# Community Care Matters Limited

# Marlcroft

## Inspection report

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24 September 2018
25 September 2018

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## Ratings

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

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

# Summary of findings

## Overall summary

This announced inspection of Marlcroft took place on 24 September 2018. We made phone calls to family members of people living at the service on 25 September 2018.

We last inspected Marlcroft in March 2016. The service was rated Good. We found during this inspection that the service remained Good.

Marlcroft  is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Marlcroft is a small care home for younger adults. At the time of our inspection there were four people who lived at the home and one person who was accessing the home during the weekends for respite care. The home is registered to provide care to five people.

Risks were well assessed and information was updated as and when required. We were able to view these procedures and how they worked. Staff were able to describe the course of action they would take if they felt anyone was at risk of harm or abuse, which included 'whistleblowing' to external organisations. People were supported to manage their medication by staff who were trained to do so. The registered manager had systems and processes in place to ensure that staff who worked at the service were recruited safely. Rotas showed there was enough staff to support people.

There was a supervision schedule in place, and all staff had received up to date supervisions and most had undergone an annual appraisal. Any that were due had been booked in to take place. All newly appointed staff were enrolled on the Care Certificate. Records showed that all staff training was in date.

We saw that where people could consent to decisions regarding their care and support this had been well documented, and where people lacked capacity, the appropriate best interest processes had been followed. The service was working in accordance with the Mental Capacity and DoLS (Deprivation of Liberty) and associated principles.

Staff were able to give us examples of how they preserved dignity and privacy when providing care. Relatives we spoke with were complimentary about the staff, the registered manager and the service in general. Relatives told us they liked the staff who supported their family member.

The complaints policy contained contact details for the local authorities and commissioning groups. There had been no documented complaints at the service since the last inspection.

Staff we spoke with demonstrated that they knew the people they supported well, and enjoyed the

relationships they had built with people. Care plans contained information about people's likes, dislikes, preferences, backgrounds and personalities.

Action plans were drawn up when areas of improvement were identified. Staff meetings and resident meetings took place. Quality assurance systems were effective and measured service provision. Regular audits were taking place for different aspects of service delivery.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>Service remains Good. | **Good** |
| **Is the service effective?**<br>The service remains Good. | **Good** |
| **Is the service caring?**<br>The service remains Good. | **Good** |
| **Is the service responsive?**<br>The service remains Good. | **Good** |
| **Is the service well-led?**<br>The service remains Good | **Good** |

# Marlcroft

**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 inspection took place on 24 & 25 September 2018 and was announced.

We gave the service 48 hours notice that we would be attending the service due to the service supporting a small number of young adults, who are often out during the day. We wanted to ensure someone would be available to meet with us.

The inspection was conducted by an adult social care inspector.

Before our inspection visit we reviewed the information we held about Marlcroft. This included notifications we had received from the registered provider, about incidents that affect the health, safety and welfare of people who used the service. We also accessed the Provider Information Return (PIR) we received prior to our inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service. We also sought out feedback from the local contracts and commissioning teams. We received one response which was positive.

We used this information to populate our planning tool, which is a document which helps us plan how the inspection should be carried out.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication barriers.

All of the people at the home were unable to share their views of the service with us due to cognitive impairments, however, we did contact three relatives of people who lived a the service for feedback.

Additionally, we spoke with the senior carer, the registered manager, and three support staff. We looked at the care plans for three people and other related records. We checked the recruitment files for two staff. We also looked at other documentation associated to the running of the service.

Good

# Is the service safe?

## Our findings

All of the relatives we spoke with said they felt their family member was safe living at the home. One relative said, "I just know [person] is safe there, it is their home, and they always look so happy." Another relative said, "The home is lovely, [person] is really happy there."

Staff were able to explain the course of action that they would take if they felt someone was being harmed or abused, this was reflected in the organisations safeguarding policy. Staff we spoke with also said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding, and there was information displayed around the communal areas of the home such as the phone number for the local authorities safeguarding team.

Medication was well managed. All staff had received training by a competent person in the administration of medication and additionally received annual updates and competency refreshers. We viewed a sample of MAR (Medication Administration Records) which were completed accurately by staff, and had been audited by the service.

The home was clean and tidy. Procedures were in place to ensure the safe removal of hazardous waste, and bins and toilets were regularly cleaned and checked. PPE (personal protective equipment) was available for all staff, such as gloves and aprons. Repairs and maintenance were carried out in a timely way, and there were regular checks on equipment such as PAT (portable appliance testing) electric and gas. Fire procedures in the event of an evacuation were clearly marked out, and equipment for safely evacuating people was stored securely and safely in the home. PEEPs were in place for each person which were personalised and contained a breakdown of what equipment that person needed to evacuate the home safely.

Risk assessments were in place which detailed what staff must do to keep the person safe from developing pressure sores. For example, one risk assessment stated staff complete 'skin checks, regular continence care and ensure [person] is wearing their fleece booties to prevent friction.' There was a process in place to record, monitor and analyse incidents and accidents, which included an explanation of why the incident occurred and any remedial measures put in place as a result of this.

Good

# Is the service effective?

## Our findings

We asked

Staff confirmed they were required to attend regular training. We viewed the training matrix and checked that the dates recorded matched the dates we saw on staff certificates. Staff were required to complete an induction process which covered shadowing opportunities and training.

Records showed, and staff confirmed that they received regular supervisions from their line manager. Staff who had worked at the service longer than 12 months also had an appraisal.

We checked to see if the service was working within the legal framework of the Mental Capacity Act (2005) (MCA). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This legislation protects and empowers people who may not be able to make their own decisions.

The care files viewed included mental capacity assessments and demonstrated that people were encouraged to make decisions around their daily life and that consent was sought from people and their relatives appropriately.

Relatives  told us that staff responded promptly to health needs and ensured quick access to appointments. The care files we examined showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, and opticians and that referrals were made in a timely manner.

People were supported by staff with their meals. People were supported to choose what they wanted and all specialist diets were adhered to with guidance from speech and language teams (SALT). Most of the people who lived at the home had specialist diets prepared by staff. People had food when they wanted it, and often people were supported to dine in the community.

Good

# Is the service caring?

## Our findings

We received the following comments with regards to the caring nature of the staff. "They are excellent" "Like one big happy family." Another relative said, "The staff really know and understand [relative]. I think I would know if they didn't." "The staff are very friendly and polite, nothing is too much trouble for them."

Staff we spoke with demonstrated a good understanding of how to protect and promote people's dignity. We observed staff discreetly ask people if they required support with personal care needs. We also observed staff knocking on one person's door and asking permission whether they could enter the room. We observed staff asking for consent before providing care to people. We spoke to staff members who provided examples of how they would ensure they respected people's privacy and how they promoted dignity, which included closing doors and windows when they provided personal care to people.

Care plans were either signed by the person's relative if legally allowed to do so, or via a best interest process which involved their family members. Some people we spoke with could not remember whether they had been involved in reviewing their care plans, however, care plans had been signed and dated when they had been subject to review.

People's records and personal information was securely stored in a lockable room which was occupied throughout the duration of our inspection.

The advertisement of local advocacy services in the communal area of the home ensured people could access support if required. There was no one accessing this type of support at the time of our inspection.

Good

# Is the service responsive?

## Our findings

People's support plans reflected that their support was tailored to suite their specific needs. One family member told us, "Since [relative] has lived at the home they come on loads. They do more for themselves now."

We saw support plans specifically written with peoples diverse needs at the forefront of the support. Support plans provided detailed information about people's health, behaviours, communication and the way in which they wanted their support delivered. This information was personalised and an individual personal profile was available which contained information around people's life history, likes, dislikes and personal preferences. For example, one person, who communicated using specific signs and gestures had information in place around their communication preferences so that staff could support them in a way which was right for them.

Additionally, another person who was epileptic, had a specific epilepsy support plan drawn up around their support needs, and how staff would need to offer support to them if they were to have a seizure. This included when to call the emergency services.

Someone else who lived at the home was support every few weeks to visit their family member who lived a long way away. Staff would plan the trip with the person and stay with them for the duration of the visit. This enabled the person to have a close personal relationship with their family member.

There was no one receiving end of life care at the home. However we saw that there was documents which were in place at an organisational level, which would take into account the needs and wishes of people and their families. Additionally, staff had been trained in 'six steps' which was an end of life training programme.

There was a process in place to respond and deal with complaints. This was displayed in the communal areas of the home. People we spoke with told us the process they would follow if they wished to make a complaint. We saw that there had been no complaints raised since our last inspection. The complaints policy contained details of who people should contact if they wished to complain, including the Local Authority and the Local Government Ombudsman.

People were supported to access information in way which was meaningful for them. Each person had a plan in place around accessible information which included any format information would have to be presented in so that the person could understand it. This shows that that the service is taking account people's individual needs.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post at the time of our inspection. 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.

Everyone we spoke with was complimentary about the registered manager. All of the staff we spoke with said that the registered manager was approachable. One relative told us, "The manager is great, they get on with it like everyone else." Another relative said, "I know that they are always on the end of the phone if need something."

Most of the staff had worked at the home and alongside the registered manager for a long time. All of the staff we spoke with said they were well supported by the registered manager.

We saw that team meetings were taking place every month, the last one had taken place in August 2018 and we viewed the minutes of these, as well the previous months. We saw topics such as safeguarding, training and health and safety were discussed.

There were audits for the safety of the building, finances, care plans, medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager. For example, we saw that one audit had identified the need for more information with regards to the MCA, and we saw this had been implemented following the audit.

The registered provider worked well with the Local Authorities and commissioning teams who provided positive feedback about the responsiveness of the registered provider.

There were polices and procedure in place for staff to follow, the staff were aware of these and their roles with regards to these polices.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to the Care Quality Commission as required.  The ratings from the last inspection were clearly displayed in the main part of the building