Mavern Care Limited

# Mavern House Nursing Home

## Inspection report

Corsham Road
Shaw
Melksham
Wiltshire
SN12 8EH

Tel: 01225708168
Website: www.maverncare.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

Mavern House Nursing Home provides accommodation to people who require nursing and personal care. Some people have dementia. The home is registered to accommodate up to 51 people. At our last inspection in November 2013, we did not identify any concerns.

The inspection took place on 25 and 26 October 2016 and was unannounced.
On the day of our inspection, there were 48 people living at the home. There were two lounges, an activities room, a separate dining room, bathrooms and toilets and a passenger lift to give easier access to both floors.

A registered manager was employed by the service. 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. The registered manager was present on both days of the inspection.

The ordering, storage and disposal of medicines was managed effectively. We observed a medicines round during the inspection. The administration of medicines was done in accordance with current guidelines and regulations. However, there were gaps in signing of administration of some medicines which had not been identified by staff.

People told us they felt safe when receiving care. Staff were able to tell us how to recognise signs of potential abuse and what action to take if they had any concerns. People's risk assessments had been made and recorded in people's care files.

There were sufficient numbers of suitable staff to support people and safe recruitment practices had been followed before new staff members started working at the home. Staff responded to people's needs in a calm and proficient way and had sufficient knowledge to provide support and keep people safe.

Arrangements were in place for keeping the home clean and help reduce the risk and spread of infection. People's rooms and sanitary ware in bath and shower rooms were kept clean. Staff had sufficient personal protective equipment available which we saw being used throughout the inspection.

The service had a clear understanding on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Following a recent audit which had looked at people's care plans, the need to implement improved documentation; particularly around consent had been identified and the new processes were now in place. Some care records had been updated in response to this and the service were in the process of completing this for all people using the service.

Staff received regular training in relation to their role and the people they supported and told us this had

supported them to do their job effectively. Staff received regular supervisions and an annual appraisal where they could discuss personal development plans. This meant staff received the appropriate support to enable them to provide care to people who used the service.

People were supported to maintain good health and had access to health services which included regularly seeing their GP with additional visits according to any changing healthcare requirements. We saw an example of this during the inspection when one person who had become unwell had been referred to their GP.

People and their relatives were positive about the care and support they received from staff. We saw staff support people in a kind and friendly way which also protected their privacy and dignity.

The documentation to monitor diet and fluid intake of people who were at risk of malnutrition and/or dehydration were not consistently completed. However, records to monitor risks identified in other areas such as pressure care were well recorded and this information had been well communicated between staff for example, during staff handover.

Staff understood the needs of people they were providing care for. Care plans were individualised and contained information on people's preferred routines, likes, dislikes and medical histories.

People, their relatives and staff were encouraged to share their views on the quality of the service. They told us management were approachable and they were confident if they had any concerns they would be taken seriously and addressed accordingly.

Staff spoke highly of how the service was managed and as well as there being an open door policy, regular staff meetings took place to allow staff to voice their feedback and be updated on best practice.

There were systems in place to monitor and improve the quality and safety of the service provided. Where actions to improve the service had been identified, these had been acted upon.

## 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.

Staff were knowledgeable in recognising signs of potential abuse and what to do if there were safeguarding concerns.

People had risk assessments in place and action plans were written to help minimise these risks.

There were sufficient staff to support people's care needs. Safe recruitment practices were also followed before staff were employed to work with people.

### Is the service effective?

Good

The service was effective.

People said they liked the food and there was varied menu on offer. People also had access to specialist diets when required.

Staff received the necessary training and had the right skills to meet people's needs.

People who needed support with making decisions were assessed to ensure their best interests were protected in a lawful way.

### Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the care and support provided and told us staff were friendly and caring.

Staff considered people's preferences, likes and dislikes and had a good understanding of their needs and how best to support them.

Staff were respectful towards people and knew how to protect their privacy and dignity.

### Is the service responsive?

Requires Improvement

The service was mostly responsive.

Care and support plans were personalised and were reviewed regularly however, the documentation in people's care charts to monitor the food and fluid intake of people at risk of malnutrition and/or dehydration was not consistently completed.

People were supported to follow their interests and take part in social activities. There was a varied activities program of which people could choose to participate.

The service sought regular feedback from people and their relatives to help assess the quality of care being delivered and their satisfaction of the service provided.

## Is the service well-led?

Good

The service was well led.

Staff said the management team were approachable. There was an open door policy where staff could raise concerns and seek guidance as required.

Staff felt valued and supported by the management team and told us they enjoyed working at the home.

Systems were in place to monitor the quality and safety of the service provided. Where actions to improve the service had been identified, these were acted upon.

# Mavern House Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 25 and 26 October 2016. The first day of the inspection was unannounced.

One inspector and one expert by experience carried out this inspection. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.
The areas of expertise of the expert by experience during this inspection care of older people who use regulated services with physical/sensory impairment and people with dementia.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.
We also reviewed the 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 used a number of different methods to help us understand the experiences of people who used the service. This included talking with 11 people who use the service and seven visiting relatives about their views on the quality of care and support being provided. We also received feedback from three visiting professionals. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for inspection (SOFI). We used this to help us see what people's experiences were. This tool allowed us to spend time watching what was going on in the service and helped us to record whether people had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included ten care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, managing director, and fifteen staff including care staff, registered nurses, housekeeping staff, activities coordinator and staff from the catering department.

Good

# Is the service safe?

## Our findings

We observed part of a medicines round on day one of the inspection. There were good processes in place to ensure the safe administration of medicines. People were clearly identified and had a profile page which showed a current photo of them, their date of birth, GP and any known allergies. During the medicines round the nurse administering the medicines was organised and had fresh water available for people to take with their tablets. Medicines were signed for only when the nurse was sure they had been taken. The nurse was also knowledgeable about the medicines they were administering and were able to explain to people what they were taking.

There were however, instances when the administration of medicines had not been so well documented. One person was receiving topical patches to help control their pain. A chart was in place and filed with the Medicines Administration Records (MAR) which indicated where patches had been placed, when patches had been removed, a daily record of whether they were still in place and also when a new patch was applied. Documentation on this form for application of patches was complete apart from two days where there was no entry then another day when there was no entry on this or the MAR to indicate a patch had been applied. Other gaps were seen on some Medicines Administration Records (MAR) where medicines had been due for administration 4-5 days earlier. When we asked staff about this, they told us when they saw gaps in the MAR these were addressed straight away and that it was usually due to the nurse forgetting to sign the MAR rather than doses being missed. They told us they were not aware as to the reason for these particular gaps as they had only that day returned for duty and hadn't been on duty during this time but that when gaps were identified, there was a procedure in place to follow up and identify the cause and whether people had received their medicines as prescribed. The nurse made a note of the gaps identified during the inspection and followed the procedures that were in place in order to investigate further.

All staff who administered medicines received training and received regular supervision to ensure their competency in administrating medicines. We did not see people self-administer their medicines but staff told us people were given the choice to self-administer and described how they would support people to do this.

At the time of the inspection, no one was receiving medicines covertly (without their knowledge, mixed with either food and or drink). However, staff were able to tell us what would need to be considered and who to seek advice from when there was a requirement to do this. One staff member told us about a person who used to receive their medicines covertly. Prior to this, they had checked with this person's GP and a pharmacist that it would be safe to administer medicines with their food. They told us how this had been periodically reviewed and found that as this person's condition improved, they no longer required medicines to be administered in this way.

The ordering, storage and disposal of medicines was managed effectively. Medicines trolleys were kept secure and locked when not attended and medicines were stored in conditions as appropriate to the labelling. We discussed how medicines were ordered, stored, administered, recorded and disposed of. We saw systems in place which included monthly audits for expiry of medicines and stock rotation. There were

records for the storage temperature of medicines and this was monitored and recorded on a daily basis. Staff knew what to do in the event that storage temperatures varied outside the acceptable levels. For example, one staff member told us the temperature for storage of medicines requiring refrigeration had recently exceeded acceptable limits. They told us they had removed the medicines in this fridge to a different refrigerator where the temperature was stable until the fault was rectified.

People told us they felt safe living at Mavern House. One person told us their condition could deteriorate very rapidly and they were confident that actions were in place to monitor this and urgent treatment would be provided if necessary.

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised. We saw from staff records they had received training in safeguarding adults from abuse and whistleblowing. One staff member told us how they would look for signs of potential abuse in people who may not be able to communicate concerns to staff themselves. They told us how they would do this by identifying other signals such as changes in behaviour and emotions as well as physical signs such as bruising. There were clear policies and procedures in place to inform and guide staff of the processes they needed to follow should they suspect abuse had taken place. Staff said they would report abuse if they had concerns and were confident the registered provider and registered manager would act upon these. Staff were also aware of the option to take their concerns to agencies outside of the service if they felt actions to deal with these were not being taken.

Risks to people's safety had been assessed and plans were in place to mitigate these risks. Assessments and plans were in relation to the risk of malnutrition, dehydration, risk of developing pressure ulcers, choking and falls. People's care plans included clear guidance on how to help manage these risks. For example, in one person's care plan it stated they had a wound which was present when they started living at the service. Their care plan detailed how and when this wound should be monitored for example, for signs of infection or further deterioration and the frequency that dressings should be done. A body map was in place which detailed the location, size and colour of the wound. Regular assessments of this wound were documented and included details of when and how the wound had been dressed and how healing of the wound was progressing.

Where people had capacity to make specific decisions about their care, their opinions in the management of their risks were respected. For example, in another person's care plan it detailed how they had been consulted when the management of their mental health needed to be reviewed. They were consulted in making a decision on the available care and treatments that were available to help manage this.

Sufficient staff were present to respond to people's needs and staff carried out tasks in a calm and proficient way. "A visiting professional said "Staff are always around. They are unhurried and appear relaxed". We saw people had access to their call bells and staff carried pagers which alerted them to when a call had been raised. The registered manager told us they had recently installed a new call bell system. Since this new system had been implemented, a call bell analysis had been completed to determine its efficiency. It had been highlighted in this analysis that some call bells were active for longer than ten minutes before being responded to, however, emergency calls had been answered promptly. Further to the service investigating further into this, it was identified that one call button had been faulty and needed to be replaced. In addition, for other call bells not affected by this technical issue, this had been noted for discussion at the next staff meeting in order for staff to discuss and look for possible solutions to improve response times.

Safe recruitment and selection processes were in place. Appropriate checks were undertaken before staff commenced work and new staff were subject to a formal interview prior to being employed by the service.

Staff files detailed evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence that their identity had been checked. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People were protected from the risk and spread of infection. Areas of the home were clean and tidy and there were systems in place to monitor that cleaning was done consistently throughout the home. Staff were also provided with sufficient personal protective equipment (including gloves and aprons) which we saw being used as appropriate during the inspection. We visited the laundry area which was clean and well organised. There were different laundry bags available for personal clothing, towels, nightwear and heavily soiled linen so that this could be washed separately.

Good

# Is the service effective?

## Our findings

Staff received regular training to give them the skills to meet people's needs and training in how to meet people's specific needs. The registered manager had systems in place to identify what training was required and to ensure this was completed. Training records confirmed staff had received the core training required by the provider, such as safe medicines management, safeguarding, the mental capacity act, infection control, manual handling and health and safety. Staff told us training was available in addition to mandatory training to support them in their role and other specific additional roles. For example, one member of staff told us they had been given training to help them develop their role as a tissue viability lead which had enabled them to provide other staff with advice and support when looking after people requiring skin and wound care.

New staff received a comprehensive induction which, in addition to receiving the core training included shadowing more experienced members of staff before working independently. One staff member told us about their induction. They told us they received support until they felt confident working unsupervised. They told us they were able to ask for further support if they felt they needed it.

Staff told us they received regular supervision sessions and annual appraisals with their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. One staff member told us about their supervisions. They told us that during these supervisions they were able to discuss their progress, request additional training and discuss any ideas or issues they may have.
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 legally authorised under 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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff acted in accordance with the requirements of the Mental Capacity Act 2005. The registered manager told is that due to a recent care plan audit they had identified a need to improve the documentation regarding consent, mental capacity and best interest decisions. Since then, the service had started to implement new documentation in this area. At the time of the inspection, not all care records had been updated but we were shown care records of some people using the service where this documentation was now in place.

A visiting professional told us they had provided advice to the service to help them improve documentation in recording of mental capacity assessments and best interests processes. They said the service had taken on board their comments which had led to improvements in people's care plans in this area. They also told us staff had a good understanding of the mental capacity act. The registered manager told us they had also

compiled a flow chart to assist staff in what should be considered when a person may lack capacity to make particular decisions. Where required, Deprivation of Liberty Safeguarding applications had been submitted to the appropriate authority by the registered manager and were reviewed when necessary.

During the inspection we saw staff seeking consent from people prior to carrying out tasks. For example, asking when they would like to get up in the morning and where they would like to sit for example, at meal times or in other communal areas of the home.

We observed the lunch time meal for people on both days of the inspection. People were positive about the food. There was a varied menu available which people could choose from. A choice of drinks were offered at lunchtime along with wine and sherry. People also had access to specialist diets when required for example, pureed or fortified food. Taster days and themed meals were organised with the kitchen staff and activities team where new foods were introduced and opinions sought from people before being added to the menu.

We spoke to the chef who told us they operated a six week rolling menu. They said if a person did not want what was on the menu they always tried to find an alternative for them according to what ingredients were available. Staff told us people who were unable to eat larger meals and who were at risk of malnutrition benefitted from eating smaller meals at more frequent intervals throughout the day. We observed this practice during the inspection where people were regularly offered and given drinks and snacks such as small plates of sandwiches, fruit, biscuits and crisps. Fresh fruit and vegetables were delivered daily from a local supplier and locally sourced meet delivered every other day.

Families were encouraged to eat with their loved ones. The chef told us that this was particularly positive for some people with smaller appetites as they ate more when their relatives were present. For birthdays a homemade birthday cake would be made and family buffets provided for birthdays and other occasions.

People were supported to maintain good health and had access to healthcare and other services to meet their needs. There were records of treatments relating to chiropody, dental care, eye care and visits from other health care professionals such as GPs or district nurses. We saw an example of this during the inspection where a person had being observed looking unwell. Necessary observations were carried out including their temperature and their GP practice was informed. During a handover on day one of the inspection, it was reported that one person was experiencing toothache and the dentist had been requested in response to this.

Good

# Is the service caring?

## Our findings

People and relatives were positive about the care and support they received from staff. Comments from people included "They (the staff) are providing a very good service 24 hours, seven days a week. I give them full marks" and "I can't fault the carers, I wouldn't want to live anywhere else". One person's relative came to tell us how wonderful and caring staff were. Staff spoke fondly of the people they cared for and we were told staff often came in voluntarily to help support activities and trips. The care records for people detailed how people liked to be comforted. One person's care plan said they liked hugs and holding hands when they experienced periods of stress.

Staff told us they supported each other and worked well together. Throughout the inspection, staff and visitors to the service told us there was always homely and friendly atmosphere. A visiting professional told us Mavern House always had a relaxed 'homely feel' with staff who were always courteous. One staff member told us they enjoyed working at Mavern House and that there was a "very close knit team" where everyone supported each other and how this meant people were cared for in positive way. Another staff member told us they liked working at Mavern House because they enjoyed getting to know people, spending time talking with them and listening to their life stories. Another staff member said they enjoyed their job as everyone was caring. They told us it was a "nice place to be". They went on to tell us "Whenever I walk through the door, there is a warm feeling, it doesn't feel like I am coming to work because it is so homely".

We saw staff supported people in a kind and friendly way and we observed positive interactions on both days of the inspection. We saw a staff member supporting a person to walk from their room to the dining area. They were both having fun as the person pretended to march with the staff member reciprocating this which made them both laugh. We observed one person and staff member flower arranging together. There was a lovely conversation about the names of flowers and remarks on how wonderful the arrangement looked when it was completed.

People's privacy and dignity was respected. We observed staff knocking on people's doors and seeking permission before entering their room. One staff member told us how they ensured people's dignity was maintained during personal care; by ensuring curtains and doors were closed and covering them and keeping them warm when assisting with personal care. People's bedrooms were personalised and people were surrounded by items in their rooms that were important and meaningful to them. This included items such as ornaments, photographs and their own furniture.

Staff offered people choices and involved them in making decisions about their care, treatment and support. For example, staff told us they asked people when they would like to get up or go to bed, what they would like to wear, how they would like to be addressed, whether they would like to stay in their room or join in with activities and this was reflected in people's care plans and during our observations. People were asked where they would like to spend their time. There were quiet areas available as well as a lounge with TV and an activities room. At mid-morning on day two of the inspection, a staff member assisted one person into a communal area. Another staff member kindly remarked they had got up later than usual and the

person responded saying it was because they had chosen to stay in bed later that morning. This person looked happy and soon after sitting in their armchair; began to sing to the music which was playing in the background.

At lunchtime on the second day of the inspection, a staff member asked one person what they would like to eat, giving them a choice of two different options. The person replied with their choice then went on to ask whether they could have a clothes protector on. The staff member came back with the clothes protector and asked the person whether they would like help to put this on. The person they were supporting said they would like help with this which the staff member promptly did. The staff member then explained they would go and fetch their lunch for them which they did. One staff member told us about one person's preferred daily routine which specified when they wanted to eat, what they wanted to wear and how the liked to spend their day. They told us that although this person had a preferred routine, they would still ask them what they would like, to ensure any changing needs and choices were continually met.

Another staff member told us about a person they had supported that day. They said they had supported them to get out of bed but that as soon as they had done so they had decided they wanted to go back to bed. The staff member told us they supported this person to go back to bed as this was their wish to do so.

People looked relaxed and comfortable in the presence of staff and conversations were friendly. Staff supporting people with their meals chatted to them in a friendly way which was not purely task focussed. Staff asked permission from people before assisting them. For example, we saw two staff members supporting someone to transfer from their wheelchair to an armchair. They had asked this person where they would like to sit, explained what they were doing throughout and reassured the person whilst they did this.

Care plans included details of people's preferences, likes and dislikes. In one person's care plan it stated they had difficulties in pronouncing words. The care plan detailed how this person was able to let staff know their preferences by sounds and non-verbal communication. Their care plan also detailed preferences they had already expressed such as what personal care they wanted to do independently and what they would like support with, what sort of food they liked, how they liked to have this presented and where they preferred to eat their meals.

In the care plan of another person, it detailed their end of life choices, such as who they would like to see in the last days of their life and specific choices regarding their funeral arrangements. Links with the local specialist palliative care services enabled the service to gain support and regular training events to give them the skills and knowledge to care for people during their end of life. One staff member told us such links were also beneficial in enabling them to provide emotional support to people and their relatives during this time.

The service created their own advanced care planning documentation with the support and input from a local specialist palliative care service. This promoted early discussions (when possible) with people regarding end of life including their hopes and aspirations. The managing director of the service said this helped to prepare people and their relatives and allowed for exploration of thoughts and feelings in an unhurried way.

Requires Improvement

# Is the service responsive?

## Our findings

Staff were aware of people's needs and told us how they supported people where risks had been identified and risk assessments were in place. Where specific risks had been identified, this was well communicated during shift handovers and people's care plans and daily charts were in place to monitor these risks. For example, where people had been assessed as being at risk of pressure ulcers and required regular repositioning and specialist equipment, care plans detailed what was required and charts were in place to monitor how often people were being repositioned. These charts were consistently completed in line with the guidance given in care plans.

Information provided to staff during the observation of a staff handover was detailed and provided staff with current information on people's needs including any recent changes they needed to be aware of. This included informing staff if people had become unwell, when people required pain relief, people who may need additional emotional support for example whether they were quieter than usual or whether they had any current worries and how to support them with this and whether they'd been seen by healthcare professionals. One person had received a flu vaccination the day before the handover and staff were advised to observe for any side effects such as high temperature or pain at the injection site and for another person who had their urinary catheter changed staff were asked to observe that this was draining as it should be.

However, despite the majority of care being given in line with people's care plans, we observed one manual handling practice of two staff members which was not positive. Two staff members supported a person to transfer between a wheelchair and an armchair. In doing so, they performed a lift which was unsafe and put the person at risk of injury. When we looked at the care records for this person, it stated they used a walking frame and handling belt to help them when standing and transferring between chairs however, this guidance had not been followed. When we raised this with the registered manager they told us this was not acceptable practice and staff should have been aware of this as they had received manual handling training. In response to this, the registered manager said they would investigate further and ensure staff were reminded of safe manual handling practice and would be supervised accordingly.

Although the majority of records to monitor people's care was well recorded the documentation in people's care charts to monitor the food and fluid intake of people at risk of malnutrition and/or dehydration was not consistently completed. People who were at high risk of malnutrition and or dehydration and had food and fluid monitoring charts in place to monitor their daily intake. There were gaps where nothing had been recorded on these and total daily amounts of fluid intake was not always calculated and nurse reviews not always completed as required in line with people's care plans. For example, a food and fluid monitoring chart for one person for the period of 24 hours stated they had only drunk 70mls of fluid during this time with only three entries of fluid intake for the whole day and on another day only three entries of fluid intake had been documented and a question mark written where entries should have been made during the afternoon. On this day, only 250mls of fluid intake had been documented. When we asked staff about these charts where long periods of time had been left blank and fluid intake should have been recorded, staff told us they had not completed the chart as people had been either asleep or had refused fluids.

Despite staff being reminded during a staff handover on day one of the inspection to fully complete food and fluid charts including the documentation of when people were asleep or refused fluids, this advice was not followed. For example, staff were reminded to document the fluid intake of a person who was at risk of dehydration but when we looked at their fluid chart on the second day of the inspection, there was no information available regarding their morning fluid intake and their daily fluid intake from the previous day had not been tallied. When we spoke to the registered manager about this, they told us this had been something they had recently raised with staff and were currently looking at ways to improve this. One suggestion had been to make sure fluid charts were with people at all times irrespective of whether they were in bed or spending their time elsewhere in the home so that fluid and food intake could be documented as and when it was observed. In addition to this, each person had a diary in their room which was used for staff to record general daily information such as changes to their health and emotional well-being and were used as source of information for people's relatives. In one area of the home, these diaries had a lot of detail but the diaries of people who required monitoring of fluid and food intake and lived in a different area of the home did not detail the same level of information. As food and fluid charts had also not consistently been completed for people at risk of dehydration in this area of the home, this was a missed opportunity by staff to inform relatives when their loved ones had a reduced appetite or needed support to increase their fluid intake. Documentation and completion of these diaries had been raised during a management meeting a few days prior to the inspection, where it was highlighted that in one area of the home these were working very well to keep relatives informed of their loved one's emotional needs but that in other areas of the home they were not as successful. The service responded to this by arranging workshops for staff who were proficient in completing this information to share best practice with the rest of the team and support them in doing this.

A re-evaluation of the benefit of food and fluid monitoring charts was also being considered in view of the value and need for this in relation to all risk assessments. The registered manager told us they had recently discussed whether such close monitoring was beneficial for all people or whether a different method of monitoring this for people who were at lower risk would be more efficient and easier for staff to manage and record.

People's care and support plans were personalised and were reviewed regularly. Care plans included details of the support people required and what they were able to do independently. For example, in one person's care plan it stated what they could do regarding their personal care but also that they would like to have help cleaning their teeth. The registered manager told us about a tool they used to identify when a person was becoming more frail or vulnerable and would therefore pre-empt changing needs. This tool was called the Supportive and Palliative Care Indicators Tool (SPICT). Although an example of this was not seen in use at the time of the inspection, the registered manager explained that they used this tool every month as a clinical team to identify whether the plan of care including psychological and emotional support for a person or their families is required. The registered manager told us the use of this tool had proven very successful and ensured nursing care was well coordinated and responsive, particularly for those people whose health was gradually declining and where this may otherwise not be as easily identified.

People were supported to follow their interests and take part in social activities. Care plans detailed people's choices on what activities they would like to do and there was a varied activities program for people to choose to participate. The relative of one person who had been involved with a charity for a considerable number of years told us staff had made great efforts to get to know them when they first arrived at the home. They learnt about their involvement with the charity and helped them to organise an event in relation to this. They said "For the first time in months (X) feels they have a purpose".

One person told us how they liked to help the chef by "drying the pots" saying "It is good company for me

and I like to feel as though I am helping out". Another person who said they used to work in a technical role told us how maintenance staff sometimes asked them for technical advice which they particularly enjoyed and in doing so had also made friends with them. Another person told us they liked to sit in a quiet area of the home where they could enjoy doing their artwork. During the inspection we saw people taking part and enjoying activities. These included baking, cake decorating and due to the time of year, pumpkin carving.

People had a range of activities they could be involved in. There were two activities coordinators responsible for organising activities for people. One activities coordinator also told us people liked to pick the home grown vegetables from the garden which could also be used for meals. People and their relatives told us they were always made very welcome and there was an 'open' visiting policy. Photos of recent activities were displayed in the communal areas of the home. These showed people enjoying social activities and special events. Books, magazines and daily newspapers were also available. Staff told us they had time to spend with people who chose to stay in their room or were being nursed in bed.

One staff member told us about one person who liked to stay in their room. They told us how they stayed to chat with them and do word searches which they particularly enjoyed. A therapist was also employed to give hand massage or reflexology to people who requested it. The service had links with the local community which included the local church and school. There was a choir which people from Mavern House participated and was run by the chef.

The registered manager told us it was their ethos for staff to spend time with people beyond their usual roles as this helped to build relationships and a caring culture. The registered manager told us for some people the choir was an important part of their life, one person saying that it had changed their life because they felt they "belonged to something". The choir did performances throughout the year; at garden parties and seasonal events with invites extended to the local community. People who chose to were also involved in going to the local market to sell homemade jam which was made at Mavern House.

There was a file in place which held many compliments the service had received which we saw during the inspection. People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously. A relative of one person told us they had a complaint when their loved one first arrived at the service but this had been addressed in a positive way and since making the complaint they had a very good relationship with the registered manager and staff. Other relatives told us their concerns were resolved immediately, one saying management "Make time for us at our request".

The registered manager had a log of compliments and concerns they had received prior to our inspection. There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. All had been resolved to people's satisfaction.

The provider valued people's feedback and acted upon their suggestions. Residents and relatives were sent questionnaires seeking feedback on the service. Following receipt of these any required actions would be drawn up and addressed accordingly. For example, a recurrent trend in feedback received in the last resident/relative survey was that the response to call bells was poor and not working effectively. In response to this, a new call bell system was introduced and a monthly audit put in place to monitor the effectiveness of this new system. The registered manager told us there had not been any recent resident/relative meetings and that one was planned for the Autumn however, there was an open door policy where any problems, concerns or issues could be addressed on a day to day basis.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post who was available throughout the inspection. The registered manager told us they were supported by a management team which included the managing director, finance manager, compliance manager, clinical manager and learning and development lead. There were many positive comments about the registered manager and staff team. Staff said they enjoyed working at the service and were well supported. One staff member told us "We are a very close knit team. I feel very supported. I am encouraged to challenge myself so that I can develop my skills". Care staff told us nursing staff were very "hands-on" and were very supportive. Staff told us management were approachable one saying "All managers are great, you couldn't ask for better. It's like a big family. There is an open door policy if you need help".

Staff were able to tell us about the vision and values of the service. They told us they focussed on people as individuals beyond person centred care with the emphasis they were working in people's own home not in their place of work.

The registered manager told us they had recently employed additional management support so they could increase their presence around the home. This enabled them to participate in clinical activities and have a good overview of the quality of care as well as having the opportunity to really get to know the people who used the service.

To help promote staff retention, the registered manager told us staff who were unable to continue in their current role were supported to deploy to a different role to enable them to continue working at the service. Two staff members also told us management had helped them by re-negotiating their working hours; one to give them the opportunity to take further vocational qualifications and the other to support them due to personal commitments.

The service had systems in place to monitor the quality of the service being delivered. However, there was no daily medicines audit in place to check the completion of the MAR which meant that gaps in MAR completion may not identified for up to four weeks. Audits were carried out periodically throughout the year by the registered manager and compliance manager. This covered the management of medicines, infection control, bruises, accidents and incidents, call bell timing analysis and care planning. Where issues had been highlighted, actions had been put in place to address these. For example in a recent audit which looked at the incidence of falls it had been identified that there were a higher than average number of falls for a particular month. Further to this, people who had an increase in the number of falls had their risk assessments and care plans reviewed, were seen by their GP and other measures were put in place to help reduce this risk for them. Since then a lower number of falls had occurred.

Following the identification through internal quality assurance processes that the documentation and follow-up of injuries required improvement a new procedure to monitor accidents and incidents had recently been created. This included a revised injury report form which included more information around the injury including actions taken in response to these. Plans were in place for these forms to be reviewed by

the compliance manager and an audit to be completed to observe any trends, patterns and actions. This meant injuries from accidents or incidents were carefully monitored and followed up.

A monthly clinical managers meeting took place in order to address any issues identified including compliance with clinical policies and procedures and the evaluation of people's well-being. A management team also met weekly to discuss all departments covering current challenges and successes. This would include topics around staffing, equipment, values and ethos, maintenance and repairs and future plans for example, improving the living areas of the home. There were also twice monthly nurse meetings and weekly care forums which gave all staff the opportunity to reflect on matters relating to the quality of care being delivered including listening to concerns and making requests for support.

The service were also positive about supporting mental health in employment and were signed up to a 'mindful employer charter'. The voluntary affiliation with this charter meant the service had an awareness of mental health and aimed towards working within the principals of supporting the mental wellbeing of staff.

The maintenance of the home was managed well and included regular servicing and property safety checks to ensure people were safe. This included regular fire alarm testing and gas, electric and water inspections. Servicing of equipment was also completed and recorded to ensure it was fit for purpose. The service also had appropriate arrangements in place for managing emergencies including contingency plans in the event of a fire or loss of utilities.

The registered manager told us they kept up to date with best practice by working with community teams and regularly meeting with other home managers. They told us how they worked with the local hospice and received updates as well as seeking advice from them when this was necessary. There were regular staff meetings, which were used to give the opportunity for staff feedback, share best practice and keep staff up to date. Actions raised during these meetings were implemented and documented accordingly. Surveys were sent to community healthcare professionals to seek their views of the service. Surveys we looked at all included positive feedback. Comments stated the service 'always feels a happy and relaxed environment', staff 'take time to talk to people and visiting professionals', the care was 'very individualised' and staff 'always available', 'motivated and broad thinking'.