Progress Housing

Marlow

Inspection report

8 Nursery Lane
Worthing
West Sussex
BN11 3HS

Tel: 01903212405
Website: www.progresshousing.com

Date of inspection visit:
12 June 2017

Date of publication:
04 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Marlow is registered to provide residential care for up to 15 people with a range of complex health needs, including people living with a learning disability. Accommodation is provided over two floors. On the ground floor, 11 people are accommodated in en-suite rooms, each equipped with overhead hoists. Communal areas include a large sitting room, dining room and quiet lounge. The first floor is split into two flats, each flat having two bedrooms, a kitchen and sitting room; each flat accommodates two people. The home has accessible patio and garden areas. At the time of our inspection, the home was at full capacity. Marlow is close to the town centre of Worthing and to the seafront.

At the last inspection, the service was rated Good overall and Good in each domain apart from Well-Led which was rated Requires Improvement. We found a breach of regulation relating to good governance and asked the provider to submit an action plan on how they would address this breach. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and registered manager had taken appropriate action and the regulation had been met.

This inspection was undertaken on 12 June 2017 and was unannounced.

A registered manager was 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.

Medicines were not always managed safely. Some medicines had not been disposed of as required. One medicine had not been disposed of despite it being beyond the expiry date. Another medicine should have been disposed of following a single use, but was still in the fridge. These two people's health may have been compromised because they were at risk of receiving medicines that were out of date. The temperature in the medicines room, on at least two occasions, was in excess of the maximum temperature of 25 degrees Celsius recommended under pharmaceutical guidance. Controlled drugs were not stored securely in line with the Misuse of Drugs (Safe Custody) Regulations 1973. Medicines were not stored safely in the manager's office on the first floor. There was a gap in recording on one Medication Administration Record relating to the administration of a medicine to be taken as required.

A system of audits had been put in place to measure and monitor the quality of care delivered and the service overall. In the main, these were effective in identifying any areas for improvement and actions that needed to be taken. However, the audit in place in relation to the management of medicines had not identified the issues we found at this inspection.

People felt safe living at Marlow and staff had been trained to recognise the signs of potential abuse. They knew how to report any concerns and had been trained appropriately. People's risks had been identified and assessed appropriately and there was guidance for staff on how to mitigate risks. There were sufficient

numbers of staff on duty to keep people safe and robust recruitment systems were in place.

Staff completed a range of comprehensive training to enable them to support people effectively and safely. They were encouraged to study for additional qualifications and new staff followed the Care Certificate, a universally recognised qualification. Staff had regular supervision meetings with their line managers and attended staff meetings. Staff had been trained to understand the Mental Capacity Act 2005 and put this into practice. Staff routinely asked for people's consent. People were supported to have sufficient to eat and drink and were encouraged to maintain a healthy diet. People had access to a range of healthcare professionals and services.

Staff were kind and caring with people and positive relationships had been developed. People were treated with dignity and respect. Staff knew people's likes and dislikes and their cultural needs were catered for. Staff enjoyed spending time with people. If appropriate, and if people's needs could be met at the home, then end of life care was available, in line with people's last wishes.

Care plans provided detailed information about people, including their personal and social histories. Staff were familiar with the content of these care plans and provided care in a person-centred way. Some activities were organised for people at the home and other activities were arranged in line with people's individual interests, for example, attending college or a day centre. Complaints were managed in line with the provider's complaints procedures.

People and their relatives felt the home was well managed. They were asked for their views about the home through families and friends surveys. People's views were obtained on an individual basis at 1:1 meetings with their keyworkers. Staff were asked for their feedback about the service. The home was in the process of being taken over by a new provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were not always managed safely.

People were protected from the risk of abuse by staff who knew how to support them. Staff understood the need to report any abuse to the registered manager and local authority.

People's risks were identified, assessed and managed appropriately with guidance to staff.

Staffing levels were sufficient to meet people's needs. Safe recruitment practices were in place.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained in a range of areas. Staff received regular supervision meetings and attended staff meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had a choice of what they wanted to eat. They received support from a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well.

People were treated with dignity and respect.

If their needs could be met, people could spend their last days at Marlow,

Is the service responsive?

Good

The service was responsive.

People's care plans provided staff with detailed information about people and the support they required.

People had the choice of being involved in structured activities at the home or more independently, in the community.

Complaints were managed satisfactorily.

Is the service well-led?

Requires Improvement

One aspect of the service was not well led.

Whilst improvements had been made in relation to the systems for auditing the quality of the care delivered and service overall, they had not identified the issues we found in relation to medicines management.

People and their relatives were positive about the running of the home and complimentary about the registered manager and staff.

Staff were asked for their views about the service and felt supported by the management team.

Marlow

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 checked 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 was an unannounced, comprehensive inspection. The inspection was undertaken by one inspector 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. The expert by experience had expertise in learning disability and complex needs.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with two people living at the service, spoke with three relatives and another person who regularly visited the service. We chatted with people where they were able to speak with us and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, a director of the provider, the area manager, the manager who oversaw the flats and two support workers.

Requires Improvement

Is the service safe?

Our findings

Since our last inspection, concerns had been raised as safeguarding incidents in relation to the management of medicines. These related to one person not receiving their medicines as prescribed due to delays by the provider, the medical practice and the pharmacy. We discussed the issue with the registered manager who explained the actions that had been taken to prevent reoccurrence.

At this inspection, we found that some medicines had not been disposed of as needed. For example, on the prescribing label on one medicine 'Ciproxin' it stated, 'Store in refrigerator and use before 22 March 2017'. This medicine was still in the fridge despite the fact that the date had expired. Another medicine, 'Tetracaine Gel 4%' dated 22 March 2017, had been opened. The instruction on the packaging was, 'Use once then discard'. The medicine had clearly been used, but had not been disposed of in line with the prescriber's instructions. These two examples put people's health at risk as the medicines were out of date. The day of our inspection was quite warm and we looked at the temperature recorded in the medicines room; a temperature of 25 degrees Celsius had been recorded. However, when we checked the log of temperatures for previous days, we saw that on two occasions a temperature of 26 degrees Celsius had been noted. This is in excess of pharmaceutical guidelines which state that medicines should not be stored in temperatures exceeding 25 degrees Celsius as this may affect the efficacy of the medicine over time.

We looked at the storage of medicines within the medicines room. Drugs that were subject to specific storage conditions had not been stored securely and did not comply with the Misuse of Drugs (Safe Custody) Regulations 1973. Medicines for people living in the flats were stored in a filing cabinet in the manager's office, which was not a secure or safe way of storing medicines. We checked MARs which had been completed appropriately. However, we saw that a medicine to be administered as needed (PRN) for one person had been recorded on the MAR as required, but there was no recording of the result in relation to whether the medicine was effective or not, as nothing was recorded on the reverse of the MAR. We discussed these concerns with the registered manager and with the director who agreed that actions needed to be taken to ensure the safe management of medicines.

The above evidence shows that medicines were not managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Subsequent to the inspection the provider informed us that appropriate facilities had been obtained to ensure the secure storage of certain medicines.

We observed medicines being administered to people at lunchtime and this was done appropriately. Two staff administered medicines to people. One staff member dispensed and administered the medicine, whilst the other staff member checked the Medication Administration Record (MAR) and observed the first staff member administering the medicine. Both staff members then sign the MAR.

People we spoke with said they felt safe living at Marlow and one person added, "I like it here". Relatives felt their family members were safe and our observations confirmed that people were happy and relaxed. Staff

had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns. A support worker explained, "There's different types of abuse like physical, mental, neglect or financial". They gave us an example of a safeguarding matter that they had been involved with when they worked at another home, where it was reported to the manager and investigated by police. They said, "If I saw anything that was hurting the residents, I would report it straight away".

Risks to people were identified, assessed and managed safely. One person told us they were able to go out independently and were supported to take risks in relation to this. The registered manager said that all risks were assessed as needed and people were supported accordingly. People were encouraged to try out new activities and to be as independent as possible. We observed staff supporting people in a timely manner and that people were not rushed. One member of staff was supporting a person to transfer from their wheelchair to a walking frame. The person was encouraged to stand, but was not responsive at first. The member of staff was patient and continued to calmly encourage the person, waiting for them to stand in their own time.

We looked at a range of assessments in relation to epilepsy, eating and drinking, bathing, constipation, the cutting of fingernails, drinking hot drinks, falling out of bed/use of bedrails, using a shower, moving and handling and out in the community. Each risk was identified, the severity of the risk, what control measures were put in place and recommended actions to mitigate risks were recorded. Where people had difficulty with their swallowing, a referral was made to a speech and language therapist who had provided guidance on eating and drinking and the administration of medicines. Some people received nourishment through a PEG (Percutaneous endoscopic gastrostomy) a procedure in which a flexible feeding tube is place through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medicines to be put directly into the stomach, bypassing the mouth and oesophagus. A support worker told us, "We had PEG feeding training from a nurse at the hospital". Risk assessments were completed appropriately and provided detailed guidance for staff; they were reviewed monthly or as needed. Accidents and incidents were reported and staff had taken the necessary action to prevent any reoccurrence.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. Three people had separate 1:1 support from staff during the day, due to their complex needs. In addition, there were four support workers on duty during the day, with two waking night staff on the ground floor and one waking night staff at the flats. A support worker explained, "Staff can be flexible, you help each other out. It would be nice to have more staff so we could take people out more. We have to plan it in to do outings and we have to make sure there's enough staff on". They added that days out tended to happen for people once or twice a month and said, "But we can easily pop out for a tea or coffee with people or do some shopping". Another support worker told us, "We do have some bad days when staff call in sick, but it always gets covered. I think staff are trying their best and they try and look after people so they are safe". Staff were available when people needed them. However, they also supported people from a distance when appropriate.

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

Good

Is the service effective?

Our findings

People were looked after by staff who had the skills and knowledge they needed to carry out their roles and responsibilities. Staff had a good knowledge of the people they were supporting. We observed one member of staff who was comparatively new to the home and it was clear they knew people well. A visitor to the home said, "Staff know everything about people". The registered manager told us that, aside from handover meetings which took place between shifts, communication between staff was through a communication book. This ensured all staff were aware of any issues affecting people or the home.

Training provided to staff included moving and handling, health and safety, first aid, food hygiene, infection control, safe administration of certain medicines, learning disability, fire and mental capacity. Except for some training such as moving and handling and first aid, all training was delivered on line. Otherwise a trainer visited the home to deliver face to face training to staff. Staff were also encouraged to study for additional qualifications such as diplomas in health and social care. One member of staff had completed a National Vocational Qualification at Level 4. They told us, "I've done quite a bit this year – food hygiene, fire, health and safety. I've also had my epilepsy training with the medication". This staff member said they also wanted to undertake training in Makaton, a way of communicating through symbols, where verbal communication is difficult. They added, "If you want to do training, they will find it for you". Another staff member said, "I've had all the training. The last one was first aid again. I've learned a lot about care. I like to think I've developed myself, as I learn so much from people. I've challenged myself to learn more". All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The registered manager told us that new staff might start to study for the Care Certificate whilst waiting for their recruitment checks to be completed.

Staff received regular supervisions with their line managers and these were completed approximately every two months. One staff member said, "We talk about my work practice, [named person they were keyworker for], personal and professional development; if I have any problems". Another staff member said, "If you talk to [named registered manager and area manager] they will listen to me". We looked at supervision records for staff. One staff file confirmed that supervision meetings had taken place in March, February and January 2017 and were held regularly through 2016, in the form of 1:1 meetings and observations. Staff meetings were also held throughout the year. We saw minutes of a meeting held in April 2017 and items discussed were a review of actions from the last meeting, medicines, recording charts, summer activities, keyworking, extra duties, handover, communication, speech and language therapist and residents. Staff meeting minutes had also been completed for January 2017, December, November and August 2016. The next staff meeting was planned for 17 June and we saw an agenda had been circulated.

Staff completed individual records which showed what they were doing at various points throughout the day. For example, when staff were completing daytime cleaning duties and night staff logged when they had undertaken 15 minute checks for some people where needed, or hourly checks to ensure people were safe throughout the night.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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. Staff had been trained on the MCA and understood how to apply this legislation to the people they supported. One staff member talked about consent and said, "I give people choice. Some people communicate with their eyes or by touch. You do know. I try and encourage people, but I don't force them. If people want to lie in bed, they can. It's about getting to know people and respecting them, it's two-way". Another staff member told us, "We understand that first of all when you meet someone, you have to assume they have mental capacity. It's their right to make decisions and we respect that". They gave an example of one person who lived at the home, "We talk to her and try and explain in a way she would understand. Everyone communicates differently". Where people had been assessed as lacking capacity, DoLS had been applied for, the majority of which were still awaiting to be processed by the local authority. Records confirmed that, where needed, best interest meetings had taken place, for example, in relation to people having lapbelts to prevent them from falling out of their wheelchairs and for bed rails, to keep them safe in bed.

Throughout the day, we observed staff routinely seeking consent when supporting people, for example, before helping people to mobilise and asking if they would like to go to the dining room for lunch.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. Except for people who were cared for in bed, everyone sat together in the dining room for lunch. People we spoke with said or indicated that the food was good. Some people were unable to choose what they wanted to eat, so staff prepared meals on the basis of people's known likes and dislikes. We observed people eating their lunchtime meal and most people appeared to be enjoying it. One person did not want to eat what was provided. After trying to encourage them, the member of staff asked if they would like an alternative. The person asked for cake, but there was none available. Instead, the staff member said they could go for a walk after lunch and the person could then buy their own cake. The person was happy with this choice. We observed staff supporting people to eat their lunch and there were enough staff to provide people with the support they needed. One person, who lived quite independently in one of the flats, told us they were encouraged to cook their own meals, with support from staff.

People were supported to maintain good health and had access to a range of healthcare professionals and services. People's healthcare appointments were recorded in the staff shift book and in people's care plans. Hospital passports had also been completed for people. The aim of the hospital passport is to assist people with a learning disability to provide hospital staff with important information about them and their health when they are admitted to hospital. People's care plans showed they received support from healthcare professionals such as an optician, GP, dentist, hearing specialist, chiropodist and that people had consented to receiving a 'flu jab. The registered manager told us she spent a lot of time working with healthcare professionals to ensure people's health needs were met. She said, "Families can come with us to any appointments".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed staff supporting people in a kind and caring manner. The staff demonstrated they knew how people liked to be supported by interacting with them when invited. People and relatives we spoke with all felt that staff were caring and one relative said, "The staff support people to live life". Staff supported people to be as independent as far as they were able. If a person could do something, they were supported to do so. For example, one person had a heavy cold. When they had used a tissue, they were encouraged to put it in the bin. They were also encouraged to wipe their own nose, but staff were on hand to help them if needed, thus maintaining their dignity.

People were treated with dignity and respect and we observed staff were respectful with people at all times. For example, in the way they talked with people and bending down to their level and facing the person they were talking with. We asked staff how they treated people with dignity and respect. One staff member said, "I always close the curtains and tell them what I'm doing. If people are on the toilet, I close the door".

Within people's care plans we saw that people's likes and dislikes and cultural needs were recorded. A member of the clergy visited one person every six weeks and delivered Holy Communion, in line with the person's preferences. We observed another person, who sat with us in the office, answered the office phone when it rang. When the registered manager came into the office, they praised the person for answering the phone and said, "Well done".

It was clear from our observations that staff enjoyed spending time with people. One staff member said, "I enjoy the residents. They're all different and they're really fun". Referring to one person who they were keyworker for, the staff member said, "I give her time when I can. We sit in the garden and chat". As much as they were able, people were involved in decisions relating to their care. Keyworkers were allocated to people, who met regularly with them, to check whether they needed anything or had any concerns. One person spoke Romanian, so they were allocated a keyworker who also spoke Romanian, and enjoyed conversations together. Another staff member said, "I take one person to the GP or hospital. I help mum when she takes her out".

People could spend their last days at the home if they wished and if their needs could be met. They were supported to have a comfortable, calm and pain-free death. The registered manager provided us with an example of how staff were involved in a decision about supporting one person with their end of life care. The registered manager explained, "My team are so solid. The commitment they show to end of life. Nineteen staff came to a particular meeting to discuss whether they could meet one person's end of life needs or not". Staff demonstrated their commitment and caring attitude to this person who had elected to return to the home following hospital treatment. The registered manager had sourced support from healthcare professionals to ensure the person received sensitive and appropriate palliative care. In addition, a local hospice had offered counselling sessions to support staff.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People were encouraged to participate in their care planning and reviews, but due to their complex needs, they were not always able to do so. Relatives we spoke with said they were actively involved. Staff told us that people were given as much information as they could understand and cope with. Relatives told us they were kept fully informed about their family members.

Care plans provided detailed information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority.

Some effort had been made to provide care documentation in accessible formats, such as with pictures and symbols, and we discussed the Accessible Information Standard with the registered manager. From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Care plans were routinely updated every six months or earlier if needed and families were invited to these care plan reviews. The registered manager said, "I'm in touch with families a lot and they get sent a copy of the care plan too. Families feel part of our family as well". A staff member said, "When new people come in, we get the paperwork and are updated by [named registered manager and deputy manager]". They gave us an example of one person who was moving into the home and said, "[Named person] came for a music session first, then stayed a bit longer each time. We try and know as much as possible about each new resident. I think the transition is quite good here".

Care plans we looked at contained detailed information in relation to people's life history, personality, friends, family and relationships. Guidance was also provided to staff in relation to people's personal care, morning and night routines, mobility and transport, health needs and medication. Information was recorded on any allergies people might have, eating and drinking needs, communication and behaviours and in relation to promoting their independence. A staff member explained that when they were completing their induction programme, they had spent time reading every care plan and risk assessment. They said, "Any changes are put in the 'sign and read' folder", which ensured staff knew of any issues, concerns or changes to people's care needs and could provide appropriate support. The registered manager said, "The staff team have got all the guidelines they need to support service users. The paperwork and documentation have improved. Service users are out and about more and involved with staff more. Staff are support workers not carers. It's about us reading people's needs for people with no communication".

Some activities were organised for people in a structured way and other activities were chosen by people independently. For example, on the day of our inspection, a floristry session had been organised, where people were encouraged to arrange flowers and have tea and cake. Prior to this, we heard a member of staff

asking a person if they would like to help buy the flowers for the afternoon session and the person agreed they would like to do this. People from the provider's other homes also joined in with this social event. Each person had a separate activity planner. One person attended a college nearby to improve their independent living skills. Another person attended a day centre. A third person was involved in voluntary work. People, if they wished, were encouraged to be involved with housekeeping and in preparing their own meals at Marlow. We observed this on the day of our inspection. People were encouraged in community activities, for example, walks to the seafront and went out for meals and drinks. One person had recently enjoyed attending the 'Big Church Day Out' and their support worker said, "She was in her element". A visitor to the home said they would often see people from Marlow out in the community. A relative said, "They are always doing something, or going somewhere, for example, bowling or going out for a meal". Each person had a set of goals and objectives which they were working towards. For example, in one care plan we read, 'To be encouraged and supported to do more independent tasks; to plan to go on holiday; to redecorate their bedroom so it's more up to date'. The registered manager told us about two people who, prior to living at Marlow, had shown little interest in friendships, but were now the best of friends. They said, "And staff helped them to interact. Mum is really happy that [named family member] has a friend".

We asked people if they knew how to make a complaint if they had any concerns. One person confirmed they did and gave an example when they felt that soup was too often on their menu, as a result their menu was changed. We asked relatives if they knew how to raise a complaint and they all confirmed they did. One relative told us they had only ever raised one concern in nine years and that was dealt with appropriately. A complaints procedure was on display in an accessible format, using Makaton symbols. Two complaints had been recorded in the last few months and each complaint had been dealt with to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in May 2015, we found the provider was in breach of a Regulation associated with good governance. We asked the provider to take action because there was no robust system in place to measure and monitor the quality of the service to drive continuous improvement. Action plans were not clear as to who was responsible for any actions to be taken or by which date actions should be completed. The previous manager had not informed CQC of DoLS authorisations or outcomes for people where these had been received from local authorities. At this inspection, we found that some improvements had been made and that this regulation was met. However, the audits in place had not identified the issues we found in relation to the safe management of medicines. We discussed this with the registered manager and with the provider, who agreed they would look into the issues raised.

We saw an audit which had been completed by the area manager in April 2017. This related to care management and monitoring, keyworker meetings, and environmental checks. Where actions were identified, these were clearly documented with who was responsible and a date by when the action needed to be completed. A trends analysis had been completed in relation to accidents and incidents which would identify any emerging patterns. The ratings allocated at the previous inspection were on display at the home, in line with CQC requirements.

We asked people and their relatives about the management of the home. Relatives told us they felt the registered manager was very approachable and open to suggestions. One relative said, "The manager has a 'can do' attitude, always willing to listen and try innovative ideas". Relatives told us that the current registered manager had brought stability to the home, after a period of constant change. They added that she had put together a good staff team. The registered manager said, "One of my biggest things was the families. I really wanted to gain their trust and I wanted them to feel their loved ones were happy and well-cared for. Relatives can feel confident that anything needed will be acted upon". The registered manager went on to say, "New staff we have taken on are outstanding. We induct a strong staff team and it's based on my standards".

A family and friends survey had been sent out in January 2017 and two responses had been received. The survey included questions such as, 'What does the service do well? How could the service be improved?' Comments returned included, 'Good all round. [Named family member] is happy living here at Marlow'. Residents' meetings were not held as they would not have been useful in obtaining people's feedback about the service. Instead, people had meetings with their keyworkers who fed back any comments to the management team.

Staff were also asked for their views about Marlow and seven responses had been received at the end of last year. One member of staff talked about recent changes since the home was in the process of being taken over by a new provider. They told us, "They're going to give it six months and then make changes". The registered manager said, "They're a lot more open to listening and my ideas. They were happy with what I have done". A second staff member told us they enjoyed working at the home and said, "I like it. I like learning disability, it's different. You can see the difference you make in people's lives".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users in relation to the proper and safe management of medicines. Regulation 12(1)(2)(g)