Barchester Healthcare Homes Limited

Marple Dale Hall - The New Windsor

Inspection report

Dale Road
Marple
Stockport
Greater Manchester
SK6 6NL

Tel: 01614490771
Website: www.barchester.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 26 and 27 January 2017.

We last inspected the service on 8 and 9 September 2015, we rated the overall service as Requires Improvement. At that inspection we identified two regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to the management of medicines and staffing.

This inspection was to check satisfactory improvements had been made and to review the ratings. We saw evidence to confirm that action required had been taken.

Marple Dale Hall-The New Windsor, is registered with the Care Quality Commission (CQC) to provide 24 hour nursing care and accommodation for up to 66 people with a wide variety of conditions and frailties. People are cared for in purpose built accommodation designed to meet the care and support needs of the people who live there. Accommodation is provided over two floors. The ground floor of the home provides specialist care for younger people who have a physical disability and those with an acquired brain injury or learning difficulties. The first floor of the home provides nursing care for older people with a wide variety of frailties and conditions and people living with dementia.

A registered manager was in place at the home. 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 who used the service and their relatives were complimentary and positive about the support provided and attitude of the staff team and management. People spoken with said, "We are happy with the service provided and overall our needs are being met." Two relatives spoken with told us the nurses and care staff were extremely attentive and the care provided was always person centred.

People were supported by sufficient numbers of suitably trained staff. Care staff and nurses we spoke with told us they had undergone a thorough recruitment process and following their employee induction, training appropriate to the work they carried out was always available to them. Some staff were working towards a nationally recognised qualification in care such as a National Vocational Qualification (NVQ) in health and social care and the Care Certificate. This helped to make sure the care provided was safe and responsive to meet peoples identified needs.

Staff members received regular supervision to help make sure they were carrying out their duties safely and effectively.

Staff spoken with confirmed they had received safeguarding and whistle blowing training, and knew who to report concerns to if they suspected or witnessed abuse or poor practice.

Care records were in place which reflected peoples identified health care and support needs. Information about people's dietary requirements, how people wanted to be supported, when support was required and how this was to be delivered was also included in the care records we examined.

We saw written evidence that people and their relatives were involved in the decision making process at the initial assessment stage and during their care needs review. Where people who used the service did not have the capacity to make their own decisions, the service ensured that decisions taken were in line with the principles of the Mental Capacity Act.

Systems to make sure the safekeeping and administration of medicines were followed monitored were in place and reviewed annually. Medicines were stored safely and administered only by registered nurses. Any specific requirements or risks in relation to people taking particular medicines were clearly documented.

Complaints, comments and compliments were encouraged by the provider and any feedback from people using the service or their relatives were addressed by the registered manager. People spoken with knew how to make a complaint and felt confident to approach any member of the staff team if they needed to.

The registered manager had systems in place to monitor the quality, including service user and relative surveys, to ascertain their views and opinions about their satisfaction of the service provided. Any feedback received was noted and used to make improvements to the service and the care and support being provided.

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.

Employee recruitment processes in place helped to make sure new staff starting work at the service were suitable to work with vulnerable adults.

Safeguarding policies and procedures were in place. Staff members knew how to protect people from the risk of harm.

Risks to people were identified and detailed in care records. Written information clearly showed how to mitigate any risks.

Systems were in place to make sure medicines were administered safely by suitably trained staff.

Is the service effective?

Good

The service was effective.

Staff members received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

Where people were being deprived of their liberty the registered manager had taken the necessary action to make sure people's rights were considered and protected.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and General Practitioner's.

Is the service caring?

Good

The service was caring.

People received care and support from staff members who knew them well.

People using the service and their relatives told us they were included in decisions about aspects of their own care or their relatives care.

People's care records were stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them receiving a service. Care records identified risks to people's physical health, mental health and well-being.

Multidisciplinary health care reviews were held on a regular basis or more frequently if necessary. Specialist guidance was included in people's care records.

People told us they felt confident in raising concerns or complaints with the registered manager or staff members.

Is the service well-led?

Good

The service was well-led

There was a clear management structure in place. People who used the service; their relatives and staff members spoke positively about the management team.

The registered manager promoted a person centred approach to help make sure people's needs and preferences were met.

Systems were in place in order to monitor the quality of the service.

Marple Dale Hall - The New Windsor

Detailed findings

Background to this inspection

Start this section with the following sentence:

'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.'

Say when the inspection took place and be very clear about whether the inspection was announced or unannounced, for example by saying:

'This inspection took place on [date] and was unannounced.'

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

This inspection took place on the 26 and 27 January 2017 and the first day was announced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information that we held about the service and the service provider. This included safeguarding and incident notifications which the provider had told us about. Following the inspection we spoke with a person from the local authority adult social care team who confirmed they had no current concerns about the provider and the services that were being provided.

During our inspection we spoke with two relatives of people who used the service and ten people who used the service, the registered manager, the deputy manager, the regional director, the first floor head of unit, the ground floor head of unit, three senior care workers, the clinical development nurse, three care workers, the maintenance manager, the head chef, the activity coordinator and the service administrator.

We looked at the care records that belonged to four people who used the service, six employee personnel files including individual staff training records, records relating to how the service was being managed such as safety audits and a sample of the services operational policies and procedures.

Good

Is the service safe?

Our findings

We spoke with two relatives of people who used the service and they told us they felt their relatives were safe living at Marple Dale Hall. They said, "I'm more than happy with the way she [relative] is looked after. I feel it's the safest place for her".

We saw there were arrangements in place to help protect people from the risk of abuse. The service had an up- to-date safeguarding policy and procedure in place, which was in line with the local authority's 'safeguarding adults at risk multi-agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records that showed the registered manager had effective procedures to help make sure any concerns about people's safety were appropriately reported. Management and staff members we spoke with were able to give a good account of the risks associated to vulnerable adults, the safeguards in place to minimise these risks and explain how they would recognise and report abuse whilst also being vigilant about poor practice.

Care staff spoken with confirmed they had received safeguarding and whistleblowing training and shared their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by staff) They told us they would contact the registered manager, deputy manager or one of the nurses to inform them about any concerns. Staff training records showed they had received training in this topic.

An accident and incident policy and procedure was in place. Records of any accidents and incidents were filed and had been reported appropriately to the Care Quality Commission and the local authority adult social care team.

Records to show people had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency evacuation situation such as fire evacuation. We saw that all staff had undertaken fire safety training at regular intervals.

A recruitment and selection procedure was in place and also used for the recruitment of agency staff such as registered nurses. We looked at six employee personnel files and found that all of the staff members had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. All staff members were issued with an employee handbook which contained information about Barchester policies and procedures and the organisational expectations of staff.

We examined the care records that belonged to four people who lived at the home. Each care record showed that risks to people's health and well-being had been identified. Environmental and equipment risk assessments had been completed for all people who used the service, for example when using hoists and bathing. Risk assessments in relation to people's daily living routines were also in place and were linked to the person's care plan. For example, where there was a high risk to a person of choking or developing pressure sores, their risk management plan clearly identified the cause or factors which might increase the

likelihood of the risk occurring and staff should take to reduce the risk and what to do should the risk occur. Staff members spoken with understood their role in relation to people's identified risks.

People who used the service and staff spoken with told us they felt overall there were enough staff to meet people's needs. A person who used the service said, "Sometimes when staff are off sick, we have agency staff. They put pressure on regular staff because they're not familiar with the residents". A relative of a person who used the service said about the staffing levels, "When agency staff are used there doesn't seem to be continuity of care, but normally it is first class and people seem to be safe". The registered manager advised us that appropriate staffing levels were maintained in order to meet the support needs and level of dependency of people who used the service. They told us the staff roster was planned to make sure there were enough staff to work closely with people to assist them to meet their specific needs and provide a consistent approach to those needs. When we examined the duty rosters the details confirmed appropriate levels of staff in place to deliver care and support to people safely.

When we walked around the building we saw the building was clean, well maintained and secured. The maintenance manager was responsible for making sure health and safety audits were carried out on a regular basis, including daily checks on windows, doors, lighting and heating. Records indicated that fire equipment checks and fire drills were carried out frequently. We examined records that showed checks had been undertaken for water temperature, electrical appliances and portable appliance testing. These checks had been undertaken at regular intervals. Environmental risk assessments had been undertaken and a clear system for documenting any required maintenance work and evidence that the work had been undertaken and recorded.

We spoke with eleven staff members in various roles, who described their recruitment to the service. They advised that after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered manager carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. When we examined a sample of staff recruitment records we saw evidence that staff members were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

At our last inspection in September 2015 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found medicines were not being managed safely. This included issues with the way staff administered medicines and recorded the administration of medicines. Also some nurses had not completed a medicines administration competency assessment to confirm they were able to administer medicines safely.

At this inspection we found the provider had made improvements and was meeting the requirements of the regulation. We found the registered manager had introduced a system of gap monitoring to make sure that after each medicine round all MARs were checked by a second nurse. This was shared at shift handover and with the registered manager to help make sure people received their medicines at the prescribed time and any signature gaps were identified immediately, followed up and actioned. In addition to this the registered manager had introduced a weekly medicines audit, medicines administration spot checks, a full six monthly medicines audit, a medicine accountability workbook and medicines competency assessment to be completed by all nurses at the home. We saw records showed newly employed nurses had completed the medicines competences before being allowed to administer medicines. This meant risks associated to the management of medicines were reduced.

A medicines policy was in place to ensure the safekeeping and administration of medicines. This was

followed, monitored and reviewed annually. Only nursing staff trained in the safe handling of medicines were able to administer medicines. We saw medicines were stored in locked medicine trolleys within a designated locked room. We saw a list of authorised medicine handlers [staff members] had been signed and kept up to date.

A registered nurse spoken with knew about the process for checking the right dose according to the General Practitioners (GP) instruction and administering medicines following the homes medicine administration policy. They had good knowledge of why people required their medicines, the dosage, the desired effect and the action they should take in the presentation of possible side effects.

We looked at a sample of MAR and found they were completed appropriately and were up to date. We asked 11 people who used the service if their medicines were administered on time and they confirmed they were. This was confirmed when we observed a medicines round being undertaken in the home.

The deputy manager told us the process taken should a medicines error occur such as medication given at the wrong time. They told us they completed a medicines error report form and immediately informed the registered manager or deputy manager. In addition to this they would seek advice from the person's general practitioner (GP), the out of hours GP or NHS 111. NHS 111 is the NHS non-emergency number where people can speak to a highly trained adviser; supported by healthcare professionals should they require any health or medical advice.

The medicines error report form records what the error was, what the recommendations are and how the error could have been prevented. The completed form is sent to the regional manager and shared with the internal auditing team. The registered manager and deputy manager were both responsible for addressing the error with the staff member ensuring a record was made of the discussion and action taken such as further nurse medicines competency training would be initiated.

Staff had access to personal protective equipment (PPE) to help reduce the risk of cross infection.
Staff members we spoke with told us the registered manager provided them with personal protective equipment such as disposable gloves and aprons, which helped to protect them and people using the service from the risk of cross infection whilst delivering care. Staff were aware of the need to make sure they used the protective equipment available and confirmed to us there was always plenty of PPE available for staff to use.

Good

Is the service effective?

Our findings

When we spoke with people who used the service they were complementary about the staff and their ability to provide them with care and support. People said, "The staff are lovely and super. They always go the extra mile" and "The staff are conscientious and they record everything".

Staff spoken with told us they had undertaken a full employment induction before starting work at Marple Dale hall. They told us they were given a seven day mandatory induction that covered topics such as, cardiopulmonary resuscitation (CPR) which is used to maintain circulation when the heart has stopped pumping on its own, fire evacuation, risk assessments, organisational policies and procedures, safeguarding, whistle blowing, use of hoists, choking, dysphagia (swallowing problems), first aid and control of substances hazardous to health (COSHH). This is the law that requires employers to control substances such as chemicals and cleaning products that are hazardous to health.

This induction was followed by a two week period of shadowing (working under the supervision of an experienced staff member) within the home. This gave the new staff member the opportunity to get to know the people who used the service. A probationary period of three months could be extended if required. Non care workers such as kitchen and domestic staff underwent a similar induction period and learning was specific to their job. Additional induction training was provided via the Care Certificate. This is a professional qualification that aims to equip health and social care staff with the knowledge and skills they need to provide safe and compassionate care. This meant staff members had received appropriate training to help make sure people received safe and appropriate care.

Continuous staff training was available in topics such as, dementia awareness, catheter care, duty of candour (the legal duty on health care providers to inform and apologise to patients if there have been mistakes in their care), the use of a defibrillator (device used to someone who is in cardiac arrest), suction (the practice used to clear the airway of secretions so that a patient may breathe), Percutaneous Endoscopic Gastrostomy (PEG) a medical procedure to provide a means of feeding when oral intake is not adequate, preventing pressure sores and falls prevention. The registered manager told us that training would be arranged for staff where it was identified specialised knowledge would help to meet people's specific health and treatment needs. This was confirmed when we examined the care records of people who were at high risk of malnutrition. The registered manager had contacted a nutrition specialist to seek further advice and staff training in this topic.

A clinical development nurse was employed to oversee and manage any nursing concerns, provide nurse clinical supervision and to support the nurses at the home. We examined a sample of the nurse competency and supervision records which confirmed this support had provided. Nurse training in clinical subjects for specific conditions such as wound care and tissue viability and motor neurone disease, were addressed as part of the registered nurse individual competency learning and development. In addition to this, nursing journals and information from the Care Home Forum provided nurses with up to date professional learning. The clinical development nurse also carried out the registered nurses medicines competency checks alongside the NHS Primary Care Team the home's supplying pharmacy.

At our last inspection in September 2015, We found staff had not received regular supervision and appraisal to support them in their role. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was meeting the requirements of the regulation. We saw there was an on going annual staff appraisal and supervision system in place. The system was used at regular intervals to discuss and evaluate the quality of staff member's individual performance and where best practice or practice improvement were discussed and recorded. This system was also used for any agency staff employed at Marple Dale Hall. Staff we spoke with confirmed they received regular supervision at least every three months and an annual appraisal. Staff supervision records examined showed that dates for individual staff member supervision sessions were planned in advance. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

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

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. DoLS provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need safely and where there is no less restrictive way of achieving this.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where mental capacity assessments had been completed we saw that best interest decisions were recorded including any consultation undertaken and a rationale for reaching the decision made. The registered manager and staff members were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them.

Following this inspection we spoke with two relatives of people who used the service. They told us that wherever possible consent about their relatives care, treatment and wellbeing was sought and documented. Staff members we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. Staff told us that where consent from people could not be sought they would always approach the person's relative or arrange for a meeting to be held with appropriate professionals in attendance.

The service supported people with varying levels of support needs ranging from people being able to mobilise around the home to requiring high levels of support. Some people were able to plan and select their food choices with assistance from staff members. Care records and daily records we examined showed particular attention was paid to people's dietary requirements and what they ate and drank. We examined people's daily observation records which indicated the type and amount of food people had eaten and where people required PEG feeds this was also recorded. This meant people's nutrition and hydration was monitored to ensure their needs were being met.

We saw people had choices about what they wanted to eat and where required they were assisted to eat or supported to eat their meals with prompts from staff. Dining tables were set for each meal time and where

people preferred to eat in their rooms they were supported to do so. We examined the menu and saw that a variety of meal options were available at different times of the day. We saw the meals served were well presented, looked appetising and nutritionally balanced. When we spoke with the head chef it was apparent he was knowledgeable about people's dietary and nutritional risks, and the need to follow the speech and language therapist (SALT) instructions. For example making sure that people at risk of choking received a pureed diet. SALT provides treatment support and care for people who have difficulties with communication or with eating, drinking and swallowing.

People who used the service told us that the meals served at Marple Dale Hall were good and they had a varied choice of food. For example one person said, "The chef is brilliant, if we don't like what's on the menu he will always give us something else that we do like. He always asks us what meals we prefer and will try to put the preferred meal on the menu. Friday is always fish and chips". Another person said, "There's so much food, you don't need snacks in between".

Care records showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses such as tissue viability nurses, dieticians, physiotherapists, psychiatrist and GPs, and the notes were included in people's care plans. Other care files showed attention was paid to general physical and mental well-being, including risk assessments to identify where people were at risk of developing pressure sores. Care records that recorded people's weight, dental and optical checks were also in place.

When we walked around the home we saw the design and layout of the home were suitable to accommodate the number of people using the service. There was sufficient suitable equipment in place to promote people's mobility such as handrails, hoists and wheelchairs. Shared toilets, showers bathrooms, lounge areas with appropriate seating were sufficient in numbers, well maintained and in good condition. Corridors were clutter free and wide enough for trolleys, hoists, wheelchairs and other mobility aids to manoeuvre adequately. The service maintained a homely environment to enable people's planned activities and routines to be supported effectively by staff members.

Good

Is the service caring?

Our findings

People who use the service told us they were happy living at Marple Dale Hall and felt they were receiving good care and support from the staff. They said, "I'm learning to walk and if ever I bump into anything the staff are always around to make sure I'm alright. They [staff] really do care for us" and "Before I moved in here, I was concerned about not being checked regularly at night, but the staff here do; Knowing the staff care makes me feel so much better".

A relative of people who used the service said, "Staff are extremely attentive; she [relative] is always well looked after and cared for by the staff. They [staff] are considerate and understanding. She's very happy living at Marple Dale Hall. At the point of care, there is a very loyal care team".

Two other relatives said, "I couldn't have found anywhere better for her [relative]. They [staff] are so good with her and I've never heard any of the staff speak to the residents in an uncaring way. They [staff] are very kind people" and "My wife is very happy with everything here. She's delighted, so am I. The staff really are very helpful. Both my wife and I are very satisfied".

Staff demonstrated they knew people very well and told us detailed information about how people preferred their care and support to be given. We saw these details had been accurately reflected in people's care plans which showed the staff had a good understanding of individualised care.

Care records examined had been written with empathy and understanding of people's individual needs. For example some care records described why people preferred to spend time in their room. One care plan went on to describe in detail the person's routines and practices, the risks to the person when in their room, and the need for staff to make regular visual checks during the day and night. Records to confirm such checks had been undertaken were in place. Throughout our inspection visit we saw evidence there was a culture of promoting and maintaining people's independence. Care records showed and we saw people were encouraged to remain as independent as possible, and staff supported people to manage tasks such as maintaining personal care within their capabilities and mobilising around the home. Through our observations it was apparent those people enjoyed the responsibility this afforded.

We saw that staff had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect. Staff understood people's particular communication styles and how to interact positively with them. Where people had difficulty communicating staff remained patient and took time to listen, acknowledge what they were saying and responded appropriately. We observed staff often touched people on their arm or hand before speaking with them to make sure they did not startle them and made sure they spoke with them on their level for example if the person was seated, the staff member would sit next to the person before any interaction took place.

Staff were respectful of people's wishes, knocking on bedroom doors before entering and using people's preferred names when speaking with them. It was apparent that respect and regard for the rights and dignity of people who used the service were central to the delivery of care and support and geared to

people's needs. We observed good interpersonal relationships between staff and people who used the service. For example we saw staff showing warmth and empathy towards people whilst delivering personal care. Staff interacted with people well, engaging them in conversations that were interesting to them. Some staff shared friendly conversation with people and we overheard a staff member and person jokingly discussing a newspaper article about a recent celebrity wedding. Some people had their pets living with them and we observed a person interacting and engaging with their pet which gave them comfort and joy. A pet health and safety policy and risk assessment was in place.

The registered manager told us the service was able to link in with a local advocacy service to ensure that people who did not have any relatives living nearby had someone they could turn to for advice and support when needed. An advocate is a person who represents people independently of any government body. They are able to assist people in ways such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

The registered manager told us the provider used the 'Six Steps' end of life care programme which supported staff to develop their roles around end of life care. We looked at the home's end of life care policy and procedure which was person centred and geared towards helping the person to have as much control as possible about decisions relating to their future care and end of life needs. The document also made reference to what mattered to the person's family and friends.

The registered manager and staff provided examples of how they had worked with specialist health care professionals and nurses to ensure people had experienced personalised, compassionate and dignified care at the end of their lives. This included involving and supporting family members. They told us that an end of life coordinator who specialised in palliative care (care for the terminally ill and their families) supported the home. Staff training would always be provided in this topic for new employees, and the relevant professionals such as district nurse and GP would be involved. Any programme of learning for new staff members to develop awareness and knowledge about end of life care would be put in place and an appropriate care and support plan would be implemented to consider how best to meet the person's needs at that time.

We saw that all records and documents were kept securely in locked rooms accessible only by staff members and no personal information was on display. This ensured that confidentiality of information was maintained.

Records showed people and their relatives were involved in decisions about their care. Care plans were reviewed every month and where possible had been signed by the person living in the home or their relative where a Lasting Power of Attorney (LPA) was in place, this showed they had been involved in the decision making process. We saw records were in place to show where people's relatives had this legal responsibility. LPA is a legal document that lets the person appoint one or more people (attorneys) to help make decisions on their behalf. Types of LPA can relate to health, welfare, property and financial affairs.

Good

Is the service responsive?

Our findings

People's needs had been assessed before they moved into Marple Dale Hall. The needs assessment was used to complete the care plan which enabled the person to be cared for in a person centred way. Records showed staff used the information to develop detailed care plans and support records that would identify people's abilities and the support required to maintain their independence. Assessments showed people and their relatives had been included and involved in the assessment process wherever possible.

Care plans were reviewed six monthly, or more frequently if the person experienced any health changes. They were well written, contained a detailed personal history and gave clear guidance for staff to follow. For example one care plan detailed the importance of nightly checks for a person who experienced seizures due to epilepsy. These checks gave the person reassurance and had been recorded in the daily record sheets.

During our inspection we saw people were assisted by staff shortly after using the nurse call buzzer and their waiting time was minimised. We saw staff were attentive to people's needs, responding to people and their requirements throughout the day. People who required a high level of support received care that was responsive and person centred. We saw staff sat beside people or within a short distance from people who were cared for in bed throughout the day. We saw some people were not able to tell staff when they needed assistance and relied on staff being attentive, anticipating and recognising their needs. For example regularly providing them with a drink, providing oral care, moistening people's lips and mouth to prevent them from becoming dehydrated or experiencing having a dry mouth.

We looked at four care records which contained comprehensive information about each person and sufficient detail to guide staff on the care and support to be provided. Care records included the person's emergency contact details such as their next of kin, and General Practitioner (GP), risk assessments, current support needs, the care to be provided and the desired outcome from the care provided. They contained relevant information about people's health diagnosis and associated needs, a communication checklist, nutrition and hydration assessments that included information about recent weight loss, appetite, difficulties chewing or swallowing, mobility assessments, moving and handling, tissue viability pain, sleeping, behaviour, emotions, hopes and concerns for the future, cultural, spiritual and social values .

Systems to help manage/ prevent risks prevention was required were in place. For example where care plans identified that people were at risk of pressure sores specialist equipment such as pressure relieving mattresses and pressure relieving cushions, were in place. Where people's support needs were identified as requiring two staff, the reasons why were clearly documented. This helped to make sure people's health and wellbeing was appropriately responded to and maintained.

We saw people's care and support records were clear, detailed and completed accurately with staff signatures and dates recorded to reflect the care and treatment provided. Systems for people who were being cared for in bed and needed re-positioning at regular intervals to maintain their skin integrity were also in place The system recorded each staff interaction and the person's resting position at specified times of the day and staff signed to confirm each time people were repositioned. People's weights were recorded

monthly or more frequently if necessary. A body map to record and highlight any bruising or injuries sustained, was kept in the persons care record. This meant staff could respond appropriately to help make sure people's health and wellbeing was maintained.

Care interventions were clearly recorded on the person's daily record sheet and detailed the care and support provided to people during the day. Staff members were aware of the importance of the care review system and understood information about the person was reviewed to make sure it fully reflected their current support needs.

Person centred care reviews were held every six months or sooner if required and involved the person who used the service where they had the capacity to be involved, family members and a staff member. Where necessary a social worker or another appropriate professional would also attend the review meeting. Where issues were identified these were noted and follow up action recorded. A relative of a person who used the service said, "The care records are very detailed and look comprehensive. The carers take notes during her [relative] individual care planning meeting. The last meeting held was about six months ago, I attended with [relative]. It was a very detailed meeting. I couldn't fault it".

People were supported to take part in hobbies and interests and this information was recorded in their care records. Individual and group daily leisure activities were provided for people who used the service and records of the person's involvement were kept in people's individual care records. This meant people received personalised care, treatment and support and their needs, choices, preferences were responded to and met.

A complaints policy was in place. People told us they knew how to make a complaint if they needed to and guidance telling people how to make a complaint was displayed in the home. The policy in place allowed for a full investigation and all complaints were taken seriously. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome. We reviewed a selection of complaints the service had received in the last year and noted the manager had followed the organisations complaints process. Actions had been recorded and the complaints resolved to all parties satisfaction.

Good

Is the service well-led?

Our findings

We spoke with a group of 11 service users who collectively told us they felt the service was very well led. They said, "The managers are really good and the home is well led. Management are approachable and get things done when we ask them. They're going to improve the activities like we asked. We see the registered manager and deputy manager very often. They are both visible in the home and don't lock themselves away in the office. They always make time for us even though they're busy. We see quite a lot of the regional director, she's nice too. They all listen to us and ask us how we are because they're interested in us. They act on things and sort things out."

A registered manager was in place at the home. 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.

There was a clear management structure in place and staff spoke positively about the registered manager and the team. The registered manager, senior managers and staff members, understood their role and responsibility to the people who used the service and demonstrated their commitment to the service by having clear visions and values about the home which were to improve on the services provided to people always ensuring people were safe and their needs were being met. Staff members spoken with told us they had confidence in the management team and described the culture in the home as, 'supportive and open'. Staff members said, "Marple Dale Hall is the best care home in the area" and "I'm very impressed by the quality of care here. It's a very nice home to work in and the staff team are very nice too".

We saw records to show staff meetings were in place to discuss changes to practice and legislation and too allow the staff team the opportunity for reflection and discuss what works well at Marple Dale Hall and what changes could be made to improve the service provided. Meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about the service but also what, if any, improvements could be made. Meeting notes were kept to ensure an accurate account of people's verbal contribution and improvements noted were actioned.

Systems were in place to monitor and improve the quality of care provided and included a comprehensive programme of audits to ensure the required Barchester service standards to provide high quality nursing care and support were provided. Quality first visits, regulations and compliance visits were undertaken by the Divisional Director. Any action required to address identified shortfalls in service provision were completed within appropriate timescales.

We saw issues raised from a system of audits carried out were analysed, reviewed and actioned. For example, the provider utilised a 'predictive risk report' which identified trends in areas such as near misses, accidents and incidents. These audits helped to mitigate risks, therefore preventing the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR). The system also recorded and measured good practice which enabled staff to consistently review their own practices to ensure the service could maintain a

continuous quality approach. These audits also helped to drive forward continuous service improvement.

Accidents and incidents were recorded and had been regularly monitored by an internal auditing team to ensure any trends were identified and addressed. We were told that there had been no identifiable patterns in the last 12 months. Similarly, any safeguarding alerts were recorded and checked for any patterns which might emerge.

The management team showed passion and enthusiasm in supporting people with very complex diagnosis and needs. They were open to innovative ideas and encouraged staff to seek new schemes and services that would be beneficial for people. For example staff training was being sought to improve on the good quality care already provided for a person who had developed autoimmune disorder. The registered manager also told us how they worked in partnership with key organisations such as the local authority and acquired brain injury specialists, to develop quality care moving forward.

The registered manager shared with us copies of the services policies and procedures such as, complaints and suggestions, safeguarding adults, accidents and incidents, medicines, staff recruitment and whistle blowing. All of the policies we looked at had been reviewed regularly and the next policy review date was planned. A business contingency plan was in place which identified the provider actions when an exceptional risk would have impact of the service provided to people and staff.

A quality assurance system was in place to help the provider ascertain and respond to the needs of people who used the service, relatives, representatives and stakeholders. This system provided service consistency to the required Barchester standards, which is to provide high quality nursing care and support to their service users. Quality first visits, regulations and compliance visits were undertaken by the divisional director. Any action required to reduce identified shortfalls in service provision was undertaken within appropriate timescales by management who addressed and implemented the actions as required.

The provider recognised staff kindness and caring attributes through observations of staff practices and behaviours. The regional director told us that rewarding staff was an important tool for continued delivery of kindness. Barchester operated an employee reward scheme and employee of the month award. This helped the staff team to feel valued and maintain a good standard of care

The manager understood their responsibilities to provide notifications to the Care Quality Commission (CQC) regarding significant events such as; serious injuries and deaths. Before this inspection we checked our records to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager had made appropriate notifications as required.

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The manager understood their responsibilities to provide notifications to the Care Quality Commission (CQC) regarding significant events such as; serious injuries and deaths. Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received to see if appropriate action had been taken by management to ensure people were kept safe and the records we reviewed confirmed this.