The Daughters of Charity of St Vincent de Paul

Marillac Care

Inspection report

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Date of inspection visit:
14 March 2017

Date of publication:
02 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 14 March 2017 and was unannounced. The previous inspection took place in April 2016 at which time the service was rated as 'requires improvement' as there were concerns around how risk was documented and shared, care records had not been updated and quality assurance audits were not always effective.

The Marillac is a nursing home that provides accommodation, nursing and rehabilitation support for up to 52 people with complex physical and sensory disabilities. On the day of our inspection there were 51 people using the service.

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

At this inspection we found risks were managed safely as there had been improvements made in how information around risk was recorded and shared. Staff demonstrated a good awareness of the risks to people and knew how to manage these safely.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

There were sufficient staff employed who had been recruited safely and who had the skills and knowledge to provide care and support that met people's needs and preferences.

Staff were aware of their whistle-blowing and safeguarding responsibilities. They knew the signs to look for that might indicate that people were being abused and who to report any concerns to.

Staff received regular supervision and support from the management team which provided an effective method of assessing staff competency and promoting learning and development.

People were involved in making decisions about the care and support they received. Where people experienced difficulties with decision-making, they were supported by staff who were aware of their responsibilities under the Mental Capacity Act (2005) legislation.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS), making applications when necessary.

People had access to food & drink that they enjoyed which matched their preferences and met any health needs.

The service supported people to maintain their health as they had access to a wide range of healthcare professionals.

Staff respected people's privacy and choices and treated people with kindness and respect.

People were encouraged to be independent and take part in interests they enjoyed.

The service supported people to maintain relationships with friends and family and links with their community so that they were not socially isolated.

Robust quality assurance systems were now in place which meant that the service was effectively monitoring the quality and safety of the service and driving improvements.

There was an open culture and the provider encouraged and supported staff to provide care that was centred on the individual.

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 protected from the risk of abuse by staff who were aware of their safeguarding responsibilities.

Risks were assessed and reviewed and staff were aware of risks to people and knew how to manage them to keep people safe.

Safe recruitment practices were followed.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised to ensure they were competent in their role.

People were supported to have enough to eat and drink and have access to healthcare services to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people with dignity and respect.

People's independence was promoted.

The service listened to people and included them in decisions around their care and support.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was reviewed regularly.

People were supported to engage in activities of their choice.

Complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

There was a positive culture of openness and transparency which staff valued.

Robust quality assurance systems were in place to monitor the safety and effectiveness of the service and drive improvements.

People and staff were included in the running of the service.

Marillac Care

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 14th March 2017 and was unannounced. The inspection team was made up of two inspectors, a specialist advisor who was a qualified nurse and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection, the registered manager 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 looked at the PIR and at all the information we had collected about the service. This included information received and notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

As part of the inspection we spoke with the registered manager, three unit managers, the head of care, the activities co-ordinator, three unit managers, seven other members of staff and nine volunteers. We received feedback from eight people and four relatives. We looked at eleven people's care plans and associated records, three staff recruitment files, staff training records and the staff supervision and competency checks. We reviewed a number of other documents relating to the management of the service including policies and procedures relating to aspects such as safeguarding, handling complaints, incidents and accidents and medicine management.

Good

Is the service safe?

Our findings

At our previous inspection we found we found that risks to people were not consistently well managed due to poor recording practices and information sharing. At this inspection we saw that improvements had been made and the provider now had a more robust system in place for recording and sharing information on risk.

We looked at eleven people's care records and saw that risks specific to each person had been identified with plans put in place on how to manage them. These assessments were updated monthly or sooner if people's needs changed. A lead nurse told us that any changes were communicated to the rest of the staff team during daily hand-overs. One staff member told us, "The nurses complete the risk assessments but we check the care plan for any changes to them."

Staff we spoke with demonstrated that they were aware of individual risks to people and knew what to do to minimise those risks including those staff who were new to the service. For example, one new starter told us, "I'm looking at people's life histories, going through their care plans; At the end of shift I take some time to find out about people; I know that [person] has a nut allergy and [person] needs their communication board to talk to us; [Person] can be physically aggressive so we give them space, this works well and [person] you can tell by their facial expression, they panic with their tracheotomy and needs lots of reassurance."

People were protected from the risk of developing pressure ulcers. The provider used a recognised assessment tool to assess the risks to people's skin and where people had skin wounds, appropriate measures were put in place for wound management, for example, nursing the person on an air mattress, repositioning the person regularly, application of topical creams and changing people's dressings regularly. Staff knew how to obtain advice and guidance about the prevention and management of pressure ulcers from the local NHS tissue viability nurse (TVN) and we saw that the service requested input from the TVN when required.

Despite the high risk of pressure ulcers to all of the people who lived at the service due to their complex health conditions and poor mobility we were advised that there was only one reported case at the time of our inspection which had been caused by a change in the person's wheelchair. The condition of this ulcer was improving, indicating that people were receiving good quality pressure care treatment.

However, we did find that the service had not always adhered to NICE guidelines for managing pressure ulcers as they had not documented the surface area of the wound, for example by taking photographs. We spoke to nursing staff about this and they advised that their camera was broken.

We recommend that the service follow NICE guidelines for managing pressure ulcers based on current best practice in relation to the documentation of wounds.

There was sufficient staff available to meet people's needs in a safe and timely way with an excellent ratio of

staff to people to ensure that those people whose complex needs had affected their ability to mobilise were always supported by at least two members of staff. During the day we saw staff going into people's rooms regularly to check on them and top up their drinks as most people were unable to use call bells. We checked the record logs and found that staff also regularly checked people at night to ensure they received the support they required, for example, where a person was at high risk of falls, staff supported them regularly to use the toilet to ensure the person could maintain their independence and still felt safe.

The provider employed in-house physiotherapists, speech and language therapists and occupational therapists who provided advice and guidance for care staff on how to manage risks to people as they moved about in their environment, managed their personal care and completed activities of daily living. For example, we saw how therapists worked jointly with care staff to support people to eat and drink or get dressed in the morning which promoted people's independence whilst at the same time minimising the risk of harm.

Staff told us they had received training in how to safeguard people from abuse and they were aware of the signs that could alert them someone was being abused. They understood the reporting process and told us they would tell the manager or go to the local authority if necessary. Comments from staff included; "I would speak to the head of care and consult the safeguarding policy," and, "I would escalate any concerns if required," and "I would report to the manager or go to the local authority or CQC." Staff were aware of the whistleblowing policy and procedures which were on display in staff areas. They told us they would feel confident to whistle blow without fear of reprisal and felt that their concerns would be actioned.

Medicines were given to people in a safe and appropriate way. Only staff who were trained and assessed as competent administered people's medicines. We saw that people had individual medicine administration record (MAR) sheets which had their photograph and name displayed so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. Medicines were safely stored and administered from individual locked medicine cupboards in each bedroom.

We checked people's MAR sheets and found that people were receiving their medicines as prescribed. People had separate records for medicines and cream and we saw that these were accurate and contained no gaps or errors. This showed that the new quality assurance systems that had been introduced were more effective in ensuring that people's medicines were administered safely.

Safe recruitment processes were in place for the employment of staff. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

People were safe in the service as there were arrangements in place to manage and maintain the premises both internally and externally. We saw that health and safety, maintenance, fire drills, accidents and incidents were all recorded and the necessary action taken. On each unit daily checks of equipment including oxygen cylinders and suction pumps were completed by a trained nurse. Accidents and incidents were recorded on each unit, reviewed by the unit manager and then sent to head of care to look at to see if any action needs to change to mitigate future risk.

Good

Is the service effective?

Our findings

We found that staff had the skills and knowledge to care for people effectively. When new staff joined the organisation they had a comprehensive induction which included the opportunity to read people's care records and shadow existing members of staff. This meant that staff were given the time to get to know the people they would be supporting and understand how best to meet their needs. Staff always worked in pairs so could provide each other with support and guidance if needed.

The induction provided was based on the care certificate which helps to ensure care staff have a wide theoretical knowledge of good working practice within the care sector. Staff told us that whilst they were shadowing they were observed and were provided with feedback at the end of each shift to help them learn and develop. The service had seven subject link trainers who saw all new starters to carry out competency assessments linked to the care certificate standards to ensure new staff had the necessary skills and knowledge to care for people effectively.

The provider had its own in-house trainers as well as external training providers and provided staff with a structured programme of learning to equip them with the necessary skills and qualifications to meet people's needs. Each unit manager kept a record of all staff training to identify when refresher training was required to ensure staff knowledge remained current. We saw that competency checks and appraisals had been completed to check staff learning and understanding and highlighting any areas that required improvement to promote staffs continuous learning and development.

Staff told us the induction and training was good and that further specialist training was also available which was tailored to meet the needs of people who used the service, for example, PEG feeding and tracheotomy care. One worker said, "I feel very supported with my learning, the training is excellent."

We saw that staff were supported by the provider to undertake further qualifications in health and social care to help them develop their skills and knowledge for the benefit of people who used the service. One staff member told us, "You get lots of opportunities here, I'm doing my NVQ2; they encourage you to learn more."

Moving and positioning training was provided by the in-house physiotherapists. A staff member told us, "I have learnt a lot whilst working with the physiotherapists in helping people mobilise." People's care records provided staff with comprehensive guidance regarding how they should be moved and positioned, for example, which type of hoist to use, the type and size of sling and which hoops to use to ensure people were safe and comfortable. We saw everyone had their own equipment to maintain their safety, comfort and dignity. One staff member told us, "The equipment is excellent here, I love that everyone has their own slings, two of each plus a bathing sling." We observed staff moving and positioning people throughout the day in a safe and reassuring way. The equipment and techniques used matched what was written in people's care plans.

Staff told us they felt supported in their roles and received regular direction and guidance through one to

one supervision sessions, observations of their practice, spot checks and yearly appraisals. Each unit manager kept a supervision matrix to monitor that staff were receiving regular supervision and where it was identified that staff needed more support, additional sessions were arranged, for example, where a worker had been promoted to a new position and lacked confidence the unit manager had increased their supervision sessions to weekly.

We spoke to staff about the quality of supervision. One staff member told us, "Supervision is really good, you get to have a chat, get advice, [named] is really good, very easy to talk to, you can talk to them anytime." Regular team meetings were also arranged which provided staff with additional support and guidance. Staff meetings often included a ten minute teaching session that was delivered by various nurses on subjects relevant to people living at the service, for example, pressure care and moving and positioning had been discussed at the last meeting.

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

We found that the provider continued to work within the principles of the Mental Capacity Act (2005). Staff told us, "We talk to people to support them with their decisions, but if we are concerned then decisions can be made in their best interests by talking to managers and people's families." We saw that where people had family members who had been granted lasting power of attorney, this was recorded in their care plans and best practice principles were adhered to, for example, the care plan instructed staff; 'All best interest decisions to be made in consultation with family.'

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the provider had made appropriate DoLS applications to ensure that people were not being deprived of their liberty unlawfully.

Staff understood the importance of gaining consent and explained to us how they checked for consent with people who were unable to communicate verbally. One member of care staff said, "You get to know people's personality, you know when a person doesn't like something, we look for signs, noises, gestures etcetera." We observed throughout our visit that staff always asked people's permission before helping them.

The service supported people to have enough to eat and drink which met their health needs and preferences and people told us that the food was good. We observed the lunch time dining experience for people and saw that it was relaxed and supportive. Encouragement was offered to support people to eat independently whilst people who needed support received it. Food was presented nicely and there were tablecloths on the tables with flowers as centre pieces. People were provided with various items of eating/drinking adapted equipment. We saw that if people did not want what was on the menu they were offered alternatives. One person told us, "I have a choice of whatever I want to eat."

Where people were unable to eat and drink they were supported with their nutrition via a feeding tube (PEG) by skilled staff who had received the appropriate training. Care records showed that speech and language therapy (SALT), dietician and the PEG nurse were involved in the planning and monitoring of the delivery of

this support to ensure people's nutritional needs were being met. We saw that there were regimes in place for people who were supported to eat via PEG which were recorded in an individual diary. We saw that PEGs were flushed regularly with water, checked daily and rotated and the insertion site checked for any signs of infection. This meant that people's PEG feeding was managed safely and effectively.

Care records showed that people's food preferences and requirements were recorded and were incorporated in the provision of their diets. There were a number of textures of food available to people to meet individual needs, for example, normal, pureed, mashed and fortified. The service employed in-house speech and language therapists (SALT) who provided support and guidance around eating and drinking for people with swallowing difficulties. Care workers told us how they worked with SALT to try to improve outcomes for people, one staff member said, "Me and [named] are keyworkers for [person], we are working with SALT on getting [person] back to eating."

Risks relating to people's nutrition and hydration were assessed and monitored. People were weighed and food and fluid charts were maintained and the information was shared with external health professionals to monitor people's health and identify where additional support or treatment was needed.

We reviewed a person's care records who was living with diabetes and found they had received good diabetes care with involvement from the diabetes nurse. We saw that the person had recently had a complete physical examination including blood test to assess diabetic control and had their blood pressure monitored at least daily, their weight was also monitored regularly and they had been recently had their feet checked by the chiropodist, all of which aligns with best practice for management of diabetes. However, we did find that whilst the person had a care plan for management of their diabetes it lacked some detail regarding annual checks and also information on how to manage hypo and hyperglycaemia. Nevertheless the clinical staff we spoke with on the unit were very knowledgeable about the management of diabetes.

People had access to a range of healthcare services to maintain their health and wellbeing. Records showed that people received routine health checks by dentists, chiropodists and opticians. The service organised regular GP clinics and the GP reviewed people's medicines every six months or sooner if required. The service employed a consultant neurologist who visited people on a monthly basis.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said, "The staff look after me very well, I love it here." Another said, "It's not bad here, the nurses are very caring." Staff went about their jobs in a very calm manner, there was a peaceful atmosphere and staff did not rush people and delivered care and support at a relaxed pace.

We observed interactions between staff and people and saw staff putting their arms around people to comfort them and going down on their knees to be at eye level with those seated in wheelchairs. These types of interactions had a positive effect as people responded to staff with smiles.

Values training was organised for staff annually which emphasised dignity and caring. We observed that staff were very caring and treated people with dignity and respect. Staff spoke to people in a polite and respectful way, asked for people's permission before providing any care and support, knocked on people's doors before going into their room and addressed people by their preferred names.

People's personal information was kept confidential. Each person had two files, one care plan and an additional file holding clinical information, they were colour coded for ease of access and were kept locked in the office on each unit.

Staff knew people well and were aware of their likes and dislikes. We saw how one person had been given a pint of beer with his meal, whilst another had their drink in a west ham mug. These preferences were recorded in their care plans and were known and respected by staff.

On the day of inspection, we saw staff celebrating a birthday with a person who was in bed. They had provided a cake with candles and a large number of staff appeared and they all enthusiastically sang 'happy birthday' which was done with real feeling and celebration.

Care records showed that people were involved in their care and were asked how they would like to be supported. Staff listened to people and made every effort to include them. For example, where people had communication difficulties staff used pictures to inform them about the actions they were going to carry out before they provided personal care. This meant that people knew what was going to happen and staff provided them with opportunities to express their preferences.

When communicating with people, staff moved close to people and maintained good eye contact to help people understand. Those people with complex communication difficulties had input from the in-house speech and language therapist and we saw that people had been provided with technology to help them communicate such as the eye gaze system.

We asked staff how they supported people to be independent. One care worker said, "We try to encourage people to do as much as they can for themselves, such as brushing their teeth or shaving; we only support when we are needed." We observed examples of this practice during lunchtime where people were

encouraged and supported though adapted equipment to eat independently.

People were supported to maintain important relationships with their friends and families. We saw visitors walking in and out of the home all day. The registered manager told us that there was an open door policy and friends and relatives were able to visit any time and could also stay at the service as there was a guest bedroom available. The service also supported people to go home on visits and had provided key workers to accompany people home if required.

The service recorded people's wishes for their end of life care and staff had received training to help them support people at this time. Pastoral care was available for people and their relatives to meet any emotional or spiritual needs.

Good

Is the service responsive?

Our findings

Before people joined the service a pre-admission assessment was completed. Records showed that a multidisciplinary approach was taken which meant that the service consulted people, their relatives and other health and social care professionals who would be able to provide any relevant information to ensure people's needs could be met.

People had care records which were personalised to each individual and were written in a person centred way which means they were all about the person and put them first. Friends and relatives had been included, where appropriate and had provided valuable information about people's life experiences life histories, interests and aspirations, likes and dislikes and how they wanted their care and support to be delivered; this gave staff the knowledge required to deliver person-centred care. Care records recorded people's preferences, for example, whether they liked a bath or shower and any preferred activities that were important to them and this information was then incorporated into people's daily routines.

We saw that care records were reviewed regularly and had been updated to reflect any progress that people had made. Any changes to people's care and support was communicated at staff handovers to ensure that staff remained up to date with people's current support needs.

The care, support and treatment provided was aimed at providing rehabilitation to help people be as independent as they could be, with clear goals recorded. To that end the service employed in-house therapists to work with people on a rehabilitation programme. For example, we saw that where people had identified goals in relation to the skills they wanted to regain to manage their own daily routine such as getting dressed, we observed the therapists and care staff supporting people towards these goals.

Written records showed that regular meetings were held where therapists met with the person and their family to review the goals. People had weekly time tables in their rooms which planned how their day to day needs should be met and their skills developed. Whilst supporting people mobilising we could hear staff giving positive feedback and encouragement to people, including; "Well done," "This is good," "Excellent, keep it going."

Care records were electronic; however staff said they printed a copy of the care plan so that it was more accessible for them. The care plan detailed all the activities and support the person required including the time the activity was required. For example, one care plan detailed what time the person chose to go to bed and what drink they wanted put beside their bed.

The building had a large central communal area known as 'The Street' which was a place where people and their family and friends could meet up to enjoy a wide range of activities and social events that took place throughout the year which included musicians, dancers and canine performers as well as cultural celebrations such as Diwali and St. Patricks day.

People undertook activities which supported their rehabilitation programme which was provided by an in-

house team of activity staff that provided opportunities for people to be involved in activities daily. This team was made up of a mixture of staff and volunteers. An activity schedule was in place which provided activities throughout the day from 10.15 until 17.45. There was a broad range of activities which met people's physical, emotional and cognitive needs, for example, baking, crafts, movie sessions, themed talks, quizzes, boules, shopping and reminiscence sessions.

Thought was given to how to make activities person-centred and reflect people's interests. For example, one person who used the service was previously an art lecturer; they were supported to deliver a themed talk on art deco and was able to invite their old students. People's opinions as to the type of activities was requested through the bi-monthly newsletter. For example, we saw an entry in a recent newsletter which stated 'We would love your feedback on the events we have held during 2016 What did you enjoy the most (and the least)? What would you like to see in 2017?'

Aside from group activities, the service worked on a one to one basis with people. We saw how one person who used to live in another country was supported to use google earth to look at the town where they grew up. Volunteers took people into quiet areas to have a chat or join in a quiz if they did not want to join in the group sessions.

People, visitors and staff had access to a café located in a communal area within the service where hot and cold food was available throughout the day to help people maintain relationships that were important to them and encourage social interaction. Feedback was actively sought from people as there was a notice up in the café asking people for recipes for the spring/summer menus.

The service had been designed to meet the needs of people with disabilities. It was a spacious building with wide corridors. The building was well lit, allowing for natural light and for people to see and be able to easily access the grounds and gardens. A sensory garden had been created for people to enjoy and a new sensory room had been constructed in the main building. This meant that people were provided with opportunities to engage their senses and to enjoy moments of comfort and calm. The building had its own chapel which although furnished in the catholic tradition provided a prayer space for people of all faiths so that people's spiritual needs could be met.

An outstanding feature of the service which people and their relatives appreciated was that people had access to an array of in-house therapy services including physiotherapy, occupational therapy and speech and language therapy to help people maintain and improve their health and work towards meeting rehabilitation goals. People and their relatives were also able to access an in-house psychology service to support their emotional wellbeing.

When people joined the service they received a service user guide which included information on how to make a complaint and where to escalate concerns if they felt it was not being dealt with appropriately. The registered manager advised that they had no open complaints as any concerns were dealt with as they arose. People and relatives told us they knew how to make a complaint and would feel comfortable to do so and felt that their concerns would be actioned. Comments included, "I would raise issues with [head of care] and action would be taken." Another said, "I would speak to the ward manager and to [head of care], things are generally sorted." And, "I would complain to the floor manager who responds well."

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service kept people safe. The registered manager was supported by a 'head of care' and a unit manager for each of the three units who were all qualified nurses. Together the management team was responsible for the day to day running of the service.

At our previous inspection we found that quality assurance audits were not always robust, for example, those relating to care plans, and had not always picked up on mistakes or omissions. However, at this inspection we saw significant improvements in this area. We were advised that a new assurance system that had been introduced to ensure that the audits completed were factually correct. This system allowed for the audits to be checked by the Head of Care and passed through to the Registered Manager as a three way check of compliance.

We reviewed the new system and found that each unit manager completed a random audit of at least nine care plans per month. Where they found areas that required improvement an action plan was given to the staff member responsible to complete. As an added measure, the head of care then completed their own audit and we saw that this system of checks had been effective in ensuring that the information held in people's care records was complete, up to date and relevant to each person.

Staff spoke highly of each other and the support they received from the management team and described the management ream as approachable, supportive and friendly. One staff member said, "[head of care] is very good, supportive and listens, they are not afraid to get their hands dirty; they are hard-working." Another said, "I meet with my manager weekly, they are incredibly supportive and trust me to get on with my job and make reasonable decisions." Staff worked well as a team and were very supportive of each other. One staff member said, "Whenever I need help it's as easy as asking the person next door, we do help each other and there is a good atmosphere here."

The culture of the service was one that valued staff and promoted openness and transparency, where workers were not blamed and mistakes were learned from. The manager of each unit completed monthly audits on medicines and would self-report any errors and complete an incident form. Any errors were escalated to the head of care. One unit manager told us that an open and transparent approach to reporting errors was taken and they did not look to blame but to openly discuss any errors to learn from mistakes and prevent re-occurrence.

This open culture was valued by staff. One staff member told us about their experience at staff meetings, they said, "You can say anything, knowing that you will not be victimised, it is healthy because then you don't bottle anything up." Another said, "It's a really good team, we have a good culture with support from colleagues and the head of care."

The service recognised and rewarded staff for their hard work and commitment. Each year a Care Award was presented to members of staff who were recognised by the Management team to be excellent examples of

the ' Marillac values' and for going 'above and beyond' in their work.

Bi-monthly newsletters were used to communicate with people and their families and also ask for people's input into the running of the service, for example, we saw one newsletter had been used to ask people's opinions on the seating which was due to be replaced.

Aside from the newsletters, the service invited feedback from people and their relatives through residents meetings, satisfaction surveys and other creative means of consultation, for example, when the service had decided to purchase new bed linen we saw that they had put a display of different designs of linens and pillows out in a public area for people to comment on and choose which bedding they would prefer.

The management team were responsible for quality assurance to ensure people's health and safety and identify and driving improvement. We saw that a range of audits were completed by each unit manager and these were overseen by the head of care and the registered manager to ensure they had been completed and any necessary action taken. We saw that any concerns identified were promptly addressed, for example, where a unit manager had completed their monthly infection control audit and observed a staff member wearing wrist watch, they had immediately asked them to remove it.

The provider had good links with the community and included others in the running of the service. For example, the service was well supported by a volunteer group 'Friends of the Marillac' who were involved in fundraising and organising events aimed at improving the lives of people who used the service. Volunteers were also recruited to help manage the extensive activities programme on offer.