with their meal and an open commode full of urine and faeces and another persons room smelt very strongly of urine. We could see no obvious cause for the smell but this impacted on the person's dignity although they didn't appear to notice, their visitors would. These issues were brought to the attention of staff and management.

Requires Improvement

# Is the service responsive?

## Our findings

Some aspects of the service were not responsive to people's individual needs and improvements were needed.

Prior to this inspection we received information of concern with regards to people receiving a poor standard of personal care and not receiving baths or showers.

During this inspection we found people to be clean and dressed appropriately however it was not evident that people's teeth were being cleaned routinely. Despite one care plan stating the person needed their teeth brushing there was no toothbrush in their room. When this was brought to a staff members attention they also could not locate a toothbrush. We found a dry toothbrush in a cupboard under the sink in another person's bedroom with an open tube of toothpaste, the paste could not be pushed out because was dried out indicating it had not been used for some time.

People were bathed/showered according to a list. A healthcare professional commented that although one person was on the list they had told them they had not had a bath for some time and they noted that their bed linen had not been changed.

People did not always receive care that was personalised and responsive to their needs and there was no consistent or planned approach to support people. Care plans were very detailed with regards to individual's assessed needs and risks. However they lacked clear guidance and key information for staff to enable them to support people properly, respond to their needs effectively and mitigate or minimise risk.

For example a care plan for one person clearly identified how dementia affected them with regards to short term memory loss, disorientation, loss of fine hand movement and needing assistance to start and finish tasks. It also stated that they experienced regular episodes of anxiety that have resulted in the person successfully leaving the building and hitting out at staff and windows. It was recorded for staff to occupy them with home chores and remove their walking stick and sit with them. There was no detailed and relevant information to tell staff why they may become agitated or anxious, triggers that might make this worse, or ideas about how to distract or engage positively with them. Without this understanding staff were unable to provide person centred care with a holistic approach to ensure people's well-being.

The Service User Guide for people using the service states that there is 'A wide range of activities, individual and group' to maintain physical and mental wellbeing and 'Outings' are 'tailored to individual needs such as afternoon trips/tea, theatre and walks'. Staff told us that people only went out if their families took them. One person who chose to stay in their bedroom told us that they were, "Quite happy, I'm not completely on my own. I have quite a few visitors and the staff are always in and out, we have a laugh; I am not lonely." They showed us their crocheting and knitting and told us how they made hats and table mats for friends. Another person told us that there used to be more organised activities, including painting but the person who does this only comes in three times a week. They said, "I would like to have more going on." A visitor told us, "I don't see much going on, sometimes a game or cards."

We found the quality of the conversations and providing social interaction between staff and people using the service were better for those without dementia. This showed that staff needed further training and guidance in this area. We observed people sitting with their eyes closed for long periods of time only opening them when they heard staff go by or when staff briefly spoke with them. When engaged we could see how it improved their well-being, they became more alert and smiled. Staff did not have the time to provide adequate stimulation or meet people's emotional and social needs. There were limited resources available to assist in the delivery of meaningful activities throughout the day for people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation.

Improvements were needed to ensure all people had access to stimulating occupation/activities which met their individual needs. The manager told us in their PIR that improvements planned for the following 12 months to make the service more responsive included the recruitment and appointment of an in-house activity coordinator for five days a week because they believed this would benefit people and more outings and further activities could be organised. People would also be encouraged to continue their hobbies or try new things.

We recommend that the service consults with and uses a reputable source to support them in identifying activities which people are interested / able to participate in. For example Alzheimer's Society, the Social Care Institute for Excellence and the National Institute for Health and Clinical Excellence.

The provider had a complaints policy and procedure in place. A relative could not recall reading it, but felt, "It wouldn't be a problem, if I had an issue, I would raise it with the manager who I am sure would take the appropriate action to resolve it." One person told us that they were very happy and had no concerns, however they would not hesitate in telling staff if they had, "If I wasn't [happy] I would soon complain." We asked if this person had ever had cause to complain and they replied, "No, not really, only because I've only got to tell the manager about something and she would say don't worry I will put it right."
There were two complaints logged with an outcome but there was no record of any actions taken that would ensure no re-occurrence or lessons learned.

Requires Improvement

# Is the service well-led?

## Our findings

Prior to this inspection we received information of concern from various sources about the quality and safety of care provided at Marmora. We shared this information with the local authority safeguarding team. The outcome of their visits found that elements of the concerns were substantiated.

Our findings and feedback from the local authority and other healthcare professionals indicated failures around staffing significantly contributed to the number of safeguard concerns linked to poor practice, numbers and skills mix of staff.

The provider was dismayed by the deterioration of the service and told us that because of a long episode of ill health they had not had effective oversight of the service and this had impacted on the quality and safety of the service people were receiving. They acknowledged the work required to address the shortfalls and drive improvement. However there was no long term development plan to show that the provider recognised where further investment was needed. The provider was reluctant to accept that staffing levels were not sufficient because they had been in the past, however peoples changing and individualised needs were not being considered particularly as they were becoming more dependent.

The provider had recruited a new manager in May 2017. This was their first post as a manager. The manager told us that they met regularly with the provider and felt well supported however they had not received formal supervision since they had started. Comments from people using the service and visitors told us that the new manager promoted an open culture; she was visible and approachable and had an open door policy. Staff were complimentary of the managers style and approach and felt supported by her.

The manager had been proactive and had identified many areas that needed improvement which impacted on the quality of the service; an improvement plan was implemented. However in the first eight weeks the service lost 85% of staff; the manager saw that reduction in the high usage of agency staff was a priority because of how this impacted on the continuity of care for people, disunity of staff and morale. Within the following eight weeks they had fully recruited a new staff team to join the two original staff members.

A relative when asked if they had noted any changes over the last few months and impact on care told us that besides new staff, who they felt fitted in well, had not seen any significant changes in the care but had noted improvements in the environment. The quality of service people received was inconsistent. People who were able to articulate their views were positive about the service they received. Best practice needed to be explored to influence how care was being delivered. For example effective engagement with people living with dementia, providing mental stimulation and activity and ensuring that risks linked to poor nutrition and hydration were addressed proactively.

The provider told us that they were in the process of setting up a befriending scheme for 14-16 year olds to come in to the service for four hours a week to read or play games with people.

Roles and responsibilities were unclear and staff were unsure what they were accountable for. Observation

showed there was no effective leadership to oversee and direct staff on each shift. Staff meeting minutes dated August 2017 demonstrated that although the manager recognised these shortfalls, she had not provided any clear direction or systems that would ensure clarity in these areas. The manager told us they were looking to leadership training for senior care staff.

There was no system in place to assess the quality of training staff received to ensure they had the right skills, confidence and knowledge to support people in a safe manner, for example medication. We were advised that the provider had employed a training manager to address this and at the time of our inspection they were completing their induction.

The manager had started to establish links with other organisations to keep up to date and take part in initiatives to improve practice. After identifying a high level of falls in the service they signed up to Essex County Council's Prosper project, a social care scheme to improve safety and reduce harm, primarily from falls, pressure ulcers and urinary tract infections (UTIs) for care home residents across Essex. This approach includes a greater focus on proactive prevention and monitoring of safety incidences. A system was set up to review and monitor incidents of falls, a new call bell system with an integrated sensor mat system was installed to alert staff of any movement from people at risk during the night. The manager told us that this had significantly reduced the number of unwitnessed falls during the night. We saw that were people were experiencing a number of falls they were being referred to the local community falls team for review or the GP for a medication review.

Audits had been carried out in August 2017 with regards to care and care planning documentation, health and safety, equipment and maintenance and infection control. The results of the audits were not being constructively analysed to establish where the service was failing and where immediate action was needed to make improvements, they had not been taken. The audits identified failings but had not been completed with corrective actions, target dates and who was responsible for taking the action. The manager informed us that the provider had recently employed a quality assurance manager to take on this responsibility, however we highlighted that the manager needed to have oversight of this process, particularly as the care overview audit did not reflect an accurate account. For example under the section 'challenging behaviour' it stated that staff were competent in managing behaviour that was challenging, although it was correct in stating that there were no workable behaviour management strategies in place.

The auditing and management of medicines were not effective to identify and reduce the risk of people not receiving their medicines as prescribed, or in an effective manner. A programme of refurbishment was on-going however the provider had not assessed the environmental risk to people during the refurbishment of the home.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

Additionally consideration had not been given within the refurbishment programme to review and provide a more enabling environment appropriate for people living with dementia with regards to colouring, signage and stimulation to assist people with recognition, orientation and attract peoples interest.

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The Registered Person was failing to ensure that risks were assessed, identified and mitigated to protect people from harm.<br><br>The Registered Person was failing to ensure the proper and safe management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The Registered Person was failing to ensure that staff understood their roles and associated responsibilities in relation to relevant guidance and reporting procedures, to safeguard people. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The Registered Person was failing to ensure their quality monitoring and assurance processes were operated effectively to ensure compliance and drive improvement. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The Registered Person was failing to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced |

staff deployed to meet people's needs.