

Grove Lodge Care Home Limited

Marple Lodge Care Home

Inspection report

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Marple
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Cheshire
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Tel: 01614277248

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13 June 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?

Requires Improvement ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

We carried out an inspection of Marple Lodge Care Home on the 12 and 13 June 2018, the first day of inspection was unannounced.

Marple Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is situated in Marple, Cheshire and is registered to provide accommodation for up to 19 people who require personal care and support. At the time of inspection 17 people were living at the home.

The home was last inspected in November 2016 when it was rated as requires improvement overall and in four domains, safe, effective, responsive and well-led. During that inspection we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, need for consent, good governance and staffing, specifically the lack of training provided.

Following the inspection, the provider sent us an action plan which explained the improvements they intended to make to ensure the home met legal requirements and improved the key questions, safe, effective, responsive and well-led to at least good. This inspection was carried out to check improvements had been made and review the homes rating.

At this inspection we found improvements had been made and the service was meeting all regulatory requirements, although we have made two recommendations in relation to capturing people or their legal representative's involvement in care planning and reviews and the planning and documenting of activities.

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.

Since our last inspection, a new registered manager had commenced working at the home. They had started in November 2017 as acting manager, becoming registered with CQC in April 2018. The registered manager was supported by a deputy manager, who had worked at the home under the previous manager and so provided consistency.

Each person we spoke with told us they felt safe, and enjoyed living at Marple Lodge. Relatives were also complimentary about the standard of care provided. We saw staff had received training in safeguarding, which was refreshed in line with the providers policy and staff spoken with knew how to report concerns. The home had appropriate safeguarding policies and reporting procedures in place and had submitted notifications to the local authority and CQC as required.

We found the home to be clean with detailed cleaning checklists and appropriate infection control processes in place. Staff wore personal protective equipment (PPE) to prevent the spread of infection and toilets and bathrooms contained hand hygiene equipment and guidance.

Both people using the service and staff we spoke with told us enough staff were deployed to meet needs. The home used a system to determine safe staffing levels, which we saw tallied with the rotas. This system was regularly reviewed to ensure it was accurate and reflected the current needs of people living at the home.

We saw medicines were stored, handled and administered safely and effectively. All necessary documentation was in place and had been completed consistently. The home's quality monitoring procedures, had highlighted any gaps or omissions in medicines documentation and steps had been taken to address this. Staff responsible for administering medicines had been trained and had their competency assessed.

Staff spoke positively about the support and training provided. We saw staff had completed an induction programme upon commencing employment and on-going training was provided, both e-learning and classroom based, to ensure skills and knowledge were up to date. Staff also confirmed they received regular supervision and annual appraisals, which along with the completion of quarterly team meetings, meant they were supported in their roles.

We found meal times to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal, providing support to those that required it as per their care plan. Food and fluid charts had been used where people had specific nutritional or hydration needs, with clear guidance in place for staff to follow.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. It was apparent from our observations, staff knew the people they supported and had formed positive relationships. People told us they would feel comfortable raising any issues of concern with staff members.

All staff members we spoke with demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within the principles of the MCA and had followed the correct procedures when making DoLS applications.

We looked at five care files in detail, all of which contained thorough and personalised information about the people who used the service and how they wished to be supported and cared for. Each file contained concise, yet detailed care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. However, we did note people or their relative's involvement in care planning and reviews had not been successfully captured.

We saw a varied activity programme was provided, with people's likes and interests being catered for as much as possible. A record book was in place to capture details of activities completed and who had participated, however we found historically this had not been completed consistently.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis, depending on the area being assessed and covered a wide range of areas including medication, accidents and incidents, infection control and

training.

Meetings had been held with staff members and people living at the home. Relatives opinions on the care provided had been sought via annual quality assurance questionnaires.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People we spoke with told us they felt safe living at Marple Lodge.

Staffing levels were appropriate to meet people's needs.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Is the service effective?

Good ●

The service was effective.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced through care files and the matrix.

Staff reported sufficient and regular training and supervision was provided to enable them to carry out their roles successfully.

The dining experience was positive and we saw nutritional needs were being assessed and provided as per prescription.

People's medical needs were supported and involvement of professionals clearly documented.

Is the service caring?

Good ●

The service was caring.

People living at the home were positive about the care and support provided, telling us that staff were kind, respectful and treated them with dignity.

Staff had a good understanding of the people they cared for and were mindful of the importance of promoting people's

independence.

People's preferences were captured within care files and care was provided in line with their wishes.

Is the service responsive?

Not all aspects of the service were responsive.

Although we were told people and their relatives were involved in discussing their care and completing reviews, involvement had not been captured in people's care files.

Care plans were person-centred and individualised with information about people's likes, dislikes and how they wished to be supported.

People told us they knew how to complain and would feel comfortable doing so. We saw any complaints received had been investigated and outcomes documented.

The home provided a varied choice of activities, although completion of these had not been consistently documented. People and relatives, we spoke with were positive about what was provided and enjoyed taking part.

Requires Improvement 

Is the service well-led?

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service and ensure continuous improvement.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by the registered manager.

Team meetings were held regularly to ensure that all the staff had input into the running of the home and were made aware of all necessary information.

The home sought the views of people and relatives via meetings and quality assurance questionnaires.

Good 

Marple Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 12 and 13 June 2018, the first day was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC) and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Before commencing the inspection, we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality assurance team at Stockport Council.

During the course of the inspection we spoke to the registered manager, deputy manager, director and four care staff. We also spoke to 11 people who lived at the home and two visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included five staff files, five care files in detail and four more to check for key documents, six Medication Administration Record (MAR) charts, supplementary charts, meeting minutes, policies and procedures and audit documentation.

Is the service safe?

Our findings

We checked the progress the provider had made following our inspection in November 2016 when we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not protected people against the risks associated with the safe administration and management of medicines. Specifically, we identified concerns with the completion of documentation, a lack of guidance for staff regarding when and how to administer medicines, including creams and lotions and policies and procedures for the administration of covert medicines had not been adhered to.

At this inspection we found the provider had made improvements to the overall management and oversight of medicines and was meeting all regulatory requirements. Medicines care plans had been introduced which covered any medical issues the person had experienced, all medicines prescribed, what these were for and when they needed to be administered or applied, in the case of lotions and creams.

For people who may require medicines to be administered covertly, which is without their knowledge, we saw best interest meetings had been held and documented, authorisation to administer covertly had been granted by the person's GP and advice sought from the pharmacy on the procedure to follow.

Each person had a medicines cover sheet in place which contained their name, photograph, allergies along with GP and next of kin details. We saw 'as required' (PRN) protocols in place for people who took this type of medicine, such as paracetamol. These provided staff with information about how much to give and when to administer, in case the person couldn't tell them. This ensured medicines had been administered safely and when needed.

We found medicine administration records (MAR's) had generally been completed accurately and consistently. We identified some gaps in signatures on historical records, however these had also been identified by the daily and weekly medicines audits carried out, and action taken to address the omissions.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). At the time of the inspection, nobody was prescribed a controlled drug, however the home had the necessary systems in place to facilitate this if required.

People and their relatives we spoke with said they felt safe as a result of the care and support provided by the home. Comments included, "Safe, absolutely", "I've always felt secure here" and "Very good care here, no concerns about [relatives] safety."

We looked at the home's safeguarding systems and procedures. Local authority guidance for reporting concerns was clearly displayed in the home. The home had a safeguarding file in which each reported incident had been stored separately along with any supporting documentation, such as statements, meeting minutes and outcomes. Staff we spoke with confirmed training in safeguarding had been provided and they knew what to look for and how to report any concerns. One told us, "Yes, we have done training. I would pass any concerns onto the management, who would deal with them."

We saw monthly 'harm logs' had been completed and sent to the local authority and commissioners. These described the date of time of any incidents which had occurred, details of what happened and the action taken. These supplemented the internal incident forms completed by staff and ensured all incidents had been reviewed and steps taken to minimise a reoccurrence.

We looked at four staff files to check if safe recruitment procedures were in place and saw evidence references, Disclosure and Barring Service (DBS) checks and full work histories had been sought for all staff. An audit document was present in each file, which had been used to ensure all necessary recruitment checks had been completed and documentation in place. These checks ensured staff were suitable to work with vulnerable people.

People, their relatives and the staff we spoke with all told us enough staff were deployed to safely meet needs. One person told us, "There's enough staff to look after me." A relative said, "Yes, there is a good number of staff here to care for mum", whilst staff comments included, "We have two on at night, this is manageable, no problems and can always meet needs" and "Staffing here is good, we can 100% meet needs and use very few agency staff, which is good for consistency."

We saw the home used a system for working out the number of staff needed per shift to meet people's needs; these are sometimes called a 'dependency tool'. Each person had a completed dependency assessment in their care file, which determined the amount of support they required throughout the day. This information was added to the tool, to make sure the number of care hours provided by staff, were sufficient to meet the needs of everyone living at the home.

As part of the inspection we checked the systems in place to ensure safe infection control practices were maintained. Bathrooms and toilets contained hand washing guidance, along with liquid soap and paper towels. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons, to minimise the spread of infection. Each area of the home was clean and free from offensive odours. Detailed cleaning schedules had been used, which included which area needed to be cleaned, how often and the equipment required, which had all been colour coded to prevent cross contamination.

We looked at the processes in place to maintain a safe environment for people who used the service, their visitors and staff. We found health and safety checks such as water temperature monitoring and legionella prevention were carried out on a regular basis. Gas and electricity safety certificates were in place and up to date. Hoists, the lift and fire equipment had been serviced within required timeframes with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order.

Care files we viewed contained a range of personalised risk assessments, covering areas such as falls, moving and handling, mobility and personal emergency evacuation plans (PEEP). A PEEP is a document that details peoples' individual support needs to ensure the safety of a person in the event of an emergency evacuation. Each risk assessment included details of how assessed risks would be minimised. Where assessments had indicated a person was at high risk, we saw the necessary referrals had been made to professional services such as falls team or Speech and Language Therapy (SaLT).

Is the service effective?

Our findings

We checked the progress the provider had made following our inspection in November 2016 when we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we identified gaps in staff training records and the provider did not have systems in place to assess the training needs of staff, and a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we noted an absence of mental capacity assessments in people's care records and the correct procedures for gaining consent from people who lacked capacity had not been followed.

At this inspection we found improvements had been made and the provider was now meeting all regulatory requirements.

Staff we spoke with were complimentary about the training provided. One told us, "Training is really good. We do a mixture of e-learning, which we can do at home as well as here to keep up to date and they also get people to come into the home and run sessions." People and relatives, we spoke with felt staff had the necessary skills to provide effective care. Comments included, "Yes, they all seem to know what they are doing, 100%."

The home used a matrix to record and monitor completion of training sessions and when these required refreshing. We found training was either up to date, or plans had been made for staff to complete any outstanding sessions. Training completion was monitored as part of the homes auditing and governance procedures. This helped ensure staff had the necessary skills to carry out their roles safely and effectively. We also saw evidence that the Care Certificate was in place at the home, for those staff with no experience or qualifications in care.

Staff also received support through completion of supervision and annual appraisals. The providers policy indicated supervisions should be person centred, with the frequency and style of meetings determined by each staff member and their supervisor. Staff we spoke with confirmed meetings took place and were happy with the current system and frequency of meetings. The home used a matrix to monitor completion, which showed all staff had completed two supervisions so far this year.

We looked at how the home sought consent from people who lived there. People we spoke with provided mixed views on whether staff asked for their consent, some stated this was done consistently, others said this never occurred. From speaking with staff, it was evident they were mindful about the importance of gaining consent prior to providing care, and told us they always did so. Our observations during inspection showed this was done consistently.

Within the care files we viewed, we noted people deemed to have capacity had signed consent forms in place, which included consenting to care and treatment. For those without capacity, relatives with the legal authority to do so had completed these documents. For all others, the home had liaised with the local authority and it had been agreed for their social worker to review this during reviews as part of best interest

procedures.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Mental capacity assessments had been completed where people were deemed to lack capacity to consent to elements of their care and treatment. Where necessary best interest meetings had been held to make decisions. We noted DoLS applications had been submitted to the local authority for anybody deemed to lack capacity, with a matrix in place to log referrals and outcomes.

We observed the meal time experience on both days of inspection. All but one person sat in the dining area during meal times, the remaining person chose to eat elsewhere, which was accommodated. Tables had been set prior to meal times and appropriate staff resources were allocated to ensure food was served timely. People were encouraged to eat at their own pace, with those requiring assistance to eat or with modified diets in place, provided with these as per their care plan.

People we spoke with told us the meals were good and there was always plenty to eat and drink. Comments included, "The food is very good", "I like the food served" and "You can get snacks if you are hungry between meals."

We saw evidence staff had been responsive to people's changing needs regarding dietary management. One person had been re-referred to Speech and Language Therapy (SaLT) due to being observed coughing when eating. The person had been re-assessed and their diet modified accordingly. We saw guidance in place for staff to follow to ensure they knew the types and consistency of food this person could now eat.

Where necessary people's fluid intake had been monitored, with guidance on how much they needed to consume and action to take if they had not done so, contained in their care file.

People had been weighed weekly or monthly depending on medical recommendations, with a file in place to document these. We saw Malnutrition Universal Scoring Tool (MUST) guidance and monitoring was in place, to assess whether people were at risk of malnutrition or obesity.

We saw the service worked closely with other professionals and agencies to meet people's health and welfare needs. People told us they were supported to access healthcare as required. Comments included, "Yes, they would ask the doctor to see me if needed" and "A doctor would come if I am poorly." Involvement was clearly recorded in care files and individual record books, set up for the GP and district nurses.

We found appropriate systems in place to manage people's pressure care needs. The Norton score was used to monitor people at risk of developing a pressure area and regular checks had been carried out, with body maps used to record any marks or bruises noted. Where necessary pressure relieving equipment, such as special mattresses and cushions had been used to support people at risk of developing a pressure area, along with regular positional changes.

Is the service caring?

Our findings

When asked, all the people we spoke with living at Marple Lodge told us they were happy and content with the care provided by the staff who supported them. Staff were reported to have a caring attitude and be kind and considerate. One person told us, "I am settled here and feel looked after by the staff." Another stated, "Staff are great, fantastic."

Relatives were equally positive about the care provided to their loved ones. Comments included, "Staff care here is very good" and "Staff are very easy to approach, friendly and helpful."

Each person we spoke with felt staff respected their dignity and privacy, for example, by knocking on bedroom doors before entering. One person commented, "Staff definitely show us respect." Staff we spoke with were able to tell us the different ways in which they promoted dignity and privacy and why this was important. One stated, "I make sure doors are closed, curtains are closed and clearly explain what I intend to do. Talking to people and explaining is a massive factor in respecting their privacy and dignity, as they can always refuse."

Staff were also knowledgeable on the importance of promoting independence. One told us, "Let people do what they can for themselves, such as wash themselves and make their own choices." In regard to providing choice, another staff told us, "We offer choices, ask the residents what they want, offer alternatives, such as which of these tops would you like to put on, things like that." People confirmed they were given choice and were listened to by the staff. One told us, "Staff are very friendly, if I have a problem, I would not be afraid to tell them." Another said, "Staff act on things you say to them."

Over the course of the inspection we spent time observing the care provided in all areas of the home. People appeared relaxed and settled and were well-groomed. It was noticeable staff had a good knowledge of the people they supported and people felt comfortable in staff's presence. The reduction in the use of agency staff had ensured greater consistency, which was apparent. Staff we spoke with told us learned about people from spending time chatting and reading through background information in care files. One stated, "We sit and chat to people, get to know them and what they like and don't like. That way we can support them better."

We observed care interactions that were kind, and sensitive. Staff spoke quietly and discreetly to people, to help preserve their dignity. For example, one person required support with personal care after having an accident, staff calmly and quietly encouraged this person to follow them to the bathroom. We observed staff speaking kindly and sensitively with people they were supporting to eat their meal in the dining room and during tea trolley time.

There was a positive culture at the service and people were provided care that was sensitive to their needs and non-discriminatory. Staff were mindful of the importance of catering for people's diverse needs, whether these be sexual, spiritual or cultural. Care files contained sections which captured people's needs, wishes, religious and cultural beliefs or requests. At the time of inspection nobody living at the home had

any specific requirements, however staff told us these would be catered for.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. We saw people had communication care plans which explained the most effective ways to support the person to communicate. For those who were unable to communicate verbally, this included reference to facial expressions used to communicate needs and wishes. The service also used picture cards, which people could refer to when being offered a choice or asked questions in order to communicate their preference.

Is the service responsive?

Our findings

People using the service who we spoke with could not recall being involved in planning their care, nor could remember looking at their care files. Comments included, "Care plans, no idea, they have not asked for my views and opinions" and "Me put forward my own views, this has never occurred." Relatives told us staff kept them informed of any changes or reviews of care, but could also not recall being shown or asked to read the care plan.

The registered manager told us where possible, care plans had been discussed with people and their relatives, however we could find no documentary evidence to support this. In each of the nine care files we viewed, we found no records to indicate people or their legal representative, had read the care plans and signed to confirm they agreed to these being put in place. We noted monthly reviews of each care plan had been completed by staff members, with a tracker used to monitor completion and ensure these had been carried out timely. However, the review documentation did not indicate that people or their representative had been involved in this process either.

We recommend the provider develops a robust system for capturing people or their legal representative's involvement in the care planning and review process.

We saw pre-admission assessments had been completed for all people living at the home. These captured key information about the person including past and present medical information, areas of need and support required, which ensured staff had an understanding of the person's needs prior to moving in and assisted with the initial writing of the care plan.

Each person had 13 care plans contained within their care file, these covered a range of areas including health and hygiene, safety and wellbeing, independence and choice and night time arrangements. At the front of each person's file, we saw a spider diagram had been included, this had the person's picture in the middle, with lines leading off containing a brief overview of their needs and support required in each care plan area. This provided a quick reference guide for staff on how to support each person. The care plans themselves were concise yet clearly detailed the care and support each person wanted to receive.

We saw a range of person centred information within each care file. For example, people's sleep preferences had been sought and clearly recorded, this included how many pillows they preferred, if they liked a lamp on or off, curtains opened or closed and a duvet or sheets. Each person also had a 'this is me' document within their care file. These provided staff with information about the person's background, life history, interests along with routines important to the person. This ensured staff had the necessary information to provide person centred care.

Each person had a keyworker allocated to them, who was responsible for ensuring the person's room was clean and tidy, their personal care needs met, including ensuring they had enough toiletries. We saw a keyworker file had been set up to support this process. This included monitoring charts for areas such as toileting, showering and bedroom tidies. Each person also had a personal care chart present, which

indicated whether their bedding had been changed, oral hygiene carried out and they had had a shower or full body wash each day of the week.

None of the people we spoke with or their relatives had made any complaints about their care, but told us if they had a problem they would speak to a member of staff. Comments included, "I could talk to the manager if I am unhappy" and "Know how to complain, it's no good sitting back and doing nothing."

The complaints procedure was clearly on display within the home and also contained within the service user guide, which was given to all people upon admission. The home had a complaints file in place, in which any complaints received would be logged, along with action taken. We noted only two formal complaints had been made since our last inspection in November 2016 and none within the last nine months.

The home displayed thank-you cards and notes on noticeboards within the home, as well as storing these in a designated thank-you's and compliments file. Examples of recent communication received from relatives included, 'Thank you so much, you have all been so professional, helpful and caring' and 'Many thanks for the care and kindness shown to [person's name].'

We asked people living at the home, how they spent their time and if enough activities were provided to keep them occupied. Responses received included, "Relax, watch TV, read newspaper, play bingo, do quiz games, sit in the garden, go on outings." A relative told us, "Staff arrange entertainment for the residents. Last week animals were brought in and they often have musical sessions."

During the course of the inspection we observed a movement to music session, and a music and singing session being completed by staff in one of the lounges, which people were encouraged to attend. The home had an activities book, in which they recorded what activities had been completed and how many people had participated. So far in June 2018 people had participated in board games, ball games, art and craft, outdoor fun in the garden, watched films and had animals visit the home. However, we did note that prior to the end of May 2018, the book had not been completed consistently, with a number of gaps noted. This meant it was not possible to confirm activities had been offered each day. We also did not see any posters or activity schedules on display, which let people know what was available or planned for each day.

We recommend the provider reviews the scheduling and documenting of activity completion within the home.

At the time of the inspection nobody using the service was in receipt of end of life care, however the staff members we spoke with told us they had received training in this area. One told us, "Yes, we do training in this. District nurses and the GP will support this process if residents choose to remain here." People's care files contained death and dying wishes sections, which captured their wishes where they had been willing to discuss and share these with the staff. Where this had been declined, this was recorded, for example, 'my family will make the arrangements when the time comes'.

Is the service well-led?

Our findings

We checked the progress the provider had made following our inspection in November 2016 when we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems to monitor the safety and quality of the service to ensure compliance with the regulations required improvement, as we had identified continued breaches in the regulations.

At this inspection we found the provider was meeting all regulatory requirements.

Since the last inspection, a new registered manager had commenced working at the home. They had been in post since November 2017 with their registration being completed in April 2018. The registered manager was also responsible for another home owned by the provider and shared their time between the two services. In order to ensure consistency, we saw a deputy manager was in place at Marple Lodge, who was responsible for the day to day running of the home. We asked the registered manager about oversight of the home. They told us, "I have a deputy and good senior carers. I either call in in the morning and spend time here or do so on my way past in the evening to check on things. I am also always available by phone if anyone needs me."

Staff we spoke with confirmed the registered manager was a regular presence in the home, and accessible should they need any advice or support. One told us, "[Registered manager's name] is here at least three times a week, though the deputy is here all the time. [Registered manager's name] is always available if I need them. If they are not actually in the home, I can ring."

Staff also told us they felt the management structure worked well and offered them the support they required. Comments included, "I feel very much supported, any problems at all I can go to [Registered manager's name] or [deputy's name] and they will sort it out" and "The management works well how it is, it's a much better set up than it used to be before [Registered manager's name] came here. I feel we are now better supported."

During conversations with the registered manager they told us about their aims and plans for the home, both since taking over responsibility in November and moving forwards. They had identified some issues with documentation, gaps in auditing and quality monitoring and that meetings had not been completed consistently. They had been working hard with the support of the deputy and staff to address these. We also saw the home had been supported by the quality assurance team from Stockport Council, who had completed a number of visits to the home and provided action plans relating to areas for improvement. We noted the home had been proactive in addressing the areas listed on the action plans and had clearly made good progress.

We saw a range of audits had been carried out on the 15th of each month, covering areas such as falls, accidents and incidents, care plans and the nurse call system. We noted additional audits completed throughout the month looked at food and fluid monitoring, weight management training, maintenance and staff files. Audits included details of issues noted and action taken.

On a daily basis the home completed daily risk assessments, safety and cleanliness checks, which ensured the environment was safe, clean, tidy and free from clutter. Fire doors, fire alarms, escape routes and the key safe were checked as part of this process.

We looked at what meetings had been held within the home. The registered manager had introduced quarterly staff meetings, with two being held so far in 2018. Staff we spoke with told us they were happy with the frequency of meetings, found them useful and had the opportunity to contribute to the agenda.

The registered manager told us historically resident and relative meetings had not been completed, which was an area they had wanted to address. We saw one meeting had been held so far this year, in April, with another scheduled for July. We noted there had been a lack of interest in the meetings, with only one person attending to date. This was an area the registered manager stated they wanted to improve upon, and was looking at ways to better promote the meetings. People we spoke with could not remember if meetings had been held, however a relative told us, "One meeting has taken place in the last 3 months".

We saw annual questionnaires had continued to be circulated to relatives, to capture their views on the care and support provided to their loved ones and ask for recommendations. The questionnaires, which had been sent out in April 2018, consisted of nine questions, which included whether anything needed changing, how would they rate the care provided, if they had been provided with enough information, had comments or complaints been listened to and were their relatives offered choice. All responses had been positive, with relatives speaking highly of the care provided. One commented, "The girls are lovely and very caring."

We noted positive examples of partnership working during the inspection, including the home's involvement in a research project. This was being run by the Ageing and Dementia Research Centre at Bournemouth University and looked at 'The impact of improving the delivery of nutritional care for people with dementia living in care homes.' The aim of the project was to produce a new shortened version of the workbook 'Eating and Drinking Well: Supporting People Living with Dementia'. Staff had been invited to take part in interviews, discussion and focus groups at the start and end of the project, which ran for eight weeks. The project also involved reviewing nutritional screening procedures, the dining environment and mealtime experience within the home and completion of activities linked to meal times, such as helping set tables, folding napkins and food based reminiscence.

We saw the home's policies and procedures were provided by an external organisation and had been modified by the registered manager, to ensure suitability to the home. The home received updated policies, whenever changes to legislation or working practices, occurred, to ensure they had the most up to date information available and staff were adhering to best practice.