Fidelity Healthcare Limited

Marlborough Lodge

Inspection report

83-84 London Road
Marlborough
Wiltshire
SN8 2AN

Tel: 01672512288

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 22 and 23 October 2018.

Marlborough Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 can accommodate up to 18 people. Accommodation is provided in one adapted building over two floors. Not all the rooms have en-suite facilities, there are communal bathrooms and toilets available. There was a small garden area at the back of the property.

At our last inspection in August 2017 we found one breach of the Regulations because the environment was a risk to people's safety. In addition, we were concerned about the way in which the service recorded people's food and fluids. At this inspection we found the improvement to the environment had taken place and fluid charts were also recording totals of fluid consumed. However, we have found concerns in other areas and have made two recommendations.

There was a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had also employed an additional home manager who was in the process of registering for this service. For the purposes of this report we will refer to them as the home manager.

People were not always able to have the help and support they needed, when they needed it because they had to wait for staff. This had an impact on mealtimes. Whilst people had sufficient food and drink, they did not have the support to eat at the time they needed it. People had to wait for staff to be available before they could have their meal.

Staff were not always trained and supported effectively. New staff received an induction but it was not robust and did not follow the industry standard. Staff did not have sufficient opportunity for supervision to enable them to feel supported.

The provider had adapted the conservatory to become an office which had removed a communal room. This meant people had less space to use to seek a quieter room or talk to relatives in private. The premises lacked orientation signage to help people move around the building.

The service overall was clean and well maintained. There were no unpleasant odours. Staff followed good infection prevention and control practice guidelines. The premises and equipment were maintained and serviced when required.

People's needs were assessed and where needed referrals were made to visiting healthcare professionals. Records demonstrated that people had access to services such as GP's, physiotherapists, speech and language therapists and community nurses.

People had the opportunity to record their wishes for end of life care, this information was in people's care plans. Where the service had provided end of life care the staff had worked with healthcare professionals to make sure people were as comfortable as possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were aware of the principles of the Mental Capacity Act (2005) and how they applied this to their day to day practice.

Medicines were managed safely. We observed staff administering medicines and found their practice to be safe. Medicines were stored safely and people had their medicines reviewed by their GP.

Accidents and incidents had been recorded in detail and action taken to minimise the risk of reoccurrence. All accidents and incidents had been reviewed by the registered manager to look for trends.

Risks had been identified and safety measures put in place to keep people safe from harm. All risk assessments were reviewed regularly. Care and support plans contained sufficient detail to support the staff to deliver personalised care.

Staff were recruited safely as the required pre-employment checks had been completed. Staff understood the different types of abuse and how to report any concerns.

Complaints were managed and records demonstrated the actions taken. Quality assurance systems were in place but were not robust.

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.

Staffing levels required a review at peak times.

People were protected from harm by staff who had been trained to recognise abuse. Safe recruitment procedures were followed.

The environment was clean and well maintained. Staff followed good infection prevention and control practice.

Medicines were managed safely.

Risks had been identified and risk management plans were in place to give staff guidance to follow.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always trained and supported to care for people effectively.

There was sufficient food and drink however there was not always the support available for people to eat their meal.

People's health care needs were met by visiting healthcare professionals.

The service worked within the principles of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People had their privacy and dignity promoted by a team of staff who knew them well.

Confidentiality was promoted at the service; personal information was kept secure.

People and their relatives told us they thought the staff were kind and caring.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and reviewed regularly. This meant that staff understood people's preferences.

Complaints were managed in line with the provider's policy.

There was activity provided and plans were in place to improve provision.

Is the service well-led?

Good

The service was well-led.

Staff we spoke with did not know the provider's values.

Quality assurance systems were in place but were not robust.

People liked the management at the service and felt listened to.

The management team role modelled good practice.

Marlborough Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 October 2018 and was unannounced. On day one the inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two the inspection team consisted of one inspector and an assistant inspector.

Before the inspection, we asked the provider to complete a Provider Information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information we held about the service and notifications we had received. This included statutory notifications from the provider that they are required to send us by law about events that occur at the home such as deaths, accidents/incidents and safeguarding alerts.

During the inspection, we spoke to three people who could speak to us, for other people who had difficulties communicating we observed their care and support, their interactions with staff and we asked for feedback about the service from four relatives. We spoke with the registered manager, the home manager and seven members of staff. We also spoke with one healthcare professional.

We looked at a range of records during our inspection. This included four care plans, three staff files, training records, meeting minutes and other records relating to the management of the service. Following our inspection, we contacted five healthcare professionals for their feedback.

Good

Is the service safe?

Our findings

At our last inspection we found a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014. This was because the provider had not ensured the communal lounge was safe during refurbishment. We also found other concerns with the environment that could impact on people's safety. At this inspection we found that the work had been completed in the lounge. In addition, action had been taken to address the shortfalls in the environment to make sure it was safe.

The service overall was clean and there were no odours present. There were cleaning schedules in place which ensured all areas were cleaned. We noticed that some of the chairs in the lounge required cleaning. We raised this with the registered manager who told us they would address this. The kitchen had recently been inspected by the local authority and had achieved a rating of '5'. This meant the kitchen had very good hygiene standards. We observed staff wearing personal protective equipment such as gloves and aprons and we saw it was available throughout the service. Staff had been trained in basic food hygiene and carried out safety tasks such as monitoring fridge and freezer temperatures. These were recorded and we saw they were all in a safe range. We observed that staff probed food prior to serving so they could check the temperature was within a safe range.

At our last inspection there was carpet that could be a hazard to people due to its poor condition. At this inspection we found the provider had replaced all the worn carpet with new flooring. Furniture had been moved out of hallways to ensure there was adequate space for people to move around the service. Communal bathrooms and toilets were free from equipment and clutter which made them safe and more inviting to use.

External contractors visited the service to regularly service equipment such as hoists, fire equipment and electrical equipment. Fire checks were carried out and included a check on emergency lighting, fire alarms and fire extinguishers. There was a fire risk assessment in place which had been reviewed. There were also detailed risk assessments for the environment. These were also kept under review and updated where necessary.

Staffing levels were provided depending on people's needs. The registered manager told us they used a dependency tool and had sufficient staff on duty. People's views on staffing availability was mixed. Comments included, "I try not to ask too much of them, they're very busy", "Help can be a long time coming" and "Never have to call them [staff] as they are always here." We saw at times that there were not always enough staff to meet people's needs. This was noticeable during a mealtime service. Staff told us at times there was not enough of them to meet people's needs. They told us at weekends when there was no management available to help it was a concern for them. There had also been occasions at a weekend when staff had called in at short notice unable to work. When no cover for them could be found it left the service short of staff.

We discussed this with the registered manager who told us that staff calling at short notice to say they were unable to work had been an issue. They were addressing this through their absence management policy and

were sure this would improve absence management. A number of staff had left the service over the last 12 months which had impacted on staff available. The registered manager had plans in place to recruit staff to cover shifts at short notice.

People and their relatives told us they felt safe at Marlborough Lodge. Comments included, "Most definitely, 100% safe", "What we see here, it's good" and "No issues here."

Medicines were managed safely. People were receiving their medicines as prescribed by staff who were trained. People told us they got their medicines on time. Medicines Administration Records (MAR) were printed and contained the necessary information such as the person's date of birth and if the person had any allergies. There were no gaps on the MAR charts seen. Records of the position of transdermal patches were recorded on body maps. The position of patches should be rotated so the same section of skin is not being used repeatedly. We saw that staff followed this practice which reduced the risk of people's skin becoming irritated.

The new home manager had reviewed the process of how the service managed topical creams. People's creams were recorded on a body map which had been high-lighted to guide staff on where on the body to apply creams. Staff then signed a separate MAR for all the topical creams they applied. We did see some gaps in the MAR for creams. We checked people's daily records and saw that creams had been applied. We raised this with the new home manager who told us this process was still new for staff. They told us gaps were identified in the MAR and a process is in place to make sure there are no omissions.

Medicines were stored safely and the temperature of the rooms where they were stored was checked daily. People had their medicines reviewed by their GP. Where people had been prescribed 'as required' (PRN) medicines there was a PRN protocol in place. These gave staff guidance on when this type of medicine should be administered. There were suitable arrangements in place to order and dispose of medicines.

Recruitment checks were in place for all staff. The staff files we checked contained pre-employment checks including references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with adults at risk. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with people.

Staff we spoke with understood their responsibility in relation to protecting people from abuse. All the staff we spoke with knew the different types of abuse and were aware of the term whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Staff knew who they could report concerns to outside of the organisation. One staff member said, "I can report concerns to the police or the CQC if I needed to."

Records seen indicated that accidents and incidents were reported, recorded and reviewed. There was evidence that action was taken in response to accidents and incidents. The registered manager reviewed each accident and incident and analysed the information. They looked for patterns and trends to identify if there was any learning to be gained. Where people had fallen the registered manager reviewed the environment to identify if there were any hazards that could be removed or rearranged. They told us they 'mapped' falls monthly to analyse how they happened and what could be learned.

Risks to people had been identified and assessed. The management team at the service completed all the risk assessments and care plans. People had individual risk assessments for areas such as developing pressure ulcers and moving and handling. Where risks had been identified there were plans in place to

reduce the risks. Where people had been assessed as needing equipment such as hoists for transfers, this had been recorded. People had their own slings and we observed staff used this equipment safely.

At our last inspection we found that food and fluid charts had not been completed in enough detail to monitor people's intake. At this inspection there was one person who had been assessed as being at risk of dehydration and they were having their fluid intake monitored. Improvements had been made to the fluid monitoring, we saw the person had a daily target amount of fluid. Fluids offered were recorded and the daily amount totalled. This was shared with the person's GP weekly.

Where people had behaviour that required additional support this was recorded in their care plan. The service kept the support given under review and involved the local dementia specialist team. Behaviour support plans were evaluated to make sure the staff were providing a consistent approach. For example, one person who was new to the service had a behaviour support plan in place. The registered manager added details to this during our inspection following a healthcare professional visit. They explained they were still getting to know this person, what their likes and dislikes were and how best to support them. Their support plan was a work in progress as the relationship with the person developed. One healthcare professional told us, "Both managers understand the importance of using support strategies for anxious or distressed residents."

Requires Improvement

Is the service effective?

Our findings

For people who required full support from staff to eat there was, at times, a delay with receiving their meal. This was due to the staffing arrangements. For example, on our first day of inspection, one person had their meal in front of them for 45 minutes. It had a cover on it but it was sat on the table. Other people around them were eating their meal and staff were supporting other people to eat. On day two of our inspection another person waited one hour for their meal. People around them had their meal at 12.30pm, they had theirs at 1.30pm. This was because they needed full support from staff who were busy supporting others to eat.

The cook asked people if they enjoyed their meal or if they wanted more to eat. They finished their shift at 1.30pm which was before lunch was finished. After 1.30pm if anyone required something different or additional food the care staff would have to prepare it. Desserts were pre-prepared and left for care staff to serve. In the evenings whilst the cook had prepared the evening meal the care staff were expected to heat it up and serve. This was often a simple meal of soup, sandwiches and a lighter hot choice. However, it still required care staff to alternate from their caring role to a kitchen assistant role over the meal time service. This reduced the amount of staff available to support people to eat. One member of staff told us this meant some days it could be "hectic" and "feel like it is understaffed." Following our inspection the registered manager told us they had employed a cook to work in the kitchen during the evening. This would help the support available during the evening mealtime.

There was sufficient food and drinks provided. Comments about the quality of the food from people and their relatives were positive. They included, "The food is good", "I would sit and eat it myself it looks appetising", "The food looks good and people eat it well" and "The food is home cooked and looks good." People had a choice of meals every day and were offered hot and cold drinks regularly. People could eat where they wished, most people chose to eat in the dining room or the lounge.

The environment at meal times was busy, there was music playing from the TV. On day one of our inspection a DVD had been playing prior to the mealtime and had come to an end. The intro for the DVD played on a loop throughout the mealtime which was repetitive. Members of staff did not notice or address this. On day two a member of staff put some music on over the mealtime. They didn't ask anyone what music they wanted, they just selected a channel on the radio and played it.

Staff had received training in areas such as moving and handling, dementia and equality and diversity. Most training was provided online via e-learning programmes. Some training was provided to staff in classroom style sessions such as first aid and manual handling. Staff views about training was mixed. Some staff told us they had received lots of training and felt able to carry out their role effectively. Some staff did not feel they had been given sufficient training to support them to feel competent.

We observed a member of staff supporting a person to eat their meal. Whilst they were sat down supporting them to eat, they did not communicate with the person at all throughout the experience. They did not tell the person what was on the utensil, they did not make sure the person was comfortable and check they

were enjoying their meal. We asked the member of staff if they had received training to support people to eat, they told us they had not.

Not all staff received supervision sessions with their line manager. Supervision is a process where staff can meet with their supervisor on a one to one basis to discuss concerns, training and development needs. Records demonstrated that over half of the staff team had not yet received supervision in 2018. The registered manager told us they provided staff with two supervisions per year and one appraisal meeting. An appraisal is where a member of staff meets with their supervisor or manager to review their performance for the previous year. It also gives the member of staff the opportunity to identify any development opportunities for the next 12 months. The new home manager recognised that supervision had fallen behind what the service would like to provide. They had started trying to catch up with supervision sessions, we saw that six had taken place since they commenced their role in August 2018.

The service was not using the Care Certificate for its induction. The Care Certificate is a set of 15 standards that care workers are expected to complete to make sure they can demonstrate the right skills, values, knowledge and behaviours to provide quality care. We discussed with the registered manager their decision to stop using this as part of the staff induction. They told us they had been using the Care Certificate but had found staff had left following completion. The registered manager told us they did not want to invest time doing the Care Certificate with staff who may leave Marlborough Lodge. They told us they encouraged staff to complete a health and social care diploma once they had completed their six-month probation. The health and social care diplomas had similar standards to the Care Certificate.

In place of the Care Certificate the service used their own induction. Where providers are not using the Care Certificate for their induction we expect the provider induction to meet the national standards of good practice. The induction consisted of a tour of the building, being shown policies and procedures and online training. We were not able to see any record of observations of practice, or feedback for new staff to support their learning. The registered manager told us they aimed for new staff to receive a supervision after three months of working at Marlborough Lodge. This was not effective when supporting new members of staff, particularly staff new to the sector.

We recommend the provider seeks advice and guidance about providing a comprehensive induction that meets the industry standard.

The design and layout of the environment was not always appropriate to people's needs. The provider had recently reduced the communal space at the service by changing a conservatory into a staff office. This meant that there was only one lounge and dining area for everyone at the home to use. People all had their own rooms which did give them private space, however there was no quiet space for people to sit. The lounge/dining area was a busy space. The TV or radio was always on, there was noise from the kitchen, staff were constantly moving through the area and some people were calling out. This could be a sensory overload for some people living with dementia. Some people would benefit from a quieter space where their senses are not overloaded with noise and activity. We discussed this with the registered manager who told us they had made the change because nobody was using the conservatory.

One room had been divided into two rooms. The provider told us they planned to use one part of this room for staff to sleep in. We were concerned about the impact this may have on the person living in the other part. There was a door separating the rooms and the person could lock the door if they wished. We found that the door could be opened from the staff sleep in room side which meant the person could not be assured of privacy. The staff sleep in room was not in use during our inspection. We discussed this with the registered manager who assured us that as the room had external access there would be no reason for staff

to go into the person's room. They told us they would monitor the situation once the room was in use.

People's needs were assessed before they moved into the service. The registered manager or the new home manager would visit the person and complete a full assessment. They told us that people and their families were encouraged to visit the service to look around. This helped people and their families to see if it would be an appropriate environment for them before making any decisions.

The local GP visited every week to assess and monitor people's health. This enabled health issues to be discussed at an early opportunity. People could see healthcare professionals when needed as referrals were timely. We could see in people's records that professionals such as community nurses, physiotherapists and the mental health team had visited people. During our inspection we were able to speak to a healthcare professional who told us they always received timely referrals from the service. They told us the referrals were appropriate.

People's weights were checked regularly and if there were any concerns about weight loss or gain advice was sought from the GP and the speech and language therapists (SALT) team. The cook told us that if people were at risk of malnutrition they would provide a fortified diet. This is a diet with additional calories added to try and support weight gain.

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. Mental capacity assessments had been completed and there was evidence of best interest's meetings. Staff we spoke with had an understanding of the MCA and could tell us how it related to their work.

People can only be deprived of their liberty so that they 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 are called the Deprivation of Liberty Safeguards (DoLS). The service had applied to the local authority for DoLS authorisations and were waiting for the local authority to assess the individuals. No DoLS authorisations had been approved at the time of our inspection.

Good

Is the service caring?

Our findings

There was a relaxed and homely atmosphere at Marlborough Lodge. Comments included, "It is homely, I like it", "There is a friendly, homely atmosphere here at Marlborough Lodge", We observed that people were relaxed around staff and looked comfortable asking them for help and assistance. Staff treated people with kindness and respect. We observed staff used people's names, they asked people how they were and responded with kindness. Staff used appropriate touch to respond, for example, we observed staff hold people's hands and gently stroke people on the arm.

People and their relatives told us they thought the staff were kind and caring. One person told us, "The staff are delightful, everyone is very kind." Another person said, "The staff are friendly, and treat me with respect." One relative told us, "The staff are very attentive towards [relative]'s needs, they are all lovely." Whilst there had been a number of staff leave, people and their relatives believed there had been a "continuity of care" at Marlborough Lodge.

There were life stories in place which gave staff good information about people's lives and important events. This helped staff to understand what was important to people based on their preferences and experiences. One healthcare professional told us, "The staff know their residents well and take the trouble to find out their history which they relay to me."

Staff tried different ways to communicate with people, they made sure they were on the person's level, they spoke clearly and to the person's face, they used gestures such as 'thumbs up' and we saw staff smiling at people. Overall staff knew people well and could respond to their needs. This was noticeable for people living with dementia who were not always able to communicate their needs. Staff knew the people which enabled them to communicate effectively. For example, for one person who was finding it difficult to communicate, a member of staff made sure they had their doll. The person responded well to the staff giving them their doll and was comforted by having it by them.

People could make choices about their care and support. Staff told us people could choose when they got up in the morning and when they went to bed. We observed staff supporting people to choose where they sat in the lounge and where to eat their meal. The home manager told us they had held a 'residents and relatives' meeting within the last two months. They said it was well attended and planned to use that forum to support people to be involved in the service as much as possible.

People's privacy and dignity was mostly respected. People received personal care in private. We observed staff making sure that doors of rooms were closed when they were supporting people with their personal care. Staff we spoke to told us they made sure people were always covered with a towel if they were having a wash, so they never felt exposed. One relative told us, "I wouldn't leave [relative] here if I didn't think [relative] wasn't treated with dignity, [relative] is my priority." We did however, observe two staff supporting a person to transfer using a hoist. The person was wearing a skirt and no attempt was made to make sure the person's dignity was maintained. We saw another occasion where a person was supported to see a community nurse. The staff made sure a screen was in place to ensure the person had privacy. We discussed

our observation with the registered manager who said it was not always possible to use the privacy screen due to space. They told us they would ensure a blanket was used to protect people's dignity when using a hoist.

Independence was promoted throughout the service with people being encouraged to maintain their skills. The registered manager told us about one person who had made a recovery from a hip operation. Due to the staff encouraging mobility and following professional guidance the person was now walking short distances.

People could personalise their rooms if they wished. People had been encouraged to bring in their own items of small furniture, decorative accessories and pictures of their family and people who were important to them. Whilst there were no restrictions on people receiving visitors, the service had recently introduced 'restricted meal times'. The new home manager informed us this was not a restriction on people being able to have visitors as visitors were still welcome.

Confidentiality was respected throughout the service. Confidential records were stored in the office which was only accessed by staff. Information was available around the service on how to access local advocate services. Advocates are independent people who can speak for a person when they are no longer able to communicate their needs.

Good

Is the service responsive?

Our findings

Before moving into the service each person was assessed and an individual care plan was produced for people's needs. Care plans were detailed and gave staff guidance on a range of support required. All care plans were kept up to date and reviewed regularly by management. People had a 'one-page profile' which was a summary of their needs and what was important to them. This gave staff detailed information on one page that could be read easily.

Staff recorded care and support provided in 'daily records'. These were completed for all support provided. Whilst there was detail recorded on how needs were met the records were task focused. This meant there was not much detail on how people were feeling during a day, or how their emotional needs had been met. We discussed this with the registered manager and new home manager. They told us they had already identified this and were planning training sessions to support the staff with their record keeping skills. Staff received a handover at the start of their shift. This gave them up to date information about each person so they would know what their current needs were.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's communication needs were recorded in their care plans. If people needed additional support this was high-lighted and provided by staff. The service used pictures to involve people at the service as much as possible. The kitchen had produced pictorial menus which supported people to make a choice of meal. The registered manager told us they could provide information in different formats if needed such as large font.

People had the opportunity to record their end of life wishes. If people wished they could remain at the home until the end of their lives. We saw that people had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNARs) orders in place. This was at the front of people's care plans so visiting professionals would be clear of their wishes. The service worked with healthcare professionals to make sure people had good pain management and the equipment they needed.

There was a 'resident of the day' board which was on the wall in the dining room. 'Resident of the day' was a process which identified one person each day to have their care and support reviewed. All heads of department visited the 'resident of the day' to review the information they held about them. The person's room was checked and had a deep clean.

The service had a complaints procedure and policy in place. Since our last inspection there had been one complaint which had been dealt with appropriately. One relative told us, "I have every confidence that they [management] would handle all my concerns." There was a suggestions and complaints box in the foyer where people could leave a card with their views. This could be done anonymously if people, families, professionals or staff wished.

Activities were being provided by staff. One member of staff was doing a joint role of care worker and activity

co-ordinator. There was an activity plan which for the week of our inspection, recorded that there would be one identified activity per day. We saw that the activities advertised included nail care, armchair exercises and skittles. The home manager told us that there were more activities available but it was an area they were reviewing. During our inspection we saw that people watched a DVD, listened to music and enjoyed painting sessions. We also saw a game being played with balloons. The local library visited regularly and delivered a range of books for people to enjoy.

Staff had received training on equality and diversity and told us they treated people as individuals. People were supported to participate in religious activities that were important to them. The registered manager told us they organised for local clergy to visit to hold communion if people wanted this. The service also supported people to celebrate national festivals if they wished.

Good

Is the service well-led?

Our findings

Quality assurance systems were in place and covered a range of areas. The new home manager had identified some areas that required improvement, such as supervision for members of staff. They also told us they planned to introduce observations of practice. They hoped this would support staff and capture people's responses to the care provided. Some people living at the service were not able to provide verbal feedback about the service easily. The home manager recognised that the care and support could be improved by observing interactions between people and staff. However, quality monitoring had not identified the effectiveness of the provider's induction or the quality of the mealtime.

We recommend the provider seeks advice and guidance about quality monitoring systems that are robust to cover all areas of the service.

There was a registered manager in place who was the provider. The provider had employed a new home manager who was in the process of becoming registered. The provider was working with the new home manager to make sure they received a thorough induction. Comments from people and their relatives about the management of the service were positive. People and their relatives said, "I don't forget the [registered] manager, he's always been good to me", "They [management] will always listen and it makes a difference" and "There are regular meetings and management definitely listen to what people say." The new home manager had started a 'managers surgery' once a week. This was time where the home manager would be available to talk to anyone who wanted to discuss anything. The home manager explained they were available at any time, but this was an advertised, regular session where people, relatives, staff or visiting professionals could discuss their views or concerns.

None of the staff we spoke with knew the provider values. We raised this with the management team who told us they had identified this as an area of improvement. They said they wanted the staff to deliver good quality person-centred care and would ensure staff were aware of this. There was not always a positive and open culture at the service. Some staff we spoke with did not feel able to approach the registered manager with their ideas or to ask questions. They told us that staff morale had been affected by the amount of staff who had left the home. This had placed pressure on staff to work extra shifts which they were not always able to do.

All the management team role modelled good practice. During our inspection we saw they were administering medicines, supporting people to eat and doing some activities with people. We saw that all the management team knew people well, they were knowledgeable of their needs and knew how to support people. There was consensus amongst staff and people that the new home manager was a positive addition to the team. Comments included, "The new manager is very good, very hands-on", "The new manager is friendly" and "[Home manager] is supportive."

Community links were being developed. The home was on the outskirts of Marlborough but there were transport links into town if people wished to use them. The home manager told us that they were developing a new talking newspaper link. The service worked in partnership with a range of professionals.

Feedback from them was positive about the work Marlborough Lodge did. One healthcare professional told us, "I very much enjoy working with the team, if I have less positive feedback, they accept it and act upon it." There was a desire from the management to improve and develop as a service. The registered manager told us they recognised that the service needed to be sustainable and provide a good quality service. They were trying to develop links with other registered providers to learn from others. The registered manager told us they had recently been visited by the local authority's commissioning team who had completed some quality monitoring. They were awaiting the report but told us they were receptive to what others felt about the service.

The rating from the previous inspection was displayed at the service and on the provider's website. The registered manager also notified us of important events that happened at the service which they are required to do by law.