The Regard Partnership Limited

The Marshes

Inspection report

The Marshes
3b Nursery Close
Hailsham
East Sussex
BN27 2PX

Tel: 01323440843
Website: www.regard.co.uk

Date of inspection visit:
29 September 2016
30 September 2016

Date of publication:
08 November 2016

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

We inspected The Marshes on the 29 and 30 September 2016 and the inspection was announced. We inspected The Marshes at the same time as we inspected the service's sister home, which was next door. The Marshes provides accommodation and personal care for up to six people with a learning disability and complex needs. The young adults require support with personal care, mobility, health, behavioural and communication needs. There were six people living at the service at the time of our inspection, however, three people were on holiday during our inspection. Accommodation for people is arranged on the ground floor, with a sleep-in room for staff in the staff office. The home was adapted to meet the needs of people living there. The home was adapted to meet the needs of people living there. The Marshes belongs to the large corporate organisation called 'The Regard Partnership Limited.' Regard provides care nationwide and have several homes within the local area.

The service had a registered manager. 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.

Risks to people's health, safety and wellbeing had been assessed and plans were in place which instructed staff how to minimise any identified risks to keep people safe from harm or injury. However, risks assessments did not consistently embed, implement or follow nationally recognised tools and guidance such as the Malnutrition Universal Screening Tool (MUST). We have made a recommendation about risk assessments.

The registered manager and staff had received training and were knowledgeable about of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been completed for the decision 'does the individual have the capacity to make decisions about daily living whilst living at The Marshes.' However, assessments of capacity were not decision specific and incorporated a wide range of decisions into one assessment. This is not in line with best practice requirements. We have made a recommendation about mental capacity assessments.

Staff told us they worked as part of a team, that the home was a good place to work and staff were committed to providing care that was centred on people's individual needs. There was a strong caring culture in the care and support team.

People received care and support that was responsive to their needs. Care plans provided detailed information about people so staff knew exactly how they wished to be supported. People were at the forefront of the service and encouraged to develop and maintain their independence. People participated in a wide and varied range of activities. Regular outings were organised and people were encouraged to pursue their interests and hobbies.

Systems and processes were in place to help protect people from the risk of harm and staff demonstrated that they were aware of these. Staff had received training in safeguarding adults and knew how to recognise and report any concerns or allegations of abuse.

Staff had access to on-going training and supervision to ensure they had the skills and knowledge required to support people effectively. Systems were in place to make sure people received their medicines safely. Arrangements were in place for the recording of medicines received into the home and for their storage, administration and disposal. However, documentation did not consistently record the stock level carried forward from one month to another. We have made a recommendation about the monitoring and documentation of medicines.

Staff treated people as individuals with dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. They approached people in a calm, friendly manner which people responded to positively. Relatives spoke highly of the service. One relative told us, "They couldn't be in a better place."

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 Marshes was safe.

Staffing levels were organised according to people's needs and the provider followed an appropriate recruitment process to employ suitable staff.

The environment was safe and well maintained. Risks to people's health and welfare were identified and steps were taken to minimise these without restricting individual choice and independence.

Medicines were managed safely. People received their medicines as prescribed and when needed.

Is the service effective?

Good

The Marshes was effective.

People were given choice about what they wanted to eat and drink and received food that they enjoyed.

Staff understood people's individual needs. They had received appropriate training and gained further skills and experience to promote good outcomes for people.

People's health needs were met in conjunction with a range of specialist and community services.

Is the service caring?

Good

The Marshes was caring.

The home was relaxed and friendly with a homely feel to the environment.

Staff were kind and caring. They were aware of, and took into account, people's preferences and different needs. People were supported to be as independent as possible.

Staff treated people with respect and they ensured that people's

dignity was maintained at all times. Attention was given to ensuring that people's bedrooms as far as possible reflected their choices and tastes.

Is the service responsive?

Good

The Marshes was responsive.

People's care reflected their complex individual needs and the way they liked their care and support to be provided. Any changes in their health and wellbeing were responded to quickly.

People led busy lifestyles with access to a range of meaningful activities which were tailored to individual needs.

Systems were in place for receiving, handling and dealing with complaints.

Is the service well-led?

Good

The Marshes was well-led.

Relatives and staff expressed confidence in the management of the service.

They commented that the management was approachable and listened to their views.

Systems were in place to assess and monitor the quality of the service and the day-to-day running of the service.

The Marshes

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 29 and 30 September 2016. It was announced. The provider was given 48 hours' notice so that key people could be available to participate in the inspection and people could be made aware that we would be visiting the service. The inspection team consisted of two inspectors. The service was last inspected on 29 July 2014 and no concerns were identified. The inspection took place over two days because we inspected The Marshes sister home, Lynfords at the same time. We did this because some elements of care, such as training, human resources and quality assurance were managed centrally for both homes.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we spent time with people who lived at the service. We spent time in the lounge, kitchen, and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted. People were unable to use structured language to communicate verbally with us, so we took time to observe how people and staff interacted at lunch time and during activities. We spoke with three staff members and the locality manager. We contacted three people's relatives via telephone after the inspection to obtain their views. Their feedback has been included within the body of the report.

We reviewed three staff files, three care plans and associated risk assessments, four weekly staff rotas, medication records, policies and procedures, health and safety files, compliments and complaints

recording, incident and accident records, quality monitoring documentation, meeting minutes and surveys undertaken by the service. We also looked at the menu and weekly activity plans.

We 'pathway tracked' three of the people living at the home. This is when we looked at people's care documentation in depth; obtained their views on their experience of living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

Due to communication needs, people were verbally unable to tell us if they felt safe living at The Marshes. Observations of care demonstrated that people were comfortable in the presence of staff. People's behaviour also showed us they felt safe. For example, the interactions and communication with all of the staff were open and warm. People freely approached staff and responded to staff with smiles. Relatives confirmed they felt their loved ones were safe in the hands of staff at The Marshes. One relative told us, "I feel confident that (person) is safe at The Marshes."

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in locked cupboards in their individual bedrooms. One staff member told us, "When giving medicines, there is always two staff present. If the person is in the lounge, we ask them if they are happy taking their medicine there or if they'd like to go to their bedroom for privacy." Once staff had confirmed the medicine had been taken they signed the Medicines Administration Record (MAR) straight away. MAR charts were clear and accurate and reflected that medicines were given in accordance with individual prescriptions. They contained individual information and photographs to support safe administration. Medicines that required storage in accordance with legal requirements had been identified and stored appropriately. Registers of these medicines matched the stock numbers held. Some people were prescribed pain relief on an 'as required basis'. The MAR chart for one person did not consistently record the stock level carried forward from one month to another. This meant the provider had no awareness of how much pain relief they had in stock. Another person had pain relief stocked in their medicine cupboard which was prescribed by their GP; however, this wasn't recorded on their MAR chart. We brought these concerns to the attention of a staff member and the locality manager who confirmed action would be taken immediately.

We recommend that the provider seeks guidance from a national source on the monitoring and documentation of medicines.

Individual medicine profiles were in place to promote the safe management of medicines. Medicine profiles included an overview of the medicine, what it was for, dosage and any side effects. Where people had been prescribed medicines to be taken when required (PRN) clear guidance was available to staff about how and when these should be given. People had regular medicine reviews with relevant professionals to promote good health. Staff had completed training in the safe handling of medicines and the registered manager completed observations of staff practice to ensure they were competent in medicines management.

Staff were recruited safely subject the completion of appropriate checks. This included a requirement for two references and a Disclosure and Barring Service (DBS) check. DBS checks are used to determine that people are suited to working with adults at risk. Staff records contained evidence of an application form, references, DBS check and photographic identification. Documentation reflected that newly appointed staff were monitored and assessed during a probationary period.

There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had

received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place.

There was a sufficient number of staff to meet people's needs in a safe way. Our own observations supported that there were sufficient numbers of staff available. Staffing rotas indicated that enough care staff were deployed during the day, at night time and at weekends. Staffing levels consisted of three staff throughout the day with one staff member at night along with a sleep in member of staff. The locality manager told us, "Staffing levels are based on people's individual needs. If someone's needs increased, we would increase staffing levels to meet their needs and liaise with the funding local authority." One staff member told us, "When people are accessing the community, we also increase staffing levels, to ensure people receive 1:1 care when going out and about." Staff members commented that they felt staffing levels were sufficient.

Regular health and safety checks ensured people's safety was maintained. Checks included infection control and cleaning checks, gas and electrical servicing, hoists and specialist bath servicing and portable appliance testing. All staff had received fire safety training and people had personal emergency evacuation plans. They contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. The risks associated with scalding and burning had been mitigated and risk assessed. Hot water temperatures were checked every morning. High water temperatures (particularly temperatures over 44°C) can create a scalding risk to adults at risk who use care services. People's risk of scalding had been individually assessed and included within their personal care risk assessment. Staff members confirmed people received 1:1 care when having a bath or shower and the water temperature would always be tested in the morning to ensure the risk of scalding was minimised.

Risks to people's health and welfare were identified and managed appropriately in the least restrictive way. Risk assessments considered the identified goal, indicators of success, the associated risks and the steps required to mitigate any potential risks. Associated risks included personal care; mobility, behaviour support and finances. For example one person was identified as being at risk of financial abuse. Their risk assessment identified that they required full support in all aspects of managing their money. Guidance was in place for staff to follow to mitigate the risk of financial abuse. Guidance produced by the Department of Health advises that people living with a learning disability can be at heightened risk of choking. Where people had been identified at risk of choking, nutritional risk assessments were in place which provided guidance on the steps required to mitigate any choking risks. Some people required thickened fluids in their drinks to minimise aspiration and without prompting, staff could consistently tell us the quantity of thickener people required compared to fluid. Where staff identified that people were losing weight, food and fluid charts would be implemented and people's weight would be monitored regularly. One staff member told us, "We used to weigh people every month, however, we were then told, unless there's a need too, it could be seen as institutional weighing people every month." We queried how staff would recognise when people may become at risk of malnutrition. Staff confirmed that they would monitor people and if they felt they were not eating and drinking sufficiently, they would escalate their concerns.

Documentation reflected that people's weight was stable and where concerns had been raised, staff were monitoring weight on a regular basis for specific individuals. Although systems were in place, the provider had not consulted national guidance, such as the Malnutrition Universal Screening Tool (MUST). MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. The MUST tool enables provides to monitor people's risk of malnutrition and acts as a baseline assessment.

We recommend that the provider seeks guidance on the implementation of nationally recognised risk assessment tools and frameworks.

The Marshes provided care and support to those living at high risk of falls. There can be a high prevalence of falls in adults living with a learning disability. Where people had been assessed at high risk of falls, staff worked in partnership with external professionals to mitigate the risk of falls whilst promoting autonomy. For example, specialist adapted shoes had been sourced for one person to help minimise the risk of falls. Specialist guidance from a physiotherapist had been sourced and included within the falls risk assessment and care plan. Staff demonstrated a firm awareness of how support was required to manage the falls, whilst enabling the person to live their life with choice and autonomy. One staff member told us, "We have to monitor one person for risk of falls as they can fall suddenly. However, it's still important that they go out and about and walk about the home freely."

Guidance produced by the epilepsy society advises that epilepsy is more common in people living with a learning disability. Where people had a diagnosis of epilepsy, clear guidance and risk assessments were in place. Guidance included on when medical care should be sought. For example, the risk assessment for one person identified that 999 should be called if the person hadn't recovered after eight minutes of administering their emergency epilepsy medicine. Epileptic seizure monitoring charts were in place along with seizure reports which included documentation on the person's mood before the seizure, activity prior to the seizure, description of the seizure, duration and recovery following the seizure. This demonstrated that the overall management of epilepsy and seizures was safe.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet the needs of the people living at The Marshes. Relatives spoke highly of the service and staff's abilities to meet their loved one's care needs. One relative told us, "They look after (person) extremely well." One staff member told us, "I feel extremely supported here. I get regular supervision and we have staff meetings where we get together and discuss any concerns or queries we may have." Staff received training that was tailored to the needs of people they supported.

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. Training records demonstrated that staff received training on the MCA and staff members told us how they worked within the principles of the act. One staff member told us, "Although people can't verbally communicate, they are still able to provide consent. For example, I always offer people the choice of a bath or shower. One person will stamp their feet which indicates no." Mental capacity assessments had been completed for the decision 'does the individual have the capacity to make decisions about daily living whilst living at The Marshes.' These assessment of capacity included a range of decisions, such as the person's capacity to make decisions around the management of finances, bathing, personal care, when to eat and what to drink. Additional information was provided about each of the individual decisions. Although people's capacity was assessed, the provider was not following the principles of the MCA 2005 Code of Practice. A capacity assessment should be recorded for specific decisions at a specific time. Although an overarching mental capacity assessment was in place which included a range of decisions. Each of these decisions requires an individual mental capacity assessment to determine and evidence why the person lacks capacity and how care will be provided in their best interest.

We recommend that the provider implements the principles of the MCA 2005 Code of Practice.

People can only be deprived of their liberty so that they can 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). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS referrals had been made for everyone living at The Marshes. The registered manager was awaiting further contact regarding the outcome and had been in touch with the Local Authority DoLS team to seek an update.

People received effective support from staff that were skilled in helping them to maximise their independence and increase their quality of life. Staff had completed training in supporting people to meet their individual health needs. All staff members were trained in epilepsy and the administration of emergency medicine. Training also included communication, diet and nutrition, dementia and equality and diversity. Staff spoke highly of the training provided and also confirmed that their competency was assessed through observations.

Staff were aware of their roles and responsibilities and confirmed they felt valued as employees. Upon commencing employment with the provider, new staff were subject to an induction programme. This included shadowing senior care workers for approximately two weeks before they could demonstrate their competence and work on their own. The Care Certificate had been introduced for new staff as part of their induction. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that care homes are expected to uphold. Care staff received one to one supervision sessions on a regular basis to review their performance and development needs.

Staff worked in partnership with external health care professionals to promote good outcomes for people. Relatives also confirmed that they felt confident in staff's abilities to meet their loved one's care, support and health needs. One relative told us, "Oh yes, staff have an excellent understanding of (Person's) needs and how best to meet their needs." People had regular access to GPs, chiropodists, dieticians and Speech and Language Therapists (SALT). Following any appointments, staff members would record an overview of the appointment and any follow up information. Each person had their own health action plan and hospital passports. Hospital passports were specifically designed for people with learning disabilities by the NHS. It includes key information on people's medical background, along with important information staff should know about them. This included information that is important to the individual along with key information on their health and social care needs. Where's people's healthcare needs deteriorated, staff took action. For example, one person was experiencing heightened levels of seizures. Staff supported the person to have a medication review with their GP. Following a change in medication, the person hasn't experienced any subsequent seizures.

People received the support they needed to manage their nutritional intake. Each person had a nutritional care plan which provided guidance on any dietary requirements, such as the need for soft or puree diet. Guidance was also provided on how the person liked their food and drink. For example, one person found having their food cut into small bite size pieces easier to manage. Thought and consideration had gone into how people could be involved in the design of the weekly menu. One staff member told us, "We sit down with everyone and using pictorial cards, design the weekly menu. Everyone points to the pictures of the meals they enjoy and from those we design the weekly menu. We then also work out what allergies there are in each meal and display that, so it's easily accessible to staff." The weekly menu was displayed in pictorial format, so people could know what was available that day. People's independence with eating and drinking was promoted and staff told us how some people were supported to make their own drinks or simple meals. Specialist cutlery and plate guards were also provided to enable independence with eating and drinking. Throughout the inspection, people were offered a wide range of drinks and were empowered to make decisions about what they wished to drink. Where people required support to eat and drink, staff sat down at the table with them, providing support at their own pace.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with people living at The Marshes in a manner which was kind, compassionate and caring. Staff adapted their communication style to meet the needs of each person. People's privacy and dignity was upheld and staff supported people in a manner which promoted their autonomy and freedom. Relatives spoke highly of the caring nature of staff. One relative told us, "Staff are lovely and it's the best place for my loved one."

People were not always able to tell us about their experiences. We observed that people had good relationships with staff members and they were happy and comfortable in their presence. Staff had developed positive relationships with people. With pride, staff spoke to us about people's likes, dislikes and how they supported people. People's likes and preferences were also documented throughout their support plans. For example, even before meeting a person from reading their file we could identify the type of food they liked and their favourite activities when out and about. One staff member told us, "The people are best part of this job. I love interacting with them."

Care was delivered by staff in a patient, friendly and sensitive manner. We observed and listened to interactions between people and staff throughout the duration of our inspection. We saw numerous examples of positive and caring interactions, including mealtimes, staff supporting people in personal care and staff supporting people to attend outside appointments. The home environment was structured to enable people to move freely around. Staff worked in an unobtrusive way but always maintained a watchful and caring eye on people in case they required support.

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People were encouraged to treat the home as their own. People's bedrooms were highly personalised to their own tastes and preferences. For example, people had chosen their own colour schemes and décor. People's likes and hobbies were reflected in the pictures and ornaments they had in their rooms. One staff member told us, "We've recently painted one person's bedroom to reflect their colour choice and preferences."

Guidance produced by the National Institute for Health and Social Care Excellence (NICE) advises that sensory stimulation for those living with a learning disability can promote quality of life. Sensory equipment was available throughout the home and in people's individual bedrooms. This included lights of various colours to help aid a sensory experience. One staff member told us, "We are creating a sensory box in the lounge, which people can use. I've recently added bubble wrap, as one person particularly likes popping it. We also support people to have sensory time in their bedrooms. We put the various lights on which they enjoy."

People had an allocated key worker who was knowledgeable about the person's likes and dislikes. A key worker is a person who co-ordinates all aspects of a person's support and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Key workers told us it was essential there was a bond and respect between the person and their key worker to ensure people

received the best possible support. Keyworkers worked to plan how they were able to achieve more independence. One staff member told us, "Key-working is really helpful; it allows us to build a relationship and support that person as much as possible."

People's right to privacy was respected and upheld. Staff described how they conducted personal care in a private and discreet manner. Staff told us that they knew how people communicated if they wished for a change of environment. Staff were respectful when people wished to have time away from others. One staff member told us, "We recognise that people want private time, so we support them to go to their bedroom and close the door." In a discreet manner, staff supported people to access the toilet on a regular basis throughout the day.

People were able to maintain relationships with those who mattered to them. One staff member told us, "We support people to write letters to their families. Keeping their families updated as to what they've been doing and how they've been getting on." Visiting was not restricted and guests were welcome at any time. Relatives spoke highly of communication within the service. One relative told us, "Staff are very approachable and always keep us updated. Any concerns they phone us immediately."

For people living with a learning disability, communication is vital in ensuring that people can express themselves and make sense of the world around them. People were unable to fully express their needs verbally. Staff demonstrated a good knowledge of how people communicated. One staff member told us, "People's facial expressions, body language and behaviour are a key when communicating with people. One person will come into the kitchen and lean on the counter and that means they want a drink." Another staff member told us, "(Person) is really happy today. Those verbal sounds indicate they are happy." People had individual communication passports. Communication passports are a person-centred booklet for those who cannot easily speak for themselves. These were personalised to the individual and provided information on how to best to communicate with the person. They included detailed information on how the person would present if they were sad, happy or angry and how best to respond. One staff member told us, "We've work hard on the communication passports and sought guidance from the local authority to ensure they were as good as they can be."

People's wishes at the end of their life had been explored and sensitive end of life care plans were in place. These were called, 'What I would like to happen after I die.' Information was provided in a pictorial format and included guidance on whether the person wished to be buried or cremated. Where they would like the service to be held, any songs they would like played and what flowers they would want.

Good

Is the service responsive?

Our findings

People received support that met their needs and was personalised to their individual choices and preferences. Individualised weekly activity planners were in place which demonstrated that people lived meaningful and active lives which met their social, emotional and psychological needs. Relatives spoke highly of the available opportunities for social engagement and stimulation.

People received individualised care which took into account their complex needs. People had been assessed prior to moving into The Marshes to make sure their needs could be met. Following the pre-admission assessment, individualised care plans were devised. The aims of the care plan included for the team to work consistently in their approach, to provide a safe environment and to work towards improving the quality of life for the individual. Care plans included a care needs assessment which provided an overview of the person's needs in pictorial format. This included areas such as general health, personality, communication, mobility and religious needs. Care plans contained good, clear objectives to guide staff on how care and support was to be provided.

People's care plans reflected their backgrounds, history, life style preferences and how they would wish to be supported. When people were unable to express their views consideration had been given to how they responded to their environment and expressed their happiness or distress. Staff had built up a picture of what people enjoyed doing and what they engaged positively with. For example, one person engaged positively with sensory lights and music. Their care plans recognised this providing a clear picture of what worked well for them, such as listening and singing along to music. Care plans also included recommendations from health care professionals about how to maintain their physical wellbeing. Some information had been produced using photographs to illustrate how best to support people using their specialist equipment and how to position them correctly, safely and comfortably.

Staff responded promptly to change in people's care needs. One staff member told us, "One person's care needs have increased and they now require a lot of supervision due to heightened risk of falls. We are liaising with the local authority to organise 1:1 care." Where people's care needs had increased, staff and the registered manager worked in partnership with healthcare professionals and implemented strategies to help them cope with these changes.

One to one meetings were held between people and their key-worker. The purpose of these meetings was to make sure the person's care plan was up to date and any changes were recorded. They also explored how the person was and if they remained happy with the care they received. Actions were also set for their next meeting. For example, one action included sourcing for sensory equipment for one person.

People were engaged in activities that were meaningful to them. Individual weekly activity planners were in place which were personalised to people. A member of staff told us, "The activity planners are based on people's likes and what they enjoy doing. A lot of people enjoy sensory time so we incorporate that into their planners. One person enjoys going out for a drive and to café's. Activities are really personalised here which I think is positive." People were supported to engage with activities that promoted their well-being and

identity. During our inspection, people were supported to go out to the shops. Listen to their favourite music and watch programmes of interest on their iPad. For example, a staff member said to a person, 'would you like to watch a programme about trains.' With permission, we went into one person's bedroom with a member of staff. They were sitting in their chair, listening to music, dancing along. One staff member was heard singing to one person whilst another was engaging with a person using musical equipment. Relatives spoke highly of the activities and opportunities for social engagement. One relative told us, "Last week when I phoned, my loved one was spending the day in Brighton doing various things. For a recent birthday, they also took them up to London to see a musical. They absolutely love music and it was really nice of staff to do that."

Support was in place for people to access the local community. People attended local colleges in the area and on the day of the inspection, three people were on holiday with staff members. Where local clubs/colleges had closed, staff and the registered manager were creative and decided to set up the club in-house. For example, people used to attend a transport club run by the local college. Unfortunately, this club closed and staff felt they could run the club in-house as people enjoyed attended the club. Every Thursday, staff would take people out and about to local transport places, such as railway and bus stations. This enabled people to pursue their individual interests and hobbies.

Staff celebrated and promoted people's strengths and independence. Each person had a 'things I'm good at doing myself care plan.' For example, one person's care plan noted they were good at putting their shoes on and selecting and making their own breakfast. Staff demonstrated a good awareness of the importance of promoting people's independence and independent living skills. One staff member told us, "We try and promote independence as much as possible. For example, I'm supporting one person to be more independent with eating and drinking. We are making good progress." Throughout the inspection, we observed people freely accessing the kitchen, making their own drinks and being actively encouraged to be as independent as possible.

People had individual personal daily outcomes (PDO) folders in place. These daily folders enabled staff to record how people's individual days were. Each person's PDO was individual to them and incorporated their weekly activity planner. For example, each PDO was a timetable of that person's day and what they did each day. Staff spoke highly of the PDO's commenting that they allowed them to evidence in a holistic way a person's day, what they did and whether they enjoyed it.

There were arrangements to listen to and respond to any complaints. Accessible complaints information had been provided for those people able to understand the easy read formats. People's experiences of their care were shared in annual surveys (which were made available in picture format), review of care and feedback from staff and advocates. These provided the registered manager with an overview of any issues or concerns. The Marshes had not received any formal complaints in over a year.

Good

Is the service well-led?

Our findings

The culture at The Marshes was open, relaxed and inclusive. Care was person centred and staff enabled people to make choices and decisions. Staff spoke highly of the leadership style of the registered manager. Comments included, "He's very approachable, always has an open door and is very supportive."

There was a positive culture within the service and the management team provided strong leadership and led by example. A member of staff told us, "The manager started as a care assistant and worked up to manager, which I think staff respect. They are very approachable, hands on and supportive." Staff commented that they felt valued and any suggestions or ideas would be listened to and acted upon. Staff felt the strength of the home was its ability to place the 'residents first'. A member of staff told us, "What do we do well. Well we support people the best we can. They always come first."

The culture and values of the provider were embedded into every day practice. The Marshes belong to the provider Regard. Regard provides care all over England and have several care homes in the local area. The philosophy of the home included 'to offer the people we serve with unconditional positive regard. We value people with disabilities as citizens with equal rights and responsibilities that are thus entitled to be consulted in all matters. We are committed to empowering the individual and supporting self-determination by promoting informed choice.' From our observations, we could see that the philosophy of the home was embedded into practice. People were empowered to make day to day decisions and live their life with choice and autonomy. Staff spoke with pride and compassion when talking about people and how they provide meaningful activities which enhanced people's quality of life. A staff member told us, "What I really enjoy about this job, is the interaction with people."

There were systems in place to review the quality of all aspects of the service. Audits were carried out to monitor areas such as infection control, nutrition, care planning and health and safety. A locality manager completed quarterly monitoring reports which considered areas of care such as fire drills, medication, finances, safeguarding's and complaints. Any outstanding actions would be identified along with a completion date. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the support delivered. For example, we saw that in light of one internal audit, new health and safety folders were introduced.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved, details of the incident/accident, immediate action taken and information on what happened. On a quarterly basis, the locality manager reviewed all incidents and accidents for any emerging trends, themes and patterns. The locality manager told us, "On a quarterly basis, I review incidents and accidents for any trends. For example, if I noticed that a large number of incidents related to behavioural incidents, I would ask our in house behaviour support team to provide input." The registered manager also monitored incidents and accidents for any recurring trends. For example, they identified a number of incidents and accident related to falls, so sought advice from the falls prevention team.

People, their relatives, staff and healthcare professionals were actively involved in developing and

improving the service. Satisfaction surveys titled 'My Opinion' were sent out to people in a picture format. With support from key workers, people's views and opinions on the service were sought. The locality manager told us, "Results are then sent to our head office for analysis. The outcomes then feed into our 'you said, we did' board. Staff feedback was sought via an anonymous survey. The locality manager added, "Results are then analysed by region, as to not identify staff." Results from the recent staff survey in May found that 85% of staff reported that 'residents' motivated them to come to work and 93% of staff felt they had been supported to develop within their role. Analysis of the staff survey identified three areas of improvement which included making staff feel more valued, developing the training provided and managing stress levels. The provider had implemented an action plan which included managers to hold more supervision at an individual and group level.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.

There was an open learning culture within the service. The registered manager welcomed input from other professionals. They recognised the skills and experience of health and social care professionals to support them and the service. They drew on resources from within the provider's organisation, for example, the behaviour support team to improve interaction with people but also external sources such as pharmacists, dieticians and speech and language therapists. Good practice was shared with managers from other Regard homes within the local area. Local managers meetings were held on a regular basis to share ideas, practice and learning. A local Regard newsletter was made available to staff and managers which included updates from the various homes. Systems were also in place to celebrate staff successes. Nominations could be made for staff awards. The locality manager told us, "People, managers and staff can nominate staff for the Regard award and this acts as a forum for us to celebrate staff and their achievements." Regard (provider) had achieved the Investor's in People Gold Award which recognises the standard for people management. The locality manager told us, "We achieved the gold award last year and it was a big achievement. Our CEO also won leader of the year which was a lovely."