Barchester Healthcare Homes Limited

Marnel Lodge Care Home

Inspection report

Carter Drive
Basingstoke
Hampshire
RG24 9US

Tel: 01256471250
Website: www.barchester.com

Date of inspection visit:
18 January 2017
19 January 2017

Date of publication:
04 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 18 and 19 January 2017 and was unannounced. At the last inspection on 2, 3 and 7 September 2015 we found the provider had breached two regulations associated with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA 2014). These breaches related to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance). The provider had not always ensured people's medicines were managed safely and that complete and contemporaneous records were maintained in respect of each service user to ensure risks to their health and wellbeing were managed appropriately.

We told the provider they needed to take action and we received a report setting out the action they would take to meet the regulation. At this inspection we reviewed whether or not these actions had now been taken and found the provider was meeting the requirements of the HSCA 2014. We found improvements had been made regarding the storage and administration of medicines and the completion of documentation relating to the delivery of people's care.

Marnel Lodge Care Home, to be referred to as the home throughout this report, is a home which provides residential and nursing care for up to 62 older people who have a range of needs, including those living with Parkinson's disease, sensory impairments as well as epilepsy and diabetes. The first floor of the home provides specialist care to people living with dementia. The home is purpose built to meet people's needs and is situated in a residential area on the outskirts of the town of Basingstoke. Facilities includes two dining rooms and two lounges on both floors with a secure rear garden and patio area as well as a café area for people, visitors and relatives on the ground floor of the home. At the time of the inspection 58 people were using the service.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service told us they felt safe, relatives agreed they felt their family members were kept safe whilst living at the home. 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 guidance provided to manage these appropriately. Appropriate risk assessments were in place to keep people safe.

Overall, sufficient numbers of staff were deployed in order to meet people's needs in a timely fashion. The registered manager was addressing unplanned staff absence, which at times had caused a staff shortage. Recruitment procedures were completed to ensure people were protected from the employment of unsuitable staff. New staff induction training was followed by a period of time working with experienced

colleagues. This ensured staff had the skills and confidence required to support people safely.

People were protected from the unsafe administration of medicines. Nurses were responsible for administering medicines and had received additional training to ensure people's medicines were administered, stored and disposed of correctly. Nurse's skills in medicines management were regularly reviewed by managerial staff to ensure they remained competent to administer people's medicines safely.

People were supported by staff who had relevant up to date training available which was regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

People, where possible, were supported by staff to make their own decisions about their care and treatment. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager showed an understanding of what constituted a deprivation of person's liberty. People had been appropriately assessed as to whether they could consent to living at the home prior to applications being submitted. Authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted.

People were supported to eat and drink enough to maintain a balanced diet. We saw meals were prepared to meet people's individual nutritional and hydration requirements. Staff followed guidance in people's care plans to ensure they received a meal which met their needs. Alternatives were offered and prepared when people did not wish to eat one of the two main meals on offer and people were encouraged to eat and drink sufficiently to maintain their health and wellbeing.

People's health needs were met as the staff and the registered manager had detailed knowledge of the people they were supporting. Staff promptly engaged with healthcare agencies and professionals when required. This was to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff had taken time to develop close relationships with the people they were assisting. Staff understood people's communication needs and used non-verbal communication methods where required to interact with people. These were practically demonstrated by the registered manager and staff during their regular and comfortable interactions with people.

People received personalised and respectful care from staff who understood their care needs. People had care and support which was delivered by staff using the guidance provided in individualised care plans. Care plans contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. People were encouraged and supported by staff to make choices about their care including how they spent their day within the home.

Relatives 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. Relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager. People and relatives were also asked to complete an annual quality assurance questionnaire to provide their views on the quality of the care and support provided.

People were supported to participate in activities to enable them to live meaningful lives and prevent them experiencing social isolation. A range of activities were available to people to enrich their daily lives. Staff were motivated to ensure that people were able to participate in a wide range of activities and encouraged them to participate where possible.

People living with dementia benefited from an environment that was adapted to meet their needs. A programme aimed at improving the care that people living with dementia experienced was underway at the time of our inspection. This included a comprehensive staff training programme to ensure all staff had the knowledge and skills to provide responsive and effective care for people living with dementia.

The registered manager ensured staff were involved in creating the values for the home, which included writing a 'Philosophy of Care' for both floors. These detailed the way in which care would be delivered to people and were openly displayed in communal areas of the home. Staff understood these and we saw these standards were evidences in the way care was delivered.

The registered manager fulfilled their legal requirements by informing the Care Quality Commission (CQC) of notifiable incidents which occurred at the service. Notifiable incidents are those where significant events happened. This allowed the CQC to monitor that appropriate action was taken to keep people safe.

Relatives told us the registered manager was competent in the efficient running of the home and staff confirmed they felt supported in their roles. The registered manager provided strong positive leadership and promoted the providers values.

Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. The provider routinely and regularly monitored the quality of the service being provided in order to drive continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

People were supported by sufficient numbers of staff. Staff employed were subject to a robust recruitment procedures ensuring their suitability to deliver care.

Medicines were administered safely by nurses, whose competence was assessed by appropriately trained managerial staff.

Is the service effective?

Good

The service was effective.

The provider ensured that staff had an induction, on-going training and support in their role to be able to proactively meet people's needs and wishes.

Staff offered people choices in a way which met their communication needs and they could understand

People were supported to eat and drink enough to meet their nutritional and hydration needs. People who had specific needs in relation to eating and drinking were provided with the additional support required to protect them from any associated risks.

Staff understood and recognised people's changing health needs and promptly sought healthcare advice for people whenever required.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring in their approach with people, supporting them in a kind and sensitive manner. Staff had developed companionable and friendly relationships with people.

People's personal care plans included information to enable staff to meet their individual needs and preferences.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to. The service responded quickly to people's changing needs or wishes.

People were assisted by staff who actively encouraged people to participate in activities to allow them to lead full, active and meaningful lives.

People's views and opinions were sought and listened to. Processes were in place to ensure complaints were documented, investigated and responded to appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture, which was based on being open, honest and treating people with kindness and compassion. Staff knew these values as these were evidenced in their working practices.

The registered manager provided strong leadership fulfilling the legal requirements of their role. Staff understood their role and felt comfortable raising concerns. They told us the registered manager was supportive and a good role model.

The registered manager and provider sought feedback from people and their relatives and acted upon this. They regularly monitored the quality of the service provided in order to drive continuous improvement.

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 functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 18 and 19 January 2017 and was unannounced; it was conducted by three inspectors and an Expert by Experience (ExE). An ExE is a person who has personal experienced of using or caring for someone who has used this type of care service; on this occasion they had experience of caring for a relative who lived with dementia. The ExE spoke with people using the service and their relatives, observed a mealtime and interactions between staff and people living at the home.

Before our 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. The provider also completed a Provider Information Return (PIR) before the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We checked this information as part of our inspection. Prior to the inspection we spoke with the local Healthwatch manager, a safeguarding adults nurse from the NHS West Hampshire Clinical Commissioning Group, senior social work practitioner from the local authority and the specialist nurse for nursing and residential homes.

During the inspection we spoke with four people living at the home and ten relatives, the registered manager (a registered nurse), deputy manager, two nurses, and six care staff, an activities coordinator and the chef. We looked at how medicines were obtained, stored, dispensed and disposed of. We also looked at the staff training matrix and four staff files. We observed care in communal areas throughout the two days including lunchtimes.

We viewed six people's care plans. We examined the Medicines Administration Records (MAR) for 25 people living at the home. We reviewed staff files containing recruitment information for four staff members and viewed staff supervision and appraisal records, staff training records and staff rotas for the dates 12 December 2016 to 18 January 2017. We also reviewed other documentation relating to the running of the

home, these included quality assurance audits, the provider's policies and procedures, complaints and compliments records.

Good

Is the service safe?

Our findings

People told us they felt safe and this was confirmed by people's relatives. One relative told us "(person) is safe and warm, eats well and is well looked after". Another relative confirmed this and said, "I can go away relaxed that (person) is being looked after". A health care professional told us that concerns about people's safety were reported appropriately and that the registered manager "Demonstrated a clear understanding of the safeguarding process".

At our previous comprehensive inspection on 2, 3 and 7 September 2015 we found the provider had failed to follow safe medicines administration practices. People were exposed to a number of potential areas of risk which included; not receiving their medicines as prescribed, unauthorised people accessing medicines incorrectly stored in public areas and the incomplete documentation relating to the administration of people's topical medicines, such as prescribed creams. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had reviewed their management, auditing and training regarding people's medicines. Where staff were no longer demonstrating an ability to manage medicines safely they were removed from this role to minimise the risk of people being exposed to any risk associated with medicines. Staff had or were in the process of completing documentation training which reinforced the importance and legal requirements to accurately and contemporaneously complete documentation relating to people's care. We could see this had resulted in a positive improvement in the completion of such documentation and working practices. Action had been taken and records showed the provider was now meeting the requirements of the regulation.

Nurses were responsible for administering medicines. Records showed that medicine administration records (MARS) were correctly completed to identify that people received their medicines as prescribed. We observed the dispensing of medication and examined the provider's medication management policy. The policies and procedures in place supported nurses to ensure medicines were managed in accordance with current regulations and guidance. Nurses were also subject to annual competency assessments as part of the provider's quality assurance processes to ensure medicines were managed and administered safely.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in lockable cabinets. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge and the room in which it was housed was monitored daily. This helped to ensure the safe storage of these medicines.

One person living at the home self-medicated, as they managed their medicines independently. We noted the provider had completed an assessment to ensure the person had the mental capacity to manage them safely. This was reviewed on a monthly basis to monitor their on-going ability to manage their medicines

safely. Some people living at the home were receiving medicines which are known as PRN or 'as required'. These included analgesics, sedatives and other medicines to manage people's pain. These are medicines that are not routinely required and may only be needed occasionally. Peoples MARS included a PRN protocol for nurses so they were able to see when PRN medicines were most appropriate, and the dosage that could be given.

The provider undertook regular audits to ensure the safe and effective management of medicines, which was also audited by an external provider. These included checking medicines had been signed for when dispensed and that medicines were safely stored and disposed of.

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse. Staff were aware of their responsibilities to report any safeguarding concern. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert, which included contacting the local Adult Services Safeguarding Team. The staff members we spoke with told us they had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would speak with the staff member if I saw them mistreating a resident. Then I would report it to the manager". Another staff member said, "I know there is a number we can ring if we aren't happy about the care but I don't have any concerns here". People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if any concerns were identified.

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, regarding their moving and handling needs, risk of skin breakdown and any identified nutritional or hydration risks. Risk assessments included information about the action staff needed to take to minimise the possibility of harm occurring to people. For example, some people living at the home had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when being transferred.

We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member told us, "We always try to keep people safe but not so they can't do anything". Our observations on the day confirmed staff were mindful of people's rights to take risks. A person's relative said "(person) is as safe as they can be particularly as I have said I want (person) to walk even though there is a risk they could fall". We observed a care staff member reminding a person to use their walking aid with two hands for their safety. One person demonstrated to us how they used their alarm pendant to call staff if they required assistance and we noted the staff attended promptly.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. 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 completed including obtaining written previous work 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 service. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

The registered manager had assessed whether sufficient numbers of staff were deployed to meet people's needs. As a result they had identified the number of staff required to enable each person to receive the care they required. Staffing rota's showed that two registered nurses and 11 or 12 carer staff were on duty during the day. There were two nurses and four care staff on night duty. There were also kitchen, domestic, administration staff as well as activities coordinators, all of whom were seen to interact and support people during the inspection.

During the inspection some staff raised concerns there were not always sufficient numbers of staff available to meet people's needs in a timely way at the weekends, as staff unable to work due to sickness gave short notice on the same day. The staffing rotas we reviewed showed sickness levels were higher at weekends. Sufficient numbers of staff had always been scheduled to work, however, due the last minute nature of the reported sickness, on occasion staff had not always been able to seek alternative staffing support. Staff told us that people still received the care they required, however, it would take a little longer to meet everyone's individual needs.

The registered manager explained that where shortfalls in staff were identified the registered manager sought the assistance of existing staff or bank staff to provide cover. Bank staff are staff members who have completed the providers recruitment, training and induction process and are available to work shifts on a casual and as required basis. The registered manager was aware of the concerns raised by staff and was in the process of improving the management of staff sickness to ensure repeat incidences were minimised. Staff confirmed improvements had been made.

The last completed annual quality questionnaire results had been completed in 2016 and the results were openly available in the main foyer of the home for people to read. This questionnaire asked for people's responses in a number of key areas, which also included requesting feedback on staff availability. 96 responses to this questionnaire had been received in total, of this figure 85% of people agreed that staff were available, however, only 39% of relatives felt there were enough staff to meet the needs of residents. Further analysis was completed by the registered manager to address this concern and it was identified that relatives could not always see staff when they were visiting their loved ones in the evenings and weekends. It was identified that these were times when staff would be most active in supporting people in their rooms and would not be immediately identifiable as available in the home. As a result a number of measures were put in place to reassure relatives that sufficient numbers of staff were available; this included displaying the staff currently working on a board within the home and the reorganisation of staff breaks to ensure staff were not taking their breaks at the same time. During the inspection we could see that people's needs were being met in a timely fashion. Throughout the inspection call bells used by people to request assistance were heard very infrequently and those which were used were answered promptly. Overall, sufficient numbers of staff were deployed to deliver care at the time it was needed.

Good

Is the service effective?

Our findings

People and relatives we spoke with were positive about the ability of staff to meet their and their family members care needs. One person told us, "Oh yes they are very good. I'd recommend it to anybody, it's very nice". Another person said, "They (the staff) work very hard. They treat you with respect. They've made me feel very welcome". A local Healthwatch organisation, which is a statutory body set up to champion the views and experiences of local people about their health and social care services, told us the comments they had received spoke positively about the 'attitude of staff'.

People were assisted by staff who completed an induction into their role. Staff induction included a period of shadowing to ensure they were competent and confident before supporting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their job. This allowed new staff to see what was expected of them. One member of staff told us about the induction, "Yes, I did quite a bit of training and shadowing. I felt okay with it". The induction process completed by staff was in line with the Care Certificate. This is a nationally recognised set of standards which care staff are expected to adhere to in their daily working life to support them to deliver safe and effective care.

Staff were able to access training in subjects relevant to the care needs of the people they were supporting. The provider had made training and updates mandatory for all staff in a number of key areas. These included, infection control, health and safety, food safety and safeguarding for example. Other training completed by staff included: The Mental Capacity Act (2005), duty of candour, customer care, record keeping and the management of dysphagia (difficulty in swallowing). A staff member told us, "Well we have quite a lot of people here whose care is quite complicated. The training has helped me manage".

Nurses were provided with clinical supervision and training to support them to meet the recently introduced revalidation process, designed to ensure all registered nurses are competent and safe practitioners. One nursing staff member said, "I use reflective practice as part of my supervision. This helps me compile information I'll need for my revalidation when it comes round".

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 development.. Staff we spoke with told us they had received supervision and appraisal and the records we reviewed confirmed this. A staff member said, "Yes, it's (supervision) very open and honest. I can say anything really".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Best interest means decisions are made on behalf of people when they no longer have the capacity to make a specific decision about their life or care. We asked staff about issues of consent and about their understanding of the MCA. All staff members had received training in this area and could tell us the

implications of the Act on people's daily lives. One staff member told us, "I wouldn't just do things to people. They are entitled to make decisions for themselves in some way or other, even if it's just what they wear". Records showed that when people had been assessed as lacking capacity to make specific decisions about their care, the provider had complied with the requirements of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that appropriately submitted applications had been made which had been authorised successfully to ensure that people were not unlawfully deprived of their liberty whilst living at the home.

People's nutritional needs were assessed, recorded and their likes and dislikes were detailed in care plans and kitchen records. When identified as necessary, records detailing what people ate were completed to inform staff if people had had adequate food and fluid during the day. People's weights were monitored regularly and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight or whether there should be a change to this weight monitoring.

People were complimentary about the food provided and said they enjoyed their meals. One person told us, "The food is very good", and a person's relative said, "There is choice at each meal and they will make something different if (person) does not want the menu, the chef would do that no problem". The chef was aware of people's food likes and dislikes and was able to cater for differing needs. For example, people's allergies or specific dietary needs such as diabetic, vegetarian, low fat or high calorie diets. This information was available in the kitchen and updated when required.

The dining rooms were small, creating a comfortable less distracting environment for people at lunchtime. Food and drink were served on brightly coloured china providing a colour contrast to food and tableware. This can assist people with dementia and sight loss to see food more easily and encourage people to eat. People were shown plates of food to choose from when seated for lunch, which assisted people to make a choice at the time they ate. We noted when pureed food was served to people who had difficulty in swallowing this was presented to be visually appealing. This encouraged people to eat. We observed care staff encouraging people to eat independently and assisting people appropriately as required during lunch. The meal time was not rushed allowing people time to enjoy their meal.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of potential illness could be identified by regular review of people's risk assessments and care plans. Where required people were supported to seek additional healthcare professional advice, which included seeing the GP, for example. We received positive feedback from an external healthcare professional concerning the management of people's healthcare needs including their emergency healthcare needs. They told us "good" clinical handovers were given to external healthcare professionals by staff and appropriate referrals were made into healthcare services.

When advice from healthcare professionals had been provided we could see this had been documented and staff had taken appropriate action to ensure this guidance was followed. For example; some people had percutaneous endoscopic gastrostomies (PEG) in place. PEGs involve placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be infused, when taking in food and drink orally was no longer possible. We noted staff were knowledgeable about the management of these; we were told all nursing staff had been trained in this area. Staff had also been regularly reviewed by a dietician and a speech and language therapist. We found staff followed the advice guidance offered by them and all external health professionals to provide safe and appropriate care.

The environment had been adapted to meet the specialist needs of people living with dementia. For example; people's bedroom doors were personalised to make them more recognisable, with pictures of interest to the person such as a photo of the person's cat. Communal areas included stimuli such as pictures or objects to help people orientate themselves and create interest. For example; an area with a dressing table, sewing machine, hat and coat stand; a garden area with benches, tools and plants and a nursery area with prams, cots and toys.

The provider had introduced a programme aimed at driving improvements to all aspects of the care they delivered for people living with dementia. This included a staff training programme to ensure that all staff, regardless of role had completed training in dementia awareness. Care staff, nursing staff and managers would then go on to complete advanced skills training in dementia relevant to their role and responsibilities. This was to ensure all staff had the skills and knowledge to support people living with dementia. Improvements had been made to the environment as part of this programme including; developing areas of interest for people, reorganising and decorating communal areas to provide a more 'homely' and relaxing environment and introducing memory boxes and life history books to engage people and assist staff to know more about the person to provide responsive care. Resources such as a pain assessment and depression screening tool had been introduced to enable staff to assess and manage the needs of people living with dementia who may not be able to verbally express their needs. People living with dementia had access to resources and were cared for in an environment responsive to their needs.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that staff were caring. One relative told us, "It's really like a family here, the way they care for (person) it's unbelievable". A person said, "They (staff) would do anything for you". Another relative said, "We want our relative to be as safe and happy as they can be and both are being met here at Marnel".

We saw people experienced comfortable, familiar and caring relationships with staff. We observed staff being engaging with people, ensuring eye contact, listening and responding accordingly, smiling, being polite with terms of endearment being used where agreed and appropriate. During the inspection all members of staff in the home chatted to people as they went about their work. Conversations were not just task orientated. Staff took time to speak with people engaging in talking about the weather, activities and relatives coming to visit them. Staff spoke to people in a warm and caring manner, and spent time chatting with them about issues they were interested in. One member of staff sat with a person who was not joining in the lunchtime dining experience and ensured they had company looking out onto allotments behind the home discussing gardening and flowers they both liked. There was a calm, relaxed and friendly atmosphere at the home. Staff interactions between people and staff were caring and professional in their approach when supporting people.

We observed care in communal areas throughout the inspection, we saw positive interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Staff knew about the people they were supporting because the care plans viewed included information about what was important to them such as their family relationships and what help they required to support them. People's care plans detailed their personal history, what activities interested them, their spiritual and cultural needs and their hopes and concerns for their future. This information assisted staff by enabling them to have an understanding of people's needs, preferences and the support they needed to remain happy. We could see that people's needs were known and people supported in the way they wanted. We could also see, for example, that people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed and clean and the gentleman shaven where preferred.

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. All the staff we spoke with were able to describe how they would support people in a caring way giving people the time and reassurance they required until they were no longer feeling unhappy. People were supported in periods of low moods and offered comfort and reassurance until they felt better within themselves.
Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people to engage with them. When communicating staff would also often gently place a hand on people's arms to communicate that they were being spoken with in reassuring way. We saw that people were comfortable and actively sought this physical contact with staff. A relative told us this comforting support was offered daily by staff, "I'm very happy with the care (person) gets here. I often find someone talking to (person) when I arrive and they don't know I am coming some of them (staff)

love (person) to bits and spoil them".

People were supported to express their views and where possible involved in making decisions about their care and support. We found evidence that people or their representatives had regular and formal involvement in on-going care planning or risk assessment. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

People told us and relatives confirmed that people were treated with respect and had their privacy maintained at all times. A relative told us, "They (staff) always knock at the door even if it's open". Staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. People's care plans provided guidance on how to support people in a way that was mindful and respectful of people's dignity. Staff were able to provide examples of how they followed this guidance.

Staff were seen to ask people before delivering or supporting them with the delivery of care. Women were provided with an additional blanket to place over their laps to ensure additional privacy and dignity whilst sat in lounge areas wearing their preferred choice of skirts of dresses. Staff were mindful of the right for people to receive care which respected their need for dignity and privacy, ensuring appropriate action was taken to maintain this whenever necessary.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by other healthcare specialists. Services and equipment were provided as and when needed. People's care plans included information about their wishes, advance decisions and funeral arrangements. This included what was important to the person at the end of their life.

Relatives were treated with compassion when their loved ones passed away. On the first day of the inspection, one person living at the home had died in the morning. Staff allowed the family the time they needed and wanted to spend with their loved one before they were taken from the home by undertakers. When the person was taken from the home staff formed a line in the foyer area allowing them to say goodbye. They offered physical and emotional support to each other at this time and towards family as they left the home for the last time.

We saw that people's differences were respected. We were able to look at all areas of the home, including people's own bedrooms. We saw rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. People were supported to live their life in the way they wanted in a homely environment which respected their individuality and met their needs.

Compliments had also been received in the home which identified that high quality care had been provided to their loved ones. A selection of these was viewed. One relative had written, 'The carers were amazing. They treated him (family member) with such kindness, patience and respect. We saw nothing but cheerfulness, care and kindness when they were being done (care delivery)…the nurses did an excellent job with a great mixture of professionalism and compassion…. The management were wonderful and we felt personally supported by them and confident that they were always doing their best on dad's behalf. People were assisted by staff who were able to recognise the traits of good quality care, ensured these were followed and demonstrated these when supporting people.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. One relative said, "They (staff) sat with mum last year and they went through it all (care plan) and discussed end of life with her"

People's care plans and daily documentation were legible and person centred. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. We asked staff what they understood by the term 'person centred care'. One staff member told us, "Each person is different so their care will be". Another staff member said, "I think it's the kind of care we'd want for ourselves". A person's relative told us "Staff absolutely know about their needs".

People's choices and preferences were documented. Care plans contained detailed information about people's care needs and actions required in response to changes in their health and wellbeing to ensure the care met their individual needs. For example, one person's care plan showed there were concerns about the person's mental wellbeing. We noted this person's care plan contained specific guidance and action planning around the support and management of the person's care in this area. This included the person's areas of interests and how staff should encourage the person to engage in activities and socialise to aid their mental wellbeing. We observed staff discussed the person's needs in handover to plan support in line with the person's needs. This care plan was regularly reviewed to ensure appropriate action was taken in response to any change should it arise.

People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. When it was 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. When healthcare professional advice had been sought the information provided had been used to update people's care plans accordingly.

Handovers between staff were held on each floor at the start of each shift change. 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 medicine needs for example medical appointments due and people's moving and handling needs. This enabled all staff to obtain an up to date understanding of the people they were caring for and their required needs. We observed a staff handover and found detailed information was communicated between staff to enable them to meet people's current needs.

The provider sought to engage people in meaningful activities with two full time activities coordinators employed. On Wednesdays the hairdresser visited which was treated as a social event and at the weekends the home was busy with visitors. All staff were aware of the need for people to be provided with interaction and stimulation and this role did not only fall on the activities coordinators. We saw this was included in the activities rota and all staff were included in having a 'tea and chat' activity session with people. At Christmas

staff had also performed a pantomime version of the Wizard of Oz which was widely enjoyed by those who attended. An activity coordinator told us how activities were planned to meet people's preferences and abilities by using feedback from people and their relatives. They said, "It is all about building good memories and getting to know people and what they like".

A sample week's activities rota was viewed, which had defined activities twice a day each day of the week. These activities included one to ones with people in their rooms, 'helping hands' sessions which included hand on hand interaction with people completing any tasks they wished such as writing letters, and dusting and polishing items in their room if wanted. Other activities included; arts and crafts, nail care, film afternoons and reviewing current news affairs. We saw that additional events were celebrated for people such as Burns Night in January and events such as a 'cruise day' which was themed around being on a cruise ship to an agreed destination with entertainment and a buffet. The home also welcomed external visitors which included, singing entertainers, children from a local primary school, visitors from the Salvation Army and church services. A church service was held on the first day of the inspection and well attended by people living in the home. The home had also created a 'Gentleman's Club' to allow the men living at the home to come together and organise any activities they wished to participate in. The club had proved so successful that ladies living at the home also wanted to join in, so a separate 'Ladies Club' was created.

Activities were a regular agenda item at the monthly residents meetings and we could see people were asked if they were happy with the activities provided and if they wished to seek alternative opportunities. When residents requested a greenhouse be made available for the Gentleman's Club we could see that this was in the process of being sourced which would allow for additional activities to be available for people. At the recently completed customer satisfaction questionnaire, 92% of the people who responded stated they were able to take part in activities and hobbies if they wished to. A person's relative said, "I like the fact that the TV isn't always on, they do their best with the activities".

People and relatives were encouraged to give their views and raise any concerns or complaints. People and relatives told us they were confident they could speak to staff or the registered manager to address any concerns. A relative said, "Everyone is very helpful and quick to put things right if we want something". The provider's complaints policy was available for people and displayed in the home's foyer. The provider had an additional policy titled 'The right to voice comments, suggestions and complaints'. This listed where and how people could complain and included details of who to complain to. The provider's complaints policy included information on how to raise concerns with the Local Authority Ombudsmen if the complainant remained dissatisfied with the outcome of their complaint. It also included website contact details for the Care Quality Commission to enable people to raise concerns about their care if required. The provider also used 'Just wanted to mention cards' which were cards which could be completed anonymously and placed into a box outside the registered manager's office. This allowed people, staff, relatives and visitors to raise any concerns before they became formal complaints and we could see action was taken then completed. For example, one raised a concern regarding the quality of one of the meals provided, we could see this concern was addressed and discussed at the residents meeting, ensuring this was actioned appropriately and no longer remained a concern.

Complaints made in writing and verbally received were documented and recorded in the complaints folder, held securely in the registered manager's office. One formal complaint had been received since the last inspection. We saw the complaint raised was investigated by the registered manager and steps were taken to address the causes of the complaint. This included involving external social care professionals to ensure that lessons were learned to minimise the risk of repeat incidences. The complaint was then responded to appropriately in accordance with the provider's policy. All of the staff we spoke with were aware of their responsibilities in relation to the management of complaints. One staff member told us, "I haven't had any

complaints directly at me yet but I know I would go to the manager if it was something I couldn't sort out myself".

Good

Is the service well-led?

Our findings

People and staff we spoke with were confident in the registered manager's ability to manage the service and address concerns. One relative told us, "The management is always approachable and gets the job done. If I had any issues I'd knock on her door and have a chat". People were able to recognise the registered manager and demonstrated they saw them regularly. People told us they were happy with the quality of the care provided. A social care professional told us they had found the registered manager to be receptive to feedback, which has led to identifying learning needs to improve the service people received.

At our previous comprehensive inspection on 2, 3 and 7 September 2015 we found the provider had failed to ensure people's care records were completed fully and contemporaneously to ensure any risks to their health and wellbeing were managed appropriately. This included; failing to fully complete people's topical medicine administration records to show they had received their medicine as required, failure to fully complete food and fluid charts to ensure people were eating and drinking sufficiently to maintain their wellbeing and daily recording of air pressure mattress checks to ensure equipment was maintained to minimise the risk of people acquiring a pressure ulcer. This was a breach of regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The provider had reviewed their management, training and auditing processes with staff regarding the completion of documentation. Staff had or were in the process of completing documentation training which reinforced the importance and legal requirements to accurately and contemporaneously complete documentation relating to people's care. We could see this had resulted in a positive improvement in the completion of such documentation and working practices. The provider had taken action and was now meeting the requirements of the regulation.

The registered manager and provider had developed an open, transparent and inclusive culture by meeting and working with people's relatives, staff and external health and social care professionals. We observed throughout the inspection the registered manager taking the time to speak with every person they met. People looked pleased to see them and there was good rapport between them. The deputy and registered managers office was next to the front door so they were a visible and recognisable presence to those who entered the home. The registered manager was keen to ensure that people living, working and visiting the home were aware that their door was always open and they were available to speak with people as and when they wanted. A staff member told us "It's a family culture here; the registered manager is very keen on this. It's so important". Another staff member said "She (registered manager) is there with you if things are hard. She is next to you and inspiring, people come first".

The registered manager promoted an 'open door' policy and was available to people and to provide support whenever required. Relatives confirmed they were able to raise any concerns at any time with the managerial staff. One relative told us, "She (registered manager) is brilliant". They went on to tell us how they always found the management team welcoming and responsive. Staff felt that they received consistent and valued support from the registered manager. Relatives told us they could always speak to the registered manager if required and were confident that action would be taken if they raised any concerns. We asked

staff if they thought the home was well led by strong managerial support. One staff member told us, "Yes, the manager is friendly and very fair". Another staff member
said, "It's very open here. I know I can say what's on my mind".

Staff had been involved in shaping the provider's visions and values and both floors in the home had their own 'Philosophy of Care'. It had been discussed with staff which values they felt would be important to them if they were receiving care. From here, the philosophies were created and were widely displayed with the home. These included the terms, 'family community' and 'care is based on love, acceptance and being a friend'. One member of staff told us, "I think it's about helping people to stay as independent as possible". Another staff member told us, "It's about understanding what it's like to live here. I did some training recently about the lived experience where I played the role of a resident and was cared for. You see how important it is when you do that". In order to achieve these values we saw staff worked well together and were friendly, helpful and responded quickly to people's individual needs. People and relatives we spoke with confirmed these values were displayed by the staff during the delivery of their care. One person told us, "They're (staff) family" a relative said "You don't see them (staff) as carers, you see them as family". A relative had sent a card to the home which confirmed the values of the staff, the relative wrote, 'We found the attitude of the staff to the residents so patient and loving'.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Staff had submitted notifications to the CQC, in a timely manner, about any events or incidents they were required by law to tell us about. They were aware of the new requirements following the implementation of the Care Act 2014, for example they were aware of the requirements under the duty of candour. This is where a registered person must act in an open and transparent way in relation to any specific incidents.

People and their relatives were actively encouraged to be involved in developing the service. The registered manager sought feedback from people to identify how the service people received could be improved. This occurred during care reviews, residents meetings, relatives meetings and quality questionnaires. The last published annual quality questionnaire survey had been completed in 2015 with the results made available in 2016. The 2016 survey had recently been completed however the results were not yet known at the time of the inspection. These questionnaires asked for feedback in key areas such as people's satisfaction with the home and environment, the care provided as well as their thoughts regarding food and activities available to them.

People were asked to rate their responses and these were collated into percentages to show people's overall experiences of the home. 98% of the 55 responses from people showed they either agreed or strongly agreed with the statement that they were happy living in the home. The responses throughout the questionnaire showed high positive responses regarding their feelings of whether they were treated with kindness, dignity and respect and if they could make choices around the care they received. 98% of the 44 responses received from relatives showed they either agreed or strongly agreed with the statement that their relatives appeared happy living in the home. Where there had been less successful judgements made, action plans had been put in place to meet these shortfalls to ensure people retained and remained their satisfaction with the quality of the care provided. The provider had processes in place to monitor the quality of the service and acted on feedback.

There was a robust system in place to monitor the quality of the service people received through the use of regular provider and registered manager audits as well as daily observations of staff in their role. The registered manager conducted a number of audits on a monthly basis which included; unannounced site visits, observations of staff during moving and handling processes, direct observation of staff in care

delivery, housekeeping and kitchen audits. Regular quality checks were also completed on key areas, such as the environment, care plans, activities and medicines. The provider's Regional Director also completed three monthly 'Quality First' quality audits. These audits were based on the Care Quality Commissions inspection process and looked at whether or not the home was safe, effective, caring, responsive and well-led making recommendations for improvement where required.

Following these audits, action plans were put in place which detailed any actions needed and timescales for any work to be completed. For example, the last Quality First audit was completed in October 2016 which identified that a number of care plans required reviewing to ensure they met the specific areas of needs for individuals. An action was put in place to ensure the registered manager and deputy manager ensured this was completed. The plan also instructed that staff received additional support in completing documentation and we saw these actions had been completed. The provider ensured through the use of regular monitoring tools, areas which required improvement were identified and timely action taken to improve the quality of the service.