Barchester Healthcare Homes Limited

Marnel Lodge Care Home

Inspection report

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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**

Overall summary

This inspection was unannounced and took place on the 2, 3 and 7 September 2015.

Marnel Lodge is a care home which provides nursing and residential care for up to 62 people who have a range of needs, including those living with epilepsy and diabetes. The care home comprised of two floors. The first floor of the home provided specialist care to those living with dementia. At the time of the inspection 57 people were using the service.

Marnel Lodge has a registered manager in post. 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.

People were not always protected from the unsafe administration of medicines. The provider did not always follow national guidance regarding the storage and administration of medicines. Topical medication charts for creams prescribed to be used directly on people's skin were not always completed fully. As a result it could not

Summary of findings

always be identified whether people had received their medicines at the correct time and whether they had been administered as prescribed. Nurses responsible for supporting people with their medicines had received additional training to ensure people's medicines were being administered, stored and disposed of correctly. Nurses skills in relation to medicines management were reviewed on a regular basis by appropriately trained senior staff to ensure they remained competent.

People were supported to eat and drink enough to maintain a balanced diet. People told us they were able to choose their meals and they enjoyed what was provided. Records showed people's food and drink preferences were documented in their care plans and were understood by staff. People at risk of malnutrition and dehydration were assessed to ensure their needs were met. However, records for people who required food and fluid chart monitoring were not always completed fully. As a result it could not always be identified whether people were eating and drinking sufficient to maintain their health.

People using the service told us they felt safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and managed. People were supported by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

Robust recruitment procedures were in place to protect people from unsuitable staff. New staff induction training was followed by staff spending a period of time working with experienced colleagues to ensure they had the skills required to support people safely.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such fire or floods. Fire drills were documented, known by staff and practiced to ensure people were kept safe.

People were supported by staff make their own decisions. Staff were knowledgeable about the requirements of the Mental Capacity Act (MCA 2005). The service worked with people, relatives and social care professionals when required to assess people's capacity to make specific decisions for themselves. Staff sought people's consent before delivering care and support. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

People's health needs were met as the staff and the registered manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the relevant supervisory body to ensure people were not being unlawfully restricted.

Staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The registered manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times. People were encouraged and supported by staff to make choices about their care including how and where they spent their day.

People had care plans which were personalised to their needs and wishes. They contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives told us and records showed that they were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager as well as the completion of customer satisfaction questionnaires.

The provider's values and philosophy of care were communicated to people and staff. Staff understood these and people told us these standards were evidenced in the way that care was delivered.

The registered manager and staff promoted a culture which focused on providing individual person centred

Summary of findings

care. People were assisted by staff who were encouraged to raise concerns with the registered manager. The provider had a routine and regular monitoring quality monitoring process in place to assess the quality of the service being provided.

Staff told us they felt supported by the registered manager.

We found 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 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?

Requires improvement

The service was not always safe.

Medicines were administered by nurses whose competency was regularly assessed by senior staff. However practices regarding the storage and administration of medicines were not consistently safe. Documents relating to people's topical medicine administration were not always fully completed therefore presenting a risk that people were not receiving their medicines as prescribed.

People were safeguarded from the risk of abuse. Staff were trained to protect people from abuse and knew how to report any concerns.

There was a robust recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability to deliver people's care.

Contingency plans were in place to cover unforeseen events such as fire or flooding to ensure people's safety.

Is the service effective?

Good

The service was effective.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. Staff knew people's preferences regarding food and drink.

Staff undertook the provider's required training. Additional training was arranged as required to ensure staff had the skills to support people effectively.

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met. Staff understood the principles of the MCA 2005 and understood the Deprivation of Liberty Safeguards (DoLS).

People were supported by staff who sought healthcare advice and support for them whenever required.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff were motivated to develop positive relationships with people.

People were encouraged to participate in creating their personal care plans.

Summary of findings

Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People received care which was respectful of their right to privacy whilst maintaining their safety.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis, additional reviews were held when people's needs changed.

People were encouraged to make choices about their care which included their participation in activities and where they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Requires improvement

The service was not always well led.

The provider did not always maintain an accurate and complete record in respect of people's care and treatment which meant people were at risk of not receiving all the care they required.

The registered manager promoted a culture which placed the emphasis on care delivery that was individualised and of high quality and sought feedback from people and their relatives in order to continually improve.

Staff were aware of their role and felt supported by the registered manager. Staff told us they were able to raise concerns and felt the registered manager provided good leadership.

The provider regularly monitored the quality of the service provided through quality assurance audits to identify where improvements could be made to the home.

Marnel Lodge 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 function. This inspection checked whether the provider was 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 the 2, 3 and 7 September and was unannounced. The inspection was conducted by two inspectors, an Expert by Experience and a Specialist Advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, their relatives and visitors. A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a nurse who had experience and knowledge of caring for people living with dementia.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 19 people, eight visitors, three nurses, two senior care staff, 11 care staff, the chef, two activities coordinators, the clinical lead for the home, the registered manager and the regional director for the provider. We looked at 18 care plans, seven care staff recruitment files, care staff training records and 26 medicine administration records (MARS). We also looked at care staff rotas for the dates 3 August to 6 September, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff, visitor and resident meeting minutes. During the inspection we spent time observing staff interactions with people including lunch time sittings.

Following the inspection we also spoke with a doctor from a visiting GP's practice.

The service was previously inspected on the 19 June 2013 and no concerns were raised.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe living at Marnel Lodge. One person told us, "I feel safe there are people to look after me, they (staff) are so good". Another person said, "I feel quite safe here. " Relatives we spoke with said they felt their family members were safe, one relative told us, "She (family member) is safe in here, the care is excellent". A visitor told us, "She (friend) feels very safe and they (staff) are lovely girls."

However, people were not always receiving their medicines safely. Arrangements were documented for the safe storage, administration and disposal of medicines. Nurse competency assessments and medicine audits were also undertaken to ensure people's medicines were administered safely.

However during the inspection we saw unsafe medicines administration practices. During a medicine round we could see that medicines were not being administered safely. On the first day of the inspection we found a pill on one person's bed which a nurse identified as a vitamin pill. The nurse had originally passed the person's medicines to another nurse to administer which included the vitamin pill whilst they signed the medicine administration record (MAR) chart to indicate the person had taken all of their medicines, without checking that they had. This meant that people were at risk of not receiving medicines as prescribed.

There was also the risk of unauthorised people access to medicines stored in the medicines trolley by unauthorised people. On the first day inspection we also saw that two people's medicines had been pre-dispensed into pots containing pieces of paper with their initials on them whilst in the medicines trolley. Another person had been left with six pills on their tray whilst the nurse went to obtain a drink to enable them to be taken. On the second day of the inspection we saw one nurse had left their medicines trolley open and unlocked whilst conducting the medicines rounds as they assisted a person elsewhere. As a result of each of these practices there was a risk that people who lacked the mental capacity to recognise the risks of taking un-prescribed medicines might have taken them. These incidents were brought to the registered manager's attention, addressed and documented with the relevant nurses. These practices were not seen again during the remainder of the inspection.

Topical Medication Administration Records (TMARS) were in place for those people who received medicine which was applied to their skin however these were not completed fully. In August and September 2015 there were gaps in people's TMARS which suggested people had not received their medicines as prescribed. There had been no deterioration in these people's conditions and staff told us that they were administering the creams however were failing to record this accordingly. Staff had failed to document the administration of people's creams which placed them at risk of having their creams applied for a second time due to poor recording.

The failure to safely store, record and administer medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a medicine fridge which was kept at the appropriate temperature for storage. Records confirmed a safe temperature was maintained. Controlled drugs medicines stocks were audited at the end of the working shift, which records confirmed. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs or medicines. Controlled medicine stock levels were correct and corresponded with the controlled medicines record.

The provider ensured that appropriate medicines were used and were able to demonstrate that alternative dosages and medicines were sought when it was identified that people were experiencing side effects. There was a clear process staff followed when they observed a person had become drowsy as a result of the administration of their medicine. Records showed that assistance was sought from the person's GP and the medicine dosage was decreased which resulted in the management of their condition without the side effect of being tired.

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns. The provider's policy provided guidance for staff regarding how and where to raise a safeguarding alert. This is a concern, suspicion or allegation of potential abuse or harm or neglect which is raised by anybody working with people in

Requires improvement

Is the service safe?

a social care setting. Staff had received training in safeguarding adults and were required to refresh this training annually. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility, nutritional, communication and people's moving and handling needs. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in their care plans which provided guidance to staff about how to support them to mobilise safely around the home and when they were being transferred. Staff understood these risks and were observed supporting people in a manner which ensured people's safety. Records showed people had received the appropriate treatment which followed their risk management plans. Risks to people's care were identified, documented and care staff knew how to meet people's needs safely.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who were of suitable character. Care staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

During the inspection staff raised concerns that staffing levels were not always sufficient to meet people's needs. The provider determined overall staffing numbers using a Dependency Indications Care Equations (DICE) assessment tool. This was completed every couple of days, when people's health needs changed or when people receiving end of life care moved to the home. People's dependency level was assessed by the registered manager using specific criteria to identify the correct number of staff who would have to be deployed to meet people's needs safely. Records showed the home had routinely operated above the minimum staffing levels. Where shortfalls in the rotas had been identified these had been supported by the use of agency and bank staff. The registered manager ensured consistency of care by using a regular pool of agency and bank staff. There had been occasions, due to last minute reported staff sickness, where support workers were working at the minimal staffing level. However support workers told us and records showed that they were still able to meet people's needs by prioritising people's care. People told us they were receiving the care at the time that they needed it. One person told us, "I never wait long for staff day or night, I have good care", another person said, "I don't wait long for staff they are very good". Staff told us when working with minimum levels of staff they were unable to have one to one conversations with people outside of the delivery of their personal care. However people told us and we saw that staff were able to spend time and talk with them. The provider had recognised that staff sickness and people leaving the service without working their notice period had led to an increase in the workload upon permanent members of staff. A recruitment process was on-going and during the inspection newly recruited staff were seen being shown around the home. This would assist staff and people by limiting the number of agency and bank staff being deployed to deliver care. People were cared for by sufficient numbers of staff to meet their needs safely.

There were robust contingency plans in place in the event of an untoward event such as accommodation loss due to fire or flood. Personal Emergency Evacuation Plans (PEEPs) had recently been updated for all people living at the location. This provided an easy to follow colour coded guide for staff and emergency personnel in regards to people who were able to mobilise independently and those who required assistance due to their complex needs in the event of a fire. Staff knew the fire drill procedure and this was practised to confirm their understanding of the events to take. If rooms were no longer suitable for habitation then people would be moved to a local hospital or two other homes within the county to ensure continuity of care. These plans allowed for people to continue receiving the care they required at the time it was needed.

Good

Is the service effective?

Our findings

People we spoke with were positive about the ability of staff to meet their care needs. People said that they felt staff were well trained and had sufficient knowledge and skills to deliver care. One person we spoke with said, "I think the staff have the correct skills, in fact they are very good. Another person told us, "The staff are well trained, I have no criticism". One person said, "They (staff) have the correct skills, they know what they are doing".

People praised the food provided and were supported by staff during meal times. One person told us, "I have as much food as I want, I am happy and content", another person said, "I eat anything and the food is pretty good in here". A visiting doctor told us, "They (staff) also have a good systematic process for picking up weight loss and signs of early deterioration". When people had been identified as losing weight, food and fluid charts were implemented however these were not always completed fully. These were started to ensure people were receiving the food necessary to regain and retain a healthy weight. We could see that people were consuming more food and drink than was documented on their records by staff. This had been identified by auditing processes and the registered manager was taking action with staff to ensure future completion.

People told us that they had the food of their choice, one person told us "If I don't like something they make me something I do like". People were supported at mealtimes by staff who were patient and attentive to their needs. Staff showed plated food choices to people to assist in deciding what to eat. People appeared to be enjoying their meals which were not rushed. When people who were being supported in their rooms to eat had not eaten well this was reported back to a senior member of staff and alternative foods were tried to encourage people to eat.

The chef was aware of people who had specific dietary needs such as due to being diabetic or those who required a pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained a visual appeal and was separated on the plates to allow people to identify what they were eating. On the dementia floor crockery was yellow to support those who have visual difficulties as well as a range of shaped plates to help retain individual independence. These were provided as standard however it would be beneficial for the provider to assess each person's ability providing crockery that suit their individual needs. People's allergies to food had been documented appropriately and the chef was knowledgeable about people's personal food preferences. When it was identified that people had been losing weight the chef was made aware and documentation in the kitchen showed that additionally fortified meals were prepared to enable them to increase their weight.

New staff received an effective induction into their role with Marnel Lodge. This induction included a period of shadowing to ensure they were competent and confident before assisting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their job. This allows new staff to see what is expected of them.

All staff were provided with induction programme folders when they started work in the home. These contained detailed information about the role of a health and social staff, equality and diversity, dementia care and effective communication. Staff were required to complete these induction folders within four weeks of starting to work at the home. Staff were required to answer questions on all the topics identified so that their mentor, an experienced member of staff, was able to check their understanding on the subject. We could see that staff had understood the information provided and were exhibiting that in the care which was provided. For example, during care delivery staff communicated with people what actions they were going to undertake in an effective way so they understood what was happening. Four staff in particular showed excellent skills supporting people with dementia in a respectful, unhurried and enabling way during the inspection. New staff were provided with the guidance and information they needed to enable them to undertake their duties safely.

All staff had received training in areas such as moving and handling, health and safety, infection control and First Aid to enable them to carry out their role. Staff were also encouraged and able to ask for additional training in areas that interested them. During the inspection one member of staff had received additional training in time management and First Aid as they felt their knowledge could be improved. This had been encouraged by the registered manager and supported by the home trainer who was visible to staff. One member of staff told us that when they were unsure of a working practice they could seek support from the home trainer. This staff member told us, "The

Good

Is the service effective?

home trainer is really good, she comes out on the floor, she'll come up and actually show you how (to do something)". The registered manager had also sought additional 'Six steps end of life care training' for two staff we spoke with who were going to be responsible for passing this information to other members of staff. This nationally recognised training prepares staff for dealing with people who are in the final stages of their life and covers areas such as how to discuss issues with people, assessment care planning, care coordination and delivery, care in the last days of life as well as care after death. This training was sought and undertaken to increase the understanding and quality of care provided to people in the final stages of their lives.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. Staff told us and records confirmed supervisions occurred every two to three months. This process was in place so that staff received the most relevant and current knowledge and support them to be able to conduct their role effectively.

People were supported to make their own decisions and ensure that people's freedom was not unlawfully restricted without authorisation. The Care Quality Commission (CQC) monitors the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using the service by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the location authority as being required protect the person from harm. The registered manager, clinical lead and nurses all had a comprehensive understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications and authorisations. All staff spoken with were able to identify that DoLS were required because people were living in a keypad secured environment but were not always able to identify that other situations such as the use of pressure control mats may also constitute the need for a DoLS. However, senior staff at the location included the registered manager, clinical lead and nurses demonstrated a comprehensive understanding of the DoLS legislation. Staff were able to identify the principles of the Mental Capacity Act 2005 (MCA 2005) and demonstrated they had complied with legal requirements. Where people had been assessed as lacking capacity to make specific decisions about their care the provider had complied with the requirements of the MCA 2005. The MCA 2005 is a law that protects and supports people who do not have the ability to make specific decisions for themselves. Records showed that staff could identify when people had fluctuating capacity, this is where people have certain periods where they can and cannot make certain decisions about their care due to their complex health needs. Appropriate guidance had been provided for staff as to when additional assistance would be sought with decision making from the registered manager and people's families in a best interests meeting.

People and relatives told us that people's consent was sought before care was delivered. One person told us, "They (staff) always ask my consent and are very respectful". Relatives told us, "They (staff) normally explain what they're going to do. They always ask (for consent) and explain". We saw that staff assisted people to make decisions and sought their consent before delivering their care.

People were supported to maintain good health and could access health care services when needed. A visiting doctor told us that when people's health needs changed, "They, (staff) they are very proactive" and that "(Nurses) are very competent and I respect their clinical judgement." One person told us, "If I need a doctor, the staff get one". Records showed that when required additional healthcare support was requested by staff. We saw that people were referred to their dental surgery and diabetic eye screening clinic when required with incontinence advice sought for people when issues identified. There was evidence of referral to the community mental health services when required and collaborative working with healthcare professionals, families, people and staff.

The first floor had been specifically designed for those living with dementia. The corridors were wide and the handrails were different colours from the walls to allow people to identify a focal point to hold on to. The toilet doors were yellow to enable people to identify clearly the room, toilets and bathroom doors also had additional signage to make identification easier. There were specific destination points at the ends of each corridor with seating and views for people to spend their time. There was a small quiet lounge for people who are noise sensitive or need time in a small quieter environment. There were items

Good

Is the service effective?

available for use around the home which included cuddly toys and dolls for doll therapy. We could see that these were being used by people during the inspection and were used as a conversation point between people and staff. There were orientation boards stating the day and date which were not updated by the time of the morning inspections, a clock in the main lounge also read a different time, all of which could be confusing to those living the dementia. This was brought to the manager's attention and on the last day of inspection these areas had been addressed.

Good

Is the service caring?

Our findings

People experienced positive relationships with staff. Relatives and people told us that support was delivered by caring staff. One person we spoke with told us, "The staff are very caring and kind…they listen to me and treat me like a human being". A relative told us, "They (staff) are absolutely caring". A visitor told us, "(person) would not be for this world without the care they (staff) give her, she is safe and well looked after here". A visiting Doctor told us, "The staff are very caring and show genuine affection towards the residents…it comes from the top, senior staff (are) very caring and maintain high standards".

Reassuring and caring relationships had been developed by staff with people. People's care plans had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families, previous work and hobbies. All staff in the home took time to engage and listen to people. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and gave them to respond appropriately, even if that took additional time. Staff told us that they saw people living at the home like family and there was a family atmosphere in the home with enjoyable, supportive and positive interactions between people and all staff. This included linking arms with people, asking to give people hugs when they looked upset and engaging in friendly conversation. Whilst staff were busy they continued to treat people with respect and showed a genuine care for people's wellbeing. One member of staff had come in to work on a day off to support a new person to settle into the home.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. One person was seen to be distressed during the inspection, staff were kind, compassionate and gentle with their approach to this person. One member of staff was able to describe how they would support people when they were distressed, "I know my residents, I know who would want a cuddle or who would want a cup of tea".

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to eat or how they would like to spend their day. The pre-assessment document completed before people moved to the home recorded consent to care and care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People were treated with respect and had their privacy and dignity maintained. People and relatives told us that they were treated with respect by the staff. A person told us, "They (staff) respect me". A relative told us, "Everybody here has treated her with great respect, it's not just when we're here and it's not put on". Staff were able to provide examples of how they respected people's dignity and treated people with compassion. People were provided with personal care in their rooms with the curtains and doors shut and staff knocked on people's doors awaiting a positive response before entering to assist.

People were also respected by having their appearance maintained. Attention to appearance was important to people and staff assisted them to ensure they were well dressed, clean and offered compliments on how they looked.

Good

Is the service responsive?

Our findings

People were engaged in creating their care plans and relatives were able to contribute to the assessment and planning of the care provided. One person told us, "Staff know what my needs are, even the younger ones". People not able or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided.

People's care needs had been fully assessed and documented by the nursing staff before they started receiving care. These assessments were undertaken to identify people's support needs and care plans were developed outlining how their needs were to be met. Records showed that the care plans reflected the information which was gathered during the pre-assessment stage. People's individual needs were routinely reviewed at a minimum of every two months and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. Relatives with a POA to assist in the decision making process were informed when care plan reviews were happening to ensure they could be present. A relative with POA for health and wellbeing told us, "We're due a review (of the care provided) and we get together as a family". When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. Records showed a person had requested a Do Not Attempt Cardiopulmonary resuscitation (DNACPR) to be completed on their behalf during a care plan review. This request was recorded, completed within a week and the person's care plan updated accordingly. People were receiving care which was reviewed regularly to ensure it remained relevant to their needs.

Handover between nursing staff were held on each floor. These were held between the nurses and this information was then shared with staff. The home used a handover sheet which contained specific and detailed information in relation to people's needs, such as, their health diagnosis, recent changes to care plans such as changes in mobility and medicines needs, medical appointments due and moving and handling needs. This enabled agency nurses and new staff to obtain a greater understanding of people they were caring for and their required needs.

Care plans viewed were personalised however often referred to people having dementia without acknowledging the other conditions and symptoms of their conditions they lived with. For example there was little guidance within two people's care plans to detail ways of communicating with them in a completely personalised way. Each person had a communication plan which detailed the level of support people required depending on their mood. This included whether people were able to respond to simple questions or instructions or if it was necessary for people to repeat what was being said or asked. During the inspection one person used their hands to emphasis their frustration, this was known, understood and responded to appropriately by all staff. However this method of communication and expression had not been documented in the person's communication plan. All staff were able to demonstrate a good knowledge of people's needs however people's specific communication needs were not always being documented accordingly. This was discussed with the registered manager who was addressing this with nursing staff.

The provider sought to engage people in meaningful activities. Care plans detailed the need to help people participate in as broad a range of social and cultural activities as possible. Care plans detailed people's particular social interaction needs. One person's care plan specified that they enjoyed outings from the home. Records showed this person was being encouraged and accompanied by an outside agency three times a week to do so. This person's care plan provided guidance that staff were to encourage this person to join external outings with activity staff on the mini bus and to access the gardens. The home had two activities coordinators who sought to ensure people were engaged in activities and meaningful occupation. One activities coordinator told us, "Our vision is to get people interacting…make sure that people have all got person centred care so we know them not as a group but as an individual". The activity coordinators recognised the importance of involving people in meaningful tasks including cleaning and washing up if they wished, "We have to give people purpose…so I say to people would you like to come and help me do a job". An activities programme for a typical month was viewed which involved, exercise time, one to one, cooking, board games, visits from external groups such as the British Legion, the local schools and church and musical bingo. People were also able to participate in external trips, such as visits to

Good

Is the service responsive?

local schools, shopping and the local public house. Where people were unable to leave their rooms, or unwilling to do so, the activities coordinators visited people in their rooms to ask if there was any activity they wished to participate with. This was important to prevent people suffering from social isolation and becoming withdrawn. One person told us, “The staff come around and talk to me, they are very good people.” One care plan showed that a referral had been made to the Hampshire Wellbeing Service for a dementia friend to visit this person. This had yet to be actioned but had been requested to provide this person with additional social support. We saw a chair exercise session in the communal lounge on the ground floor of the home which was attended by nine people. People enjoyed the session, laughing and joking with staff. The activities coordinator adopted a tactile approach encouraging and supporting people to become involved. People taking part had varying levels of mobility and communication however all were included.

People were encouraged to give their views and raise any concerns or complaints. People and relatives told us they knew how to make a complaint and felt able to do so if required. People and relatives were confident they could speak to staff or the registered manager to address any concerns. One person we spoke with had spoken with staff as they were becoming annoyed at the noise levels created by other people and staff in conversation. This had been dealt with by staff and the person had been moved to a room on the ground floor next to the quiet lounge. The provider’s complaints procedure was available in people’s care plans and in the ground floor entrance hallway. This listed where and how people could complain and included contact information for the provider and the Care Quality Commission. One person told us, “I would complain but I have never had to complain”, another person told us, “I have never made a complaint, I would tell the carers if I needed to”. The registered manager documented complaints on the homes computer system so they were accessible to review to identify trends or repeated incidents involving people or staff. One formal complaint had been received in the last year regarding the payment refund of fees. We saw the complaint had been raised, investigated by the registered manager as well as the provider and responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

The registered manager promoted an open and supportive culture at Marnel Lodge and actively sought feedback from people using the service, their relatives and staff. Whilst not all people were able to recognise the registered manager they were confident in her ability to manage the service and address concerns. One person told us, "This home is very well run just like I like it", another person said, "The service cares for me, they do as I ask and I like living here, I would recommend it". A visiting Doctor told us, "Out of all the nursing homes I've been involved with Marnel is one of the best…there has been some instability with recent changes of manager but doesn't seem to have affected level of care…junior staff are well managed". People said they were very happy with the quality of the service provided.

We found that records were not always fully or accurately completed. People's food and fluid charts, air mattress pressure checks and topical medicine administration charts (TMARS) did not always fully document that people were receiving the care they required. The air mattresses used were self adjusting to people's weight however the provider's records required that daily checks were made to ensure they were working effectively. People were placed on food and fluid charts due to losing weight or having other specific healthcare needs making it important to document what was being consumed. We saw that people were receiving food and fluid which was not always being documented. Records showed that there had been no deterioration in people's health indicating that the care was being given but was not being documented accordingly.

People were at risk of harm because the provider could not be assured that people always had their topical medicines as prescribed, that air mattress pressures were being checked to prevent the development of pressure sores and that people were receiving the food and fluid they required to regain and maintain a healthy weight.

The failure to ensure accurate and complete records were maintained in relation to each person was a breach of regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The registered manager was keen to promote a culture which was based on people, visitors, relatives and staff feeling that the home felt like a family environment. This was reinforced from new members of staff initial interviews, through supervisions and appraisals and team meetings. New members of staff were asked to consider the 'Mum's Test' when deciding how to deliver care. This is where people were asked to put themselves in the position that it was their mother who was receiving the care being provided and how they would want this to be done. The registered manager told us that it was important that the home felt like a family for people. The home had a philosophy of care which was developed collaboratively with the staff and the registered manager. It was discussed what would be important to staff if they were the ones receiving care. From here a philosophy was created which was widely displayed within the home which included terms such as , 'a family community', 'this minute in time is the most important to the person' and 'care is based on love, acceptance and being a friend'. Staff we spoke with recognised and acknowledged this philosophy telling us that despite there being a high turnover of staff at the location recently that the home was more settled and the staff felt more of a "family". A relative told, "It's a friendly atmosphere, it's more like a home than a place to live…she's (relative) is happy as she possible can be anywhere, I don't think you can find anywhere better". Another relative said, "It's like a family home".

The registered manager was keen to promote a culture which focused on people's experiences and sought information on how they could improve the service people received. Feedback was sought from people during regular care plan reviews, group meetings, friends and relative meetings and from staff during their team meetings. The registered manager had also introduced an easier format for people to raise a concern or provide feedback. This was by the use of 'mention cards'. These were slips of paper that were available for all to use and were placed in a post-box situated outside the registered manager's office. They could be anonymous or named and we saw that the information provided was responded to appropriately. One person had raised a concern that their relative's room was felt to be unclean. We could see dated on the card when this issue had been raised as well as a recordable account of the action that was taken to address.

The registered manager was a visible presence to relatives and staff. Staff were positive about the registered manager and the support they received to do their jobs. They told us that the registered manager was open to their concerns and needs. Staff said that they were able to approach her

Requires improvement

Is the service well-led?

and were confident that she would be proactive in dealing with issues raised. The registered manager was available for staff if they needed guidance or support. One member of staff said, "She's very supportive, if she can't give you an answer she'll get back to you, she wants to make the home a family". This member of staff continued, "She's the only manager who joins in and who's really got the residents to heart…she wants to know it's not lip service". Another member of staff told us, "She's good for professional and personal reasons, her door's always open".

Staff had the confidence to question practice and report concerns about people's care. Prior to the inspection we reviewed the notifications which were received from the home. A member of staff had raised concerns about a practice they had witnessed from an agency member of staff. The member of staff was supported through the subsequent investigation which was reported to the agency, safeguarding team and the CQC. The provider had processes in place to ensure that staff were supported to raise concerns and that they would be thoroughly investigated.

The quality of the service people experienced was monitored through regular care plan reviews, team meetings and use of a 'Your Care' questionnaire. Your Care is an independent national care home resident satisfaction survey. People and relatives were asked to complete an anonymous questionnaire which was submitted and the results collated. This resulted in percentages of people's satisfaction levels in areas including the quality of the care provided, ability to participate in hobbies and interests and complaints handling. The last completed survey in 2014 found that 22 people had responded and 100% of people had expressed overall satisfaction in the care they were receiving. The 2015 survey was in the process of being completed during the inspection but relatives told us that they were involved in the process. One person told us, "They ask about my thoughts on the service all the time".

The provider also completed a number of quality assurance audits at the home to monitor the service provision. These included a quarterly audit of the home which was used to form a Clinical Improvement Plan. This was in place to identify how the home was dealing with infection control, pressure ulcers and medicines errors. The registered manager also completed unannounced site visits. These included visits at 1am in the morning to speak with and interview night agency staff and assess people and staff security.

The provider also completed a regular audit called Quality First. These were detailed unannounced inspections at the home by the provider and included looking at areas such as quality of the living environment, staff supervision and appraisals, kitchen cleanliness and quality of paperwork completion. Three Quality First audits had been conducted in the previous 10 months. As a result of these audits actions were identified and the registered manager given ownership as a result.

Previous Quality First audits identified that there had been issues raised regarding cleanliness which had been addressed. A quality audit conducted in November identified that in the kitchen food items such as flour and a jars of food had been left opened. This was identified as a potential risk to people's health. This had been addressed and the kitchen had the highest available food safety rating which showed action had been taken. During the inspection the kitchen was noted for being clean, well organised and well managed by the chef and catering staff.

The latest Quality First audit in May 2015 requested that night visits were conducted by the registered manager. These were in order to check the quality of the service being provided and speak with night staff ensuring their knowledge about safeguarding's and medicines administration. We could see that this had been conducted on a number of occasions since this audit.

The May 2015 audit also identified that food and fluid charts were missing entries which had been identified during this inspection. This showed that the audit process was a thorough and effective process in identifying areas which required improvement. However, there had been delays in taking actions to address all of the identified issues. The registered manager had recently returned to the home from working at another location and was in the process of addressing and seeking ways to meet the requirements of the most recently completed audit. The registered manager was seeking to improve the completion of this documentation by speaking with staff asking what was required to make it easier for them to complete.

People, their relatives and visitors spoke highly of the quality of the care provided. People told us they had a

Requires improvement

Is the service well-led?

good degree of satisfaction with the home. Staff identified what they felt was high quality care and knew the importance of their role to deliver this. One staff told us, "It's putting the resident first and to be happy and clean, to feel like they're at home and engaging and not being withdrawn". Another member of staff told us, "It's doing the best that you can and giving them the best that they need". Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the registered manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.

Compliments when received were displayed in the foyer area outside the registered manager's office and a selection of these were viewed. Recent comments received were viewed. The following are a selection of those received. A relative wrote, "There are many outstanding carers on Memory Lane (the dementia floor) who 'go that extra mile." Another relative commented, "I would like to express my sincere thanks to each and every one of you for the kindness, dedication and professionalism you showed to my mother". Another relative wrote, "We would especially like to thank you for the loving care you gave (relative). A visitor wrote, "The world would be a sad place without people as special as you all, all you do is so appreciated".

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 Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were safely stored, recorded and administered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that complete and contemporaneous records were maintained in respect of each service user to ensure that risks were managed appropriately.