Marbrook Limited

The Marbrook Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Marbrook Centre is a care home with nursing. People in care homes receive accommodation and nursing or personal care as a 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. The Marbrook Centre delivers a service to up to 81 people. There were 43 people in residence during our inspection visits.

The home is built on three floors: each floor can be divided into two separate units or used as one unit. Each unit has single bedrooms with ensuite facilities and shared lounge/dining/kitchenette areas. Each floor provides a service to people with specific issues. Mayfield (top floor) accommodates people living with dementia; Bray (middle floor) accommodates people with long-term rehabilitation and complex nursing needs; and Eden (ground floor) accommodates people with acquired brain injury, including stroke, who are funded for a short period of intensive rehabilitation.

At our previous inspection in November 2016 and January 2017 The Marbrook Centre was rated Requires Improvement. During this inspection in March and April 2018 we found that improvements had been made in some areas and the service is now rated Good.

We visited The Marbrook Centre unannounced on 14 March 2018. We arranged with the registered manager that we would return on 11 April 2018. The registered manager sent us further information and we gave external professionals until 20 April 2018 to respond to our request for comments.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the home. 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 home is run.

During our first inspection visit we found some errors in the way people's medicines were managed, which meant we could not be sure that people received their medicines safely and as they had been prescribed. During our second visit the registered manager told us that action had been taken to address the shortfalls: we will check this at our next inspection to ensure that improvements have been made and sustained.

There were almost always enough staff deployed on Mayfield and Eden. However, we concluded that were not enough staff deployed on Bray to make sure that people's needs, including social and emotional needs were fully met at all times.

Staff had received training in safeguarding people and were competent to recognise and report any instances of harm or abuse. Some, but not all potential risks to people had been assessed and guidance put in place to minimise the risks. There was an effective recruitment process in place to reduce the risk of unsuitable staff being employed.

All aspects of health and safety were checked regularly and action taken to ensure that the home was a safe place in which to live and work. Staff adhered to the provider's policies and procedures to ensure that people were protected from the spread of infection.

Assessments of people's care, support and therapy needs were carried out to ensure that staff and equipment were available to meet each person's particular needs in the way they preferred. Various technologies and equipment, such as call bells, pressure mats and tracking hoists were in place to enhance the care provided.

Staff received a thorough induction, which included several day's training followed by shadowing experienced staff, so that they were equipped to do their job well. Mealtimes were social occasions, when people, relatives/friends and staff ate together. Healthy, nutritious and appetizing food was provided, with further choices available for people who did not want the choices being offered. Special diets were catered for and people supported to eat their meal if they needed support.

A range of external health and social care professionals worked with the staff team to support people to maintain their health and well-being. Staff worked closely with each other and with other professionals and organisations, such as the GP, hospitals, other care services and external health and social care professionals to ensure that each person received consistent care and support when they moved between services. A number of therapists were employed by the service and external professionals were called in when required, to support people to maintain their health and well-being.

The Marbrook Centre was very well designed to ensure that people received the care and support they needed in very modern, extremely well-equipped premises. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were cared for by kind, compassionate and caring staff. Staff showed empathy and understanding towards people and people's emotional as well as physical needs were met. Staff made people feel they mattered and knew each person, and the details about the support the person needed, very well. Relationships between people and staff were based on respect and there was a lot of laughter and fun.

People and their relatives/friends were involved in planning their care and information about advocacy services was available if anyone wanted an independent person to assist them with their affairs. Staff respected people's privacy and dignity and encouraged people to remain as independent as possible.

Staff made efforts to communicate with people in ways the person wanted and could understand. One person's life had been transformed by the introduction of an eye-gaze system so that they could communicate their wishes and preferences. Confidentiality was maintained.

Care plans gave staff guidance on how to meet each person's needs in an individualised way, although some details around the person's care were missing. For people staying at the home for rehabilitation, care plans included detailed discharge planning so that wheels were put in motion early on to ensure services and equipment would be available when they returned home.

Statistics showed, and comments from people and relatives confirmed, that the service provided had supported a high percentage of people to attain their goal of improving so that they could go home.

The range of activities provided for people varied across the units. On Mayfield, people were kept occupied in whatever way they chose, whenever they chose and for as long as they wanted. People staying on Eden

had therapy on five days each week so had little energy for other activities. However, trips out were arranged, including a shopper-hopper to local shops and markets and art and music therapy were arranged during people's spare time. On Bray staff had little time to carry out activities with people.

A complaints process was in place and complaints were responded to and addressed. Processes were in place so that end-of-life care could be provided if it was needed.

Numerous positive comments about all aspects of The Marbrook Centre, including the staff, the building, the management and the service provided, had been made by people and their relatives and friends. The management team, including the registered manager, were approachable, visible and interacted well with everyone.

Staff were aware of their responsibility to provide the best quality service, upholding the provider's values and ethos of the '3Cs' – Compassion, Choice and Competence. Staff had a number of ways of putting forward their views and ideas for improvements. Staff felt valued and respected by the organisation, the management and each other and enjoyed working at the home.

The registered manager had strengthened the governance system so that she had up to date and verified management information available at all times. The provider's quality assurance system included ways in which people, relatives/friends and other stake holders could put forward their views. Audits of all aspects of the service were carried out by various members of the staff team and actions put in place to address any shortfalls.

The home had a number of links with the local community and staff worked closely with other agencies and organisations, for the benefit of people using the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management of medicines did not always ensure that people received their medicines safely and as they had been prescribed. There were not always enough staff deployed in all areas to fully meet people's needs

People were protected from avoidable harm by a staff team trained and confident to recognise and report any concerns. Staff recruitment ensured that staff were suitable to work at this home.

The home was clean and hygienic and staff followed procedures and practices to prevent the spread of infection.

Is the service effective?

Good

The service was effective.

Assessments of people's needs were undertaken. Technology was used to enhance the care provided.

Staff had received training so that they had the skills and knowledge to deliver care to people. Staff received regular supervision and felt well-supported by the management team and each other.

Staff worked within the principles of the Mental Capacity Act so that people's rights in this area were protected.

Is the service caring?

Good

The service was caring.

People were supported by kind, compassionate and caring staff who knew each person and their individual needs well. People were made to feel they mattered.

People and their relatives/friends were fully involved in planning their care and support. Staff showed they cared about the people they were providing a service to.

Staff communicated well with people, respected people's privacy and dignity and encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Care plans were in place for each person and the care was personalised to meet individual needs. Further details about some aspects of care were needed.

The provision of activities in two units was sufficient to ensure that people led meaningful, fulfilling lives. Additional work was needed in this area in one unit.

Complaints and concerns were responded to. A process was in place to ensure that people's end-of-life care needs would be met when this was required.

Is the service well-led?

Good

The service was well-led

The registered manager and management team were visible, approachable and provided stable leadership to the staff team. The provider's core values were known and upheld by staff.

Staff were valued, respected and supported and their views listened to and actioned wherever possible. People, their relatives and other stakeholders had opportunities to comment and make suggestions for improvement.

The governance system had been strengthened and improved so that management information was available and actions plans in place to drive improvement.

The Marbrook Centre

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 home, and to provide a rating for the home under the Care Act 2014.

This comprehensive inspection included an unannounced visit to the home on 14 March 2018. The visit was carried out by two inspectors, an inspection manager, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of using, and caring for someone who used a range of health and social care services. One inspector and the inspection manager returned to the home on 11 April 2018 to collect further information and provide feedback to the provider. Following this, the registered manager sent us further information.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about. We asked the provider to submit a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This was completed and submitted as requested on 7 December 2017.

During our visits we observed how the staff interacted with people who were living/staying at The Marbrook Centre. We spoke with 12 people who were living/staying there, four relatives/friends of people who were living/staying there and 17 members of staff: eight care workers; three housekeeping staff; two nurses; the registered manager; the deputy manager; and the IT specialist. We looked at three people's care records as well as other records relating to the management of the service. These included records relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Following the first inspection visit we wrote to a number of external health and social care professionals who the registered manager told us had regular contact with the home. We gave them until 20 April 2018 to

respond. Five external professionals responded to our questions and some of their comments have been included in this report. We also contacted the local authority contract monitoring and safeguarding teams. The registered manager asked a number of people who had stayed at the home to complete a web form on the CQC website, which we received following our inspection visits.

Requires Improvement

Is the service safe?

Our findings

During our first inspection visit a member of the CQC medicines team looked at how the service managed people's medicines. They also looked at how information in medication records and care notes supported the safe handling of their medicines. Medicines were stored securely for the protection of people who used the service and at correct temperatures. Staff authorised to handle and give people their medicines had received training on medicine systems in use at the service.

The electronic systems in place had the capacity to enable people's medicines to be managed safely. However, frequent audits in place to enable staff to monitor medicine administration and their records had identified some numerical discrepancies. We identified several further minor discrepancies where records did not always confirm people received their medicines as prescribed. In addition, we noted that when people were not given their medicines, records did not always accurately show the reasons they were not given. For example, we were unable to establish why a person's insulin scheduled to be given twice daily by injection had not been given on the morning of 10 March 2018. Records also showed that a small number of medicines had not been given because they were not available at the home. For example, a person's pain-relief medicine scheduled to be given regularly four times daily had not been given for two days leading up to the time of inspection because it had not been obtained in time. This medicine was later received at the home on the day of inspection. Whilst there was a system in place for staff to inform managers about medicine-related incidents and some had recently been recorded, managers were not aware of these that we had identified.

Some supporting information was available on the electronic system for staff to refer to when handling and giving people their medicines and the system prompted staff to undertake medicine-related tasks. When people were prescribed medicines on a when-required basis, there was not always sufficient detail to show staff how and when to give them to people to ensure they were given consistently and appropriately. For a person with limited mental capacity to make decisions about their care or treatment there were records of assessments of their mental capacity and best interest decisions to give them their medicines crushed and hidden in food or drink (covertly). The service had consulted with and obtained written guidance from external healthcare professionals about how to give the person their medicines in this way and this was available for staff to refer to. However, for a person prescribed insulin to be given by injection subject to blood testing results, there was a lack of detail or assessment of risk for staff to refer to. Records of the use of the insulin showed staff had an inconsistent approach to giving it to the person. For another person prescribed a medicine used to manage epileptic seizures there was also insufficient person-centred information for staff to refer to when considering the use of the medicine, managing the seizure or when to call the emergency services. For medicines prescribed for external use such as creams and ointments, there was insufficient written information or body charts in use to inform staff how frequently or where on the person's body they should be applied.

When prescribers were referred to about people's medicines or changes to their medicines were made, members of staff were emailed about the interventions but they were not recorded in people's care notes. For one person whose antipsychotic medicine dose had recently been increased, the involvement of the

prescriber, the rationale for increase or expected period of time until further review was not recorded. In addition, daily care notes leading up to the change did not reflect consistent personal circumstances that would warrant the dose increase.

This meant that improvements to the way medicines were managed were required before we could be assured that people were given their medicines safely and as they had been prescribed.

During our second inspection visit the registered manager told us that they had put systems in place to ensure that the shortfalls found by the member of the CQC medicines team would be addressed. We will check that improvements have been made and sustained at our next inspection.

We checked whether there were enough staff deployed at all times to meet people's needs and keep people safe. Similarly to our previous inspection, we received mixed views from everyone involved (people using the service, relatives/friends of people using the service, external professionals and staff) about whether or not there were enough staff. We found that views about staffing were dependent on which unit was being discussed. Two people on Eden told us that they thought there were enough staff. They based this on the speed at which the nurse-call alarm was answered. One person said, "The buzzers are answered very quickly" and the second person told us, "If I ring the bell [staff] come quite quickly." One person and a member of staff did tell us that they had noticed that the number of care staff had decreased recently from five to four. The provider explained that this was because the number of people staying on the unit had decreased.

Three relatives/friends of people on Bray were sure there were not enough staff and that this had been an issue for some time. Their comments included, "The struggle is with staffing. Sometimes I have to chase up the nurse when medicine is late. I come in some mornings and [my family member] is still in bed at 11:30"; "There have never been enough staff. [My family member] was still in bed at 11:00 today. [They] had had no breakfast. [Their] care plan says [they] like to get up at 07:00"; and, "The home has facilities for my [family member] to have a bath, but staffing levels do not allow for this." A relative/friend wrote a review and said, "At times understaffed care staff wise, however, the staff do a fantastic job even though at times they are rushed off their feet."

Some staff told us that there were not enough staff and that there had been occasions when they had reported to senior staff that they felt there were not enough staff to keep people safe. One member of staff said, "It is hectic and I feel we need more staff." Another member of staff told us, "Sometimes we could do with extra staff. Today we were busy…we were short [staffed]." Staff said that on Bray everyone needed two staff to assist them with personal care. The registered manager confirmed that one of those people needed three members of staff. We learnt that on the day of our first inspection visit two members of staff had called in sick. Although the provider told us they had "removed staff from training to cover the shifts", this situation had resulted in a new member of staff (who was on only their second day of shadowing) being deployed as the second care worker for people who needed assistance from two staff. Although we understood that staff were redirected to whichever unit was short of staff, this meant that staff on the other units were then stretched.

The registered manager told us that a 'safer staffing' system had been introduced, which used red, amber and green to show whether the staffing level each day was safe. They said that if, for example, a nurse on the night shift did not arrive for work, it was an "automatic red". Staff would alert the on-call manager. The registered manager stated that "if the service was unable to get a qualified nurse to attend, both the registered manager and the deputy are qualified nurses and if necessary, could come and work the night shift." The registered manager asserted that staffing had improved since our previous inspection. They said

this was because recruitment had been successful recently and the 'safer staffing' system worked very well. They said there had not been any 'red' shifts for some time.

Nevertheless, we concluded that although for most of the time there were enough staff deployed on Mayfield and Eden, there were not always enough staff deployed on Bray and this situation needed further improvement.

The provider had a risk management system in place to try to ensure that risks were managed and minimised, whilst ensuring that people had choice and maximum control over their lives. Some potential risks to each person had been assessed and guidance had been put in place for staff so that they would know how to reduce the risks. However, we found that for some people, potential risks to their safety, such as the risk of falling, had not been assessed. One person, for example, had been admitted from hospital where they had had a fall resulting in fractured ribs. However, there was no guidance for staff on how to prevent this recurring. The dietician was in the process of training staff to complete risk assessments relating to malnutrition.

People told us they felt safe and a relative/friend stated, "I never think my [family member] may not be safe. There is no bad treatment. I never worry about [their] safety." A relative/friend of a person who had died wrote, "From the first time I came through the doors and was greeted like an old friend I knew that for the first time he was 'safe' and that I didn't have to worry…anymore." The provider had systems in place to safeguard people from abuse and avoidable harm. Staff had undertaken training in safeguarding people. The deputy manager told us that every member of staff had recently been given a safeguarding questionnaire: staff who failed had had to re-do the training. They would then have to re-do the questionnaire in a month's time. Staff were able to describe to us what they would report and to whom, both within the organisation and external organisations such as the police and local authority. One member of staff said, "I don't have any reservations about going to the safeguarding team if necessary. At the end of the day I'm here to support the residents."

The provider employed a health and safety manager who headed up a health and safety committee. Members of the committee were responsible for ensuring the safety of the premises and carrying out all the necessary checks. The health and safety manager told us that the committee had met the day before our first inspection visit and confirmed that all checks had been completed for the month. There were procedures in place relating to fire safety and each person had a personal emergency evacuation plan in place.

The provider had a robust recruitment system that meant that, as far as possible, only staff suitable to work in this care home were employed. Checks relating to the person's suitability, such as a criminal records check, references from previous employers and identity checks were carried out before the new member of staff was allowed to start work.

The home was kept very clean and there were strict procedures adhered to by staff to ensure that people were protected from the spread of infection. One person said, "The bedrooms are cleaned properly. Staff always wear gloves and aprons when they assist you with personal care. The gloves and aprons are in our rooms." Staff were clear about measures to take to prevent the spread of infection and told us about the cleaning schedules they followed each day.

Accidents and incidents were recorded and a log was kept to ensure that relevant authorities such as the local authority and CQC were informed as required. All accidents and incidents were discussed at the morning management briefing, which meant that heads of all departments as well as the management

team were aware of everything that happened. Action plans were put in place when needed to prevent recurrence as far as possible. Learning from these incidents was disseminated to the staff teams. For example, a person fell while in the shower. Their care plan was altered immediately and the new plan implemented. The registered manager told us, "We adopt a very strong lessons learned culture, which ensures continuous development…this makes us a very safe service."

Good

Is the service effective?

Our findings

A thorough assessment of each person's needs was carried out before they were offered a place at The Marbrook Centre. The assessments for people staying at the home for rehabilitation were carried out by the therapy team. This was to ensure that the team had the right skills to be able to help the person to meet their goals. The lead therapist told us they were going to Stoke Mandeville hospital the following day to assess someone's needs. A weekly meeting took place where a team of staff, including representatives from management and therapy discussed all referrals and assessments to ensure that everyone was agreed that the home could meet the person's needs. One person told us, "They won't take you in if they can't cure you." The assessment took into account the person's wishes, ensuring that the person wanted to move from hospital to The Marbrook Centre and then on to another place after their rehabilitation period had ended.

Various technologies were available throughout the home. For example, every room was linked to the call bell system. Some bedroom doors were alarmed so that, if the alarm was switched on, staff were alerted when the alarm was activated. This meant they could monitor when a person entered or left their, or another person's room. Other technology, such as ceiling hoists was available in some of the bedrooms. Additional technology, such as pressure mats to alert staff if a person had entered or left a room, or got out of bed, was available for people whose needs indicated they would benefit from this type of assistance.

One person who was unable to move or speak, used an eye-gaze system to help them communicate. Staff told us what an amazing difference this had made to the person's life, increasing their independence and ensuring that everyone was clear about their wishes and preferences.

New staff underwent a thorough induction when they first started work at The Marbrook Centre. They undertook a range of training topics, delivered face-to-face by a trainer or via e-learning on the computer. They then shadowed more experienced staff until they felt confident and were deemed competent to work on their own. One newer member of staff was very impressed with their induction. They told us they had had six day's training and then two more days a month later. We were made aware on the first day of our inspection that a new member of staff had been assisting as the second staff member for people who needed two staff, on only their second shadowing shift. Although this meant the provider's induction policy was not being fully followed, experienced staff assured us that this new member of staff was not left to carry out any tasks alone.

Further training was offered to all staff, relevant to their role, including refresher training in line with the provider's policy. The provider told us that for the majority of topics, face-to-face training was arranged. The registered manager told us that five staff who worked at the home had been trained to train other staff in moving and handling. This meant that not only was training almost always available when needed, but the training was relevant to people living/ staying at the home. The deputy manager told us they planned to undertake a nationally recognised vocational qualification in safeguarding level five and a 'train the trainer' course so that they would be competent to train staff in certain topics. A visiting dietician told us it had been identified that staff needed further training in assessing the risks to people of not eating or drinking well enough, so they had arranged to train a group of staff that afternoon.

On our first inspection visit we saw moving and handling training taking place. Staff were being trained not only in the physical side of assisting people to move but also about communicating with the person, explaining what was happening and reassuring them. The registered manager told us that staff were using footage from the CCTV cameras in the corridors to learn how to record incidents more accurately by writing down exactly what they saw. People told us they thought the staff knew what they were doing. One person said, "Staff are well-trained - I feel safe." Nevertheless, the registered manager was aware that staff wanted and needed more training in people's specific conditions, such as locked-in syndrome, stroke, dementia and learning disability.

Staff felt well-supported by everyone at The Marbrook Centre, from the management to each other. One member of staff said, "There's no end of people you can go to. The HR team has an open-door policy, nurses have specialist knowledge and [there are] really good seniors with good knowledge." Staff received supervision sessions with their line manager and an annual appraisal. This meant that people were supported by a staff team who received training and support to do their job well.

A relative/friend told us that they too had received some training. They explained, "My [family member] is peg fed. They have trained me to set up the peg feed each day. I have also been trained to give [name] medication and I have a certificate."

People, their relatives/friends and the staff all agreed that the food at The Marbrook Centre was very good and the chef was very amenable to cooking whatever people wanted. One person said, "The food is amazing and they fill my water glass, if I don't like the menu they do me an omelette." Another person told us, "The food is better here than any restaurant."

People were offered a wide choice of food at each meal. At lunchtime a choice of two hot meals arrived in a heated trolley. People were able to choose which one they wanted, or order an alternative meal from the kitchen if they did not like what was offered. There was a soft option of both meals. One person said, "You choose as the food arrives, they say to you - what do you fancy?" People who would not be able to make a choice of meal verbally were shown a sample of both meals and asked which one they would like. Staff said that the speech and language therapist employed by the service was very helpful in giving advice, for example, about how to help someone who was starting to choke. Special diets were available and charts in the kitchen assisted the chef to know about people's needs, likes and dislikes regarding food and drink.

Lunchtime was a relaxed, sociable occasion, with people, their relatives/friends and staff all sitting together to eat if they wanted to. People ate at their own pace. Staff told us that the managers asked them to have a meal with people as it encouraged people to eat. On Mayfield, staff told us, "People who walk around are given a bowl of finger food to 'eat on the go'." This ensured that the person had something to eat even if they did not want to sit at the table.

Staff worked closely with each other and with other professionals and organisations, such as the GP, hospitals, other care services and external health and social care professionals to ensure that each person received consistent care and support when they moved between services. For example, the therapy lead told us that each person's initial assessment included the beginnings of plans for their discharge so that everyone was aware of the path the person hoped to take to achieve their goals. A relative/friend of a person who moved into the home wrote to the staff, saying, "We were nervous of the impact moving into a new home would have. However, thanks to the patient efforts of your team the transition went as smoothly as any of us could have expected."

People were supported to have access to healthcare services so that their day-to-day health and well-being

needs were met. The provider employed a range of therapists to provide the treatment and support that people, especially those staying at The Marbrook Centre for rehabilitation, required. Each person had a programme of treatment, with details of the times of therapies they undertook each week. A local GP was contracted to visit the home for one afternoon every week. Staff also contacted the GP or the out-of-hours service at other times when people needed more urgent medical assistance. External healthcare professionals, such as Macmillan nurses, the falls team, tissue viability nurses, mental health nurses and a dietician were involved with people's care when needed. External professionals told us that staff were very good at following any advice and guidance they gave them relating to people's care needs.

The building was well-designed to meet the needs of the people living/staying there. All areas were light and spacious, with wide, bright corridors. There were at least two lounge/dining areas on each floor, as well as seating in corridors, which provided alternative spaces for people to sit. All the bedrooms were single rooms and all had an ensuite shower room. Each bedroom on Mayfield had a memory box outside the door to assist with identification for people living with dementia. One person wrote, "The surroundings and atmosphere at Marbrook are fully conducive to recovery and rehabilitation, being calm, restful, attractive and peaceful. A relative/friend told us, "The home is amazing. It's like a hotel."

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training relating to the MCA and DoLS and understood how the legislation related to their everyday work. They gave people choices in as many aspects of their lives as possible and asked people's consent to carry out care tasks. There were a high number of people living at The Marbrook Centre, especially on Mayfield, who did not have the capacity to make their own decisions. Assessments of people's capacity had been carried out and recorded in their care records. Best interests decisions had also been recorded. Applications had been made to the local authority for DoLS authorisations and the registered manager confirmed that an application had been submitted for every person whose liberty was being restricted. This meant that people's rights in this area were being upheld.

Good

Is the service caring?

Our findings

People were very pleased with the care and support they received and told us how caring they felt the whole staff team always was. One person said, "There's only one word to describe the care here, it is excellent". Another person told us, "The care is different here to [another service], everyone's happy. You couldn't be miserable here, they wouldn't let you." A third person said, "The housekeeping team are very friendly, they will come in and have a chat."

Relatives/friends who wrote to the home or wrote reviews were effusive in their praise of the staff, the home and the service they had received. They used words such as "amazing", "wonderful", "caring and competent", "kind, courteous and very friendly" and "fantastic" to describe the staff. One relative/friend wrote, "…thanks…for the outstanding care [our family member] received on Mayfield. [Name] was treated with great love, compassion and respect during a difficult time in [their] life….To see staff go above and beyond their job description to bring [name] comfort and joy was wonderful." Another relative/friend wrote, "This was not limited to the [care staff]. Everyone who came into contact with [our family member] greeted her by name and took time to ask how she was and interact with her. We are so grateful to everyone from the kitchen, reception, laundry and office…for their thoughtfulness and compassion." A third relative/friend summed up their praise of the staff when they wrote, "Very special people doing a very special job."

People were made to feel they mattered and staff showed that they knew people well. A relative/friend wrote: "From the first day until the last it was easy to see that you, the staff, genuinely care about your residents. You get to know them and let them get to know you. Please keep doing it because the difference you are making to these people's lives is enormous." Another relative/friend wrote, "You treated [name] with dignity and bothered to get to know [name] not just the severely disabled [person] in room 12." They added, "[Name] truly believed that he had been so lucky to be offered a place at Marbrook and thought that all the staff were amazing." The registered manager explained that in their view, "Making relationships and having an understanding of what people and families are going through is key [to providing an excellent service]."

Staff were also full of praise for each other. They made comments such as, "Staff really do care. They do a great job"; "There is excellent care here"; "Staff really do care – it's not just a job"; and "Care staff deliver a really high standard – people are well looked after." The registered manager told us that prospective staff members underwent an "empathy test" so that the managers could judge whether they had a genuinely caring attitude. One member of staff told us, "You treat people how you'd want to be treated. And you make sure other staff do the same." On the first inspection visit one member of staff told us they felt "guilty today" because they had been "running around and rushed things" and had not had any time to chat with people. Throughout the time the inspection team was at The Marbrook Centre we saw that staff and people living/staying at the home interacted well with each other and had warm, caring relationships. There was lots of fun and laughter as well as appropriate banter that people clearly enjoyed. Staff were patient and gentle and on Mayfield we saw a lot of hand-holding and hand-stroking in order to reassure and calm people.

People's relatives/friends and friends were encouraged to visit and offer as much support as the person

wanted. One relative/friend wrote: "I would finally like to thank you for the generous welcome we were given as [name's] relatives and friends. We were made to feel part of the family, consulted on all aspects of [name's] care and condition and provided with many cups of tea and slices of cake!" Another relative/friend wrote, "Thanks to the warmth of everyone at Marbrook it was less distressing to visit than it otherwise might have been." A relative/friend told us, "When we had the snow they gave me a room and all meals for 2 days." Although there were no strict visiting hours, relatives/friends could only visit when their family member wanted them to.

Staff communicated well with people and always explained what they were going to do. One person living at the home spoke very little English. Staff used a search engine on the computer to find words to communicate with the person in their first language, which reassured them. Staff also used a range of methods to communicate with people who were living with dementia. These included pictures and showing people things to choose from, such as two sets of clothes or a hot and a cold drink.

Staff respected and maintained people's privacy and dignity. They knocked on bedroom doors and waited for a response before entering. They described to us how they made sure curtains were closed and people were kept covered as much as possible during personal care. Privacy cards (similar to the 'do not disturb' cards in a hotel) were used on bedroom doors when staff were assisting the person with personal care. A member of staff said, "It's important to put yourself in their position and then do the things you would want, like knocking on doors." One relative/friend had requested that their family member only received care from female care staff. They told us, "The care [staff] are brilliant, they have agreed two female care [staff] for my [family member]." However, the registered manager said they had all come to an agreement that in an emergency, a male member of staff might have to assist for moving and handling, but not for the personal care aspect. Confidentiality was respected and staff did not talk about people to other people. Care records were stored securely so that personal information was kept confidential.

People were encouraged to be as independent as possible, in all aspects of their care. The registered manager said staff supported people to be "as independent as their condition will allow." One person had been admitted to the home so that staff could monitor and support how the person was carrying out a vital clinical procedure for themselves. People told us that they had choices in all areas of their lives. They could choose, for example, what time they got up or went to bed, what they ate and drank, where they spent their day and what they did. One person told us, "Care [staff] are respectful of my wishes. I have a choice of times to get up and go to bed."

The provider contracted an advocate to visit the home once a week, in case anyone wanted an independent person to help them with their affairs. Staff had involved an Independent Mental Capacity Advocate (IMCA) for a person who wanted to go home rather than into a care home, which their funding authority preferred.

Good

Is the service responsive?

Our findings

Each person had a care plan, which gave staff guidance on how to meet the person's needs in a responsive, personalised way. Care plans reflected the person's physical, mental, emotional and social needs. Staff told us that people, and their relatives/friends when the person wanted them to be, contributed as much as possible to planning the person's care. A relative/friend said, "My [family member's] needs are met and they have learned more and more about her." They also told us how they had suggested a change to their family member's care, which they thought might help. They were very grateful that staff had implemented this and their family member was much better. This showed that staff were responsive to people's needs. However, we found that some details, for example about cleaning stoma sites and dealing with blockages, was missing from the guidance.

For people who were staying at the home for rehabilitation, care plans included the goals that the person wanted to achieve during their stay. Progress was discussed throughout their stay and a review meeting was held prior to the person's discharge. For people living at the home for a longer period, regular reviews of the person's care were held, involving the person, their family and any health care professionals involved in their care. The registered manager told us that independent advocates and the speech and language therapist (SaLT) were also involved, to ensure that "the individual can have their voice heard."

The lead therapist told us about the assessments they used so that they could measure the progress made by each person. The registered manager said, "Our clinical outcomes are exceptional for our rehabilitation services." Statistics reflected this, including that out of 35 people admitted for rehabilitation in 2017, only five people (14%) had been unable to return home. A clinical psychologist was employed full time to work with people with acquired brain injury, and with their families. The psychologist also had regular sessions with staff from each unit to discuss any issues and support them, for example in finding ways of supporting people whose behaviour challenged the service.

Levels of activities provided varied in each unit. On Eden, people had therapy timetables and could use the home's gym when they wanted to. Staff told us that most people worked very hard on their rehabilitation, which meant they were exhausted and did not have the time or the energy to want to be involved in any other activities. However, an art therapist and a music therapist visited the home regularly and people were encouraged to join in the sessions if they wanted to. There were two vehicles available for people to use if they wanted to go out: one person visited a local restaurant regularly as part of their therapy.

Activities on Bray were somewhat limited by people's conditions, but outings were arranged, which people could join if they wanted to. One member of staff had set up a fish tank with some tropical fish on Bray. A relative/friend told us, "The fish are very therapeutic". During our first inspection visit, there was a baking session and staff made cakes with people. However, there was little else and staff told us they did not have time to do anything with people. One relative/friend told us, "There is no stimulation here, there are not enough staff. I brought [name] in a tablet but staff did not assist [name] to use it so I took it home again."

On Mayfield however, there were activities going on all the time. One person said, "I love it here, I go to the

pub and I go shopping". Staff told us about 'The Butterfly Approach' that underpinned all the work they did and the interactions they had with people. This is a recognised approach to working with people living with dementia, based on the Feelings Matter Most model of dementia care. Staff worked hard to make sure that each person felt that they mattered, did what they wanted to do and was kept as occupied as they wanted to be, for as long as they wanted. A relative/friend had written, "We thought your approach, of supporting individuals to be themselves and avoiding imposing limits wherever possible, was incredibly passionate and respectful."

There was a variety of dementia-friendly resources in the shared areas for people to get involved in, such as jigsaw puzzles, board games and art/craft equipment. There were things for people to touch, wear, look at or just move from place to place, all round the unit. One person, for example, liked drawing lines so staff provided them with as much paper and as many pens and pencils as they wanted so that they could draw lines. Sometimes this was just for a few seconds, sometimes for much longer periods. One person who lived on Mayfield used to organise lorries for a delivery firm and they enjoyed watching the traffic on the A1, which passed very close to the home. Some people enjoyed doing the things they had always done, like washing up, folding laundry or dusting and staff supported them to do this. On Mother's Day each of the ladies had been given a card and chocolates and they had had an afternoon tea.

There was a coffee shop on each floor where people and their visitors could help themselves to a drink and have a different environment to sit in, away from the unit. On Mayfield, there was also an 'outdoor space'. This was a terrace within the building, where the outside wall had been replaced with glass panels so that the area was open to the fresh air. Artificial grass had been laid on the floor and the area made to resemble a garden. Garden games were available for people to play if they wanted to.

The provider had a complaints process in place, which was on display on notice boards around the home. People and their relatives/friends knew who to complain to if they needed to. One person said they knew that "the [registered] manager's door is always open" if they needed to talk to them. Two people told us they had raised matters of concern, which were dealt with very quickly. A relative/friend told us about two examples of where they had made a complaint to the registered manager. Both complaints had been listened to, appropriate action taken and the issue had not arisen again. Staff knew what to do if anyone raised an issue with them. One member of staff said, "It's really important that people know we listen."

People were supported at the end of their lives. The registered manager told us that although The Marbrook Centre was not an end of life specialist service, they did provide care to people with life-limiting conditions. This meant there were times when people had chosen to remain at the Marbrook Centre as their life ended. Nurses led on care planning for end of life care. The registered manager said, "We are very lucky to have a great partnership with the local Macmillan nurses who give us fantastic support and lend us equipment as needed." Staff received training in palliative care, which included people's cultural requirements. A relative/friend wrote following the death of their family member and said, "You treated me with such kindness [and showed] such genuine grief and kindness, it will never be forgotten by me."

Good

Is the service well-led?

Our findings

The Marbrook Centre had received a high number of compliments and complimentary reviews on a care review website. One person wrote, "If you are in need of any kind of rehabilitation you could not choose a finer place than The Marbrook Centre. Excellent buildings and facilities, first-class therapists, wonderful and smiling nurses, carers and laundry personnel and also the receptionists. You cannot do better." A relative/friend wrote, "[Name] often told me that he was living in the best possible place, given the circumstances." Another relative/friend wrote, "The service and care provided by Marbrook was outstanding on all fronts. I could not have wished for a better place for my [family member] to have rehabilitation."

There was a registered manager in post. The registered manager provided strong leadership to a staff team that was clear about their aims and objectives. They worked as a team towards providing an excellent service for everyone who resided at the home, in spite of people's vastly different needs and goals. The registered manager felt that their biggest opportunity was to "unite all the many talents and disciplines which makes 'Team Marbrook', to work as a single team and to really own our 3Cs values."

People, their relatives/friends and the healthcare professionals we had contact with all knew who the registered manager and deputy were. They spent a lot of time out on the floor and their office doors were "always open". We saw that they interacted well with staff, people who were living/staying at the home and visitors, who were all clearly used to seeing them out and about. Relatives/friends told us, "The [registered] manager is genuinely interested in the residents"; "The home is well-managed, there's not one fault we could make, I would recommend it"; "The home is managed well now, it has improved over the last 4 months"; and, "I feel the manager and deputy listen to me. It is a growing, learning company". A healthcare professional told us, "Management at Marbrook are available, interested and competent….management cares seriously about providing safe care in a secure environment."

Staff were fully aware of their responsibility to work within the provider's values and ethos of 'the 3Cs' – Competence, Choice and Compassion. The registered manager told us these core values were embedded right from the prospective staff member's first interview and were published on all of the home's materials. She said, "These core values underpin our induction, training, supervision, governance and care delivery etcetera." One person wrote, "What makes the centre special are its staff and the philosophy of residents first. A family of committed, positive staff with 'can do' attitude throughout the organisation" and a relative/friend said, "The facilities at Marbrook are outstanding, but it was the quality of the people working there, and the ethos that they clearly understood and followed, that made the most impact on us."

Staff felt valued and respected. The registered manager said that staff retention had improved, which indicated that staff were happier in their role. On the whole, staff were pleased to be working at The Marbrook Centre, making comments such as "I love my job" and "I absolutely love it here". There were a number of ways in which staff could put forward their suggestions for improvements. A staff forum, chaired by the provider's representative, took place each quarter. Staff were nominated by their colleagues to attend, so different staff attended each time to put forward their team's suggestions. The management team said that lots of staff's suggestions were taken on board and implemented. All staff received regular

supervision with their line manager and staff meetings took place. There was a staff suggestion box and all staff knew they could speak to any of the management team at any time.

The registered manager was fully aware of their responsibility to work within relevant legislation and guidance, including sending notifications to the CQC. Notifications are events in the home that the provider is required by law to tell us about.

The provider gave people, their relatives and friends and other stakeholders a range of ways in which they could share their views about the service provided at The Marbrook Centre. The registered manager, deputy manager and other senior staff were highly visible and welcomed people's views and ideas for improvements. Meetings for relatives/friends were held regularly and there was information about ways in which people could make written comments, such as a care home review website.

The provider had a quality assurance system in place. The registered manager considered that her greatest achievement had been the introduction and embedding of governance systems. She was aware that this was "still work in progress" but felt she had access to key management information at all times. The morning management team briefing had proved "very effective" for communicating and ensuring that actions to address shortfalls had been completed. A wide range of audits was carried out regularly by staff from all areas of the organisation and these came together at the morning meetings as well as at governance meetings. Improvements had been made, ideas were being considered and continued to be 'in the pipeline' for future development of the service. A service improvement plan was in place. Daily 'floor walks', which staff could join in if they wanted to, included checking with staff any new concerns, were recorded and any issues raised were discussed and, where possible, addressed.

Digital systems were in use to enhance the quality of care. The registered manager told us that the digital care planning processes flagged up when reviews were due or if something had been overlooked. The digital medicine administration system assured staff that the system meant they were far less likely to forget someone's medicines or to give someone an overdose. Every member of staff had their own email account. This was used for everything that needed to be communicated to staff and all were copied into any communications relevant to their area of care. There was a computer tablet in the reception area for people to use to comment on the service provided. The registered manager told us, "Although still a new service we have adopted systems and processes to aid us in our quest for the best possible care experience."

Links with the local community were in place and further links were being developed. A number of community groups and charities held meetings at the home and staff provided them with drinks and refreshments. These included the MS Society, the Parkinson's Association, the Stroke Association, Headway, Carers' Bedfordshire and the East of England Trauma Network. The registered manager said, "We think that having these external links endorses our transparency and 'nothing to hide' approach." Local businesses such as a hairdresser, chiropodist and dentist visited regularly. A 'shopper/hopper' was operated twice a week to take people to local shops and markets if they wanted to go. Local suppliers, such as a butcher and a printing service were used. A free Carers' Café was held monthly, led by four local charities.

The registered manager told us, "All of the above [community involvement] has been recognised in a number of Community Award nominations, including being our MP's constituency nominee as his Parliamentary Corporate Responsibility Champion and the winners of the Carers Trust 'Carer friendly Employer of the Year 2017'."

The management team and the provider reviewed all aspects of the service provided in order to improve and ensure improvements were sustained. The registered manager gave us an example from a review of

incidents on Mayfield. They established that there had been an increase in incidents in a specific area, between two sets of corridor doors. The doors were not kept open, which meant that people could not keep walking freely as they could not just walk past each other. Door restrictors were put in place so that the doors remained open and there had been no further incidents.

The staff team at The Marbrook Centre had close working relationships with other agencies. These included the local authority, including the safeguarding team, clinical commissioning groups, local hospitals, the local GP and external therapists. This was done in an open and honest way, with information shared for the benefit of people living/staying at the home.