Barchester Healthcare Homes Limited

Marriott House & Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Marriott House and Lodge is registered to provide care and accommodation for 119 older persons with nursing, residential care and physical care needs. Accommodation is provided in two separate buildings. Marriott House provides care and support for people with nursing needs over three floors and Marriott Lodge provides residential care for people over four floors. There is a passenger lift in both buildings to provide access to people who have mobility issues. On the first day of our visit 54 people were living in Marriott House and 29 people were living in Marriott Lodge.

The home did not have a registered manager, the previous registered manager had left on 12 May 2017. 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.

A manager was in post but they had not applied to become registered with CQC. They told us that they were leaving and the second day of our visit coincided with their last day in post. The provider's regional director was present during the inspection and told us that a new manager had been appointed and was due to start the week following the inspection.

At the last inspection on 4 and 5 August 2015 we had no concerns and the service was rated 'Good' overall. At this inspection we found three breaches of the regulations and other areas of practice that needed to improve.

There were not always enough staff to care for people safely. People and their relatives expressed concerns that people had to wait for their care needs to be met. One person said, "At times I have to wait for staff and when they do come they always appear rushed." Another person commented, "Sometimes you wait over half an hour." Call bell records confirmed that people regularly waited for longer than they should reasonably expect for staff to respond. This was identified as a breach of regulations. The provider took immediate action to increase staffing levels and improvements were noted on the second day of the inspection.
Most people and their relatives spoke highly of the staff and the care they received. One person said, "They are a very nice group of girls, I call them my grand-daughters." However people's dignity was not always protected because staff were not responding to call bells in a timely way. Some people told us that staff were not always kind and caring. One person said, "There are some good ones (staff), and some are not so good. They do what has to be done but don't look beyond that." A relative described how they had heard a staff member speaking 'sharply' to their relative. People and their relatives told us that most of the staff were kind and caring in their approach however not all interactions between staff and people were consistently positive. This was identified as a breach of the regulations.

The provider had a number of management systems and processes including audits, to monitor quality at

the home. However, these had not always been effective in identifying shortfalls in the quality of the service. There was a lack of management oversight in some areas of practice which meant that the manager could not always be assured that risks to people were being effectively managed. This was identified as a breach of the regulations.

People were receiving their medicines safely but some PRN (as required) medicines were not always documented clearly. This put people at risk of receiving inappropriate doses of their medicines and was identified as an area of practice that needed to improve.

Risks to people were identified and care plans were regularly updated to guide staff in how to provide care safely. However, staff were not always following the care plans consistently. This meant that people were at risk of receiving inappropriate or unsafe care. This was identified as an area of practice that needed to improve.

There was a wide range of organised activities on offer for people at the home. However, whilst the activities programme was meeting some people's needs, other people remained at risk of social isolation. Some people said they didn't have enough to do, one person said, "The activities are very good but I don't join in because it's not my type of thing." Meeting people's need for social interaction and stimulation and supporting them to follow their interests is an area of practice that needs to improve.

People knew how to access the provider's complaints system and the manager monitored all complaints. Some people told us that they did not feel confident to raise complaints because they were not sure how their concerns would be addressed. This was identified as an area of practice that needed to improve.

Staff demonstrated understanding of their responsibilities with regard to safeguarding people and knew who to speak to if they had any concerns. People said they felt safe living at the home, one person told us, "I always felt safe here from day one." Incidents and accidents were being recorded and monitored to identify and address any patterns or trends.

People were having enough to eat and drink and they told us that they enjoyed the food on offer. Staff were knowledgeable about people's dietary needs. Staff supported people to maintain their health and to access health care services when they needed to. One person said, "If you need the doctor they arrange it." People and their relatives said that they had confidence in the skills and knowledge of the staff. Staff told us they received the training and support they needed. One staff member said, "I'm up to date with my training and I have asked to do additional training in End of Life Care because that's a particular interest for me." Staff had received training in the Mental Capacity Act and understood their responsibilities.

People were being supported to make decisions about their care. They told us that they felt their views were listened to. A relative told us, "I am here for a review today, they keep me fully involved." Staff had a good understanding of how to protect people's privacy. People told us that staff supported them to maintain their independence. One person said, "I like to be independent and do as much as I can for myself." Staff demonstrated that they knew people well and provided care in a personalised way, respecting people's wishes.

The provider sought the views of people and their relatives on the quality of the service and used this information to drive improvements. We were told that a refurbishment plan was in place to update areas of the home to give it the 'Wow factor.'

Staff had developed good links with the local community and staff told us that they had benefitted from

additional training as a result. Staff spoke highly of the management of the home and described an open and supportive atmosphere. The regional director told us that the provider was committed to making improvements at the home.

You can see what actions we have asked the provider to take at the back of the full version of this report.

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 consistently safe.

There were not always enough staff on duty to care for people safely. Recruitment procedures were robust.

Risks to people were being assessed and care plans supported staff to care for people safely. However some staff were not consistently following the guidance in care plans and risk assessments which meant some people were at potential risk of injury.

People were receiving their medicines safely, but some records of PRN medicines were not consistent and accurate.

Staff demonstrated a firm understanding of their responsibilities to safeguard people.

Is the service effective?

Good

The service was effective.

Staff received the training and support they needed to be effective in their roles. Staff demonstrated that they understood their responsibilities with regard to the Mental Capacity Act 2005.

People were supported to have enough to eat and drink and risks associated with nutrition and hydration were identified and managed effectively.

People were supported to access the health care services that they needed.

Is the service caring?

Requires Improvement

Staff were not consistently caring.

Some staff were not always caring in their approach and not all interactions were positive. People's dignity was not always protected.

People were supported to express their views about their care

and staff understood the importance of supporting people to remain independent.

Staff maintained people's confidentiality.

Is the service responsive?

Requires Improvement

The service was not consistently effective.

Some people's needs for social interaction and stimulation were not being met.

There was a complaints system in place and people and their relatives knew how to raise concerns. Not everyone felt comfortable to raise complaints.

Care plans were detailed and reflected the care that was provided to people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Management systems were not always effective in monitoring and improving the quality of the service.

Clear governance and leadership was not consistent in all areas of the home.

Staff had developed positive relationships with the local community and there was a positive and open culture at the home.

Marriott House & 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 19 and 20 October 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist adviser and two experts by experience. The specialist adviser was a nurse with experience of working with older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service including any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) before the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure that we were addressing any potential areas of concern at the inspection.

We spoke to 16 people who use the service and 15 relatives. We interviewed 13 members of staff and spoke with the manager and the regional director. We spoke with a visiting health care professional. We looked at a range of documents including policies and procedures, safeguarding, incident and accident records, medicine records and quality assurance information. We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for a further seven people and observed care and activities in both Marriott House and Marriott Lodge. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's information systems.

Requires Improvement

Is the service safe?

Our findings

People and their relatives had mixed views about safety at the home. Most people told us they did feel safe, one person said, "I always felt safe here from day one." Another person said, "I feel very safe, the staff are very good." A third person told us, "I 'm very safe, there's night -carers here and I have a bell." However, people and their relatives expressed concerns about the number of staff on duty. One person told us, "There are enough senior staff but not enough carers." Another person said, "At times I have to wait for staff and when they do come they always appear rushed." Other people also felt that staff were not available when they needed them. Their comments included, " They come eventually," and "Sometimes you wait over half an hour," and "They take a long time to respond, I have waited an hour, not always it just depends on the time of day or if it's at a weekend. There doesn't seem to be anyone here at the weekends."

Relatives also told us that they felt there were not always enough staff to care for people. One person's relative said, "It seems that if he wants someone and pushes the buzzer people don't come quickly." Another relative said, "At weekends there's not many staff, sometimes call bells don't get answered." A third visitor told us, "At times, my partner has had to wait a very long time for support." We checked the records from the call bell system and found many examples where the call bell was not answered within 5 minutes. In a three day period we found 10 records indicating that people had waited more than 20 minutes, three when people had waited more than 40 minutes and two records indicated a wait of more than one hour. We brought this to the attention of the manager and asked how they ensured that call bells were answered within a reasonable timeframe. The manager told us this was monitored through staff observation and the call bell report was not currently used however they immediately took action to review the report.

During the inspection we observed that people were having to wait for their care needs to be met. Accommodation was spread across three floors in Marriott House and four floors in Marriott Lodge. People were spending time in their bedrooms and we noted that there was not always a staff member on each floor. One person told us, "When you are in a room by yourself it's isolating. The staff are so busy." Throughout the inspection our observations were that people were calling out and using their call bells to summon staff in Marriott House. One person, who was in bed, was heard calling out and showing signs of distress. The inspector asked the person if they wanted them to find a staff member, however they could find no staff on the floor where the person's bedroom was situated. They pushed the person's bell to summon staff and waited with the person until a staff member came. One person was heard calling out for over 20 minutes because they wanted their light turned off so they could sleep. Relatives told us they were concerned that there were not enough staff deployed in all areas of the home. One relative said, "There are not enough staff around, sometimes there is only one staff member on this floor and they are running between floors. People are not getting the attention they need. My relation has not been washed." Another relative said, "I don't think there is enough staff, there are quite a few room's on this floor and I would expect more people to be around." Our observations in Marriott Lodge were similar and people told us that the lack of staff was having an impact upon their care. One person said, "I was not able to have my shower last night because there were not enough staff to support me. I only get three showers a week so I was not happy about missing one." Another person said, "If I press my buzzer they will come but you cannot be sure how long it will take. I think it's 20 minutes on average but I have waited up to 50 minutes before." A third person

said, "They are understaffed, definitely need more on duty."

Staff who worked in both Marriott House and Marriott Lodge told us that staffing levels needed to be increased. One staff member said, "There is an issue, particularly at the weekends and when staff are off sick at short notice, we can't always get cover." Another staff member said, "There are not enough staff and it impacts upon the residents. They don't always get the care in the way they should- it can be a bit of a conveyor belt to get everything done, it's a rush. We struggle to get to call bells too." Another staff member said, "Although we have enough staff on according to the rota, we are still stretched. Sickness affects it and weekends are stretched." A fourth staff member said, "There are not always two nurses on duty at the weekends, sometimes they have one nurse and one care practitioner, that's not really enough."

The provider was using a dependency tool to measure the number of staff that were needed to care for people safely. The manager told us that staff rotas were based upon this tool and that planned and unplanned absence had been a factor in recent months which affected the balance of staffing within the home. Agency staff were being used and the manager said that they requested regular agency staff to provide better continuity for people. Despite these positive measures we found that there were not enough staff to care for people safely and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We discussed our concerns about staffing levels with the manager and the Regional Director at the end of the first day of the inspection. On the second day of the inspection the Regional Director confirmed that the provider had taken action to increase the number of staff with immediate effect.

People were receiving support to take their prescribed medicines. Some people had been prescribed PRN or "when required" medicine. Good practice guidance for care homes produced by the National Institute for Clinical Excellence (NICE) states that PRN medicines, that may include variable doses, should have clear guidance for staff regarding when and how to use such medicine, what the expected effect will be and the maximum dose and duration of use. We found that PRN medicines were being well managed in Marriott House but in Marriott Lodge recording of PRN medicines was not consistent. This meant that people were at risk of not being given PRN medicines consistently and in accordance with prescribed instructions. For example, one person had been prescribed PRN medicines for pain relief which should be given at four hourly intervals. However staff had not recorded the time that the PRN medicines were given, this meant that there was a risk that staff could give another dose before the required interval. Another person had been prescribed a variable dose of medicine but recording was inconsistent and did not always indicate the dose that had been given. This meant that there was a risk that the person could be given more than the recommended dose. We have identified this is an area of practice that needs to improve.

Medicines were stored securely and systems were in place to check that medicines were stored within the correct temperature range. There were effective systems in place to ensure that medicines were ordered and disposed of when needed and all records were up to date and accurate. People who were able to consent were offered their medicines and reminded what they were for. Some people were receiving their medicines covertly, that is without their knowledge. There was clear information to support staff in administering covert medicines and best interest decisions had been documented in line with the Mental Capacity Act 2005 (MCA). We observed staff administering medicines to people and found the process was well managed and sensitively executed. Medication Administration Record (MAR) charts were accurate and auditing systems were in place to ensure any omissions in recording were addressed.

Risks to people were assessed and care plans were comprehensive and provided clear guidance for staff in how to care for people safely. However care provided was not always consistent with people's risk assessments and care plans. For example, one person was assessed as having risks associated with their

mobility. The moving and handling care plan detailed that the person should be supported to move with the use of a stand- aid. A recent review had confirmed that the person was able to stand well using this equipment and could support herself using the handles. However during the second day of the inspection we observed two members of staff using a handling belt in an inappropriate way to support the person to move. This was not in line with the person's care plan and put the person and staff at risk of injury. This was brought to the attention of the manager and is an area of practice that needs improvement.

Some people were assessed as having risks associated with swallowing and needed to have thickening powder added to fluids to reduce risks of choking or inhaling fluids into their lungs. NHS England produced a safety alert in February 2015 regarding risks associated with accidental ingestion of thickening powders which can lead to obstruction of the airways. The guidance states that such products must be stored securely to reduce the risk of accidental ingestion by people who may be vulnerable. On two occasions during the inspection we observed that thickening powder had been left within reach of people who were living with dementia and could be at risk of accidentally swallowing the powder. Staff told us they were aware of the guidance and that the powder was usually kept securely, however there had been an oversight on this occasion. We brought this to the attention of the manager who took immediate action to rectify the situation. This is an area of practice that needs improvement.

People were living with a range of conditions, disabilities and needs. Risks to people were identified and assessed and care plans guided staff in management of the risks. Validated tools had been used to assess and review risks such as a Waterlow assessment for skin integrity and pressure sores. For example, one person had been admitted to the home with some pressure sores and their risk assessment and care plan were clear and detailed. The Waterlow assessment indicated them to be at very high risk and a referral had been made to the Tissue Viability nurse (TVN). Body maps were used to identify the areas of pressure damage and advice from the TVN had been included in the care plan. Records showed that staff were following the care plan and some improvement had been seen. The person told us he was satisfied that staff were doing all they could to support his needs.

Some people needed to have their nutrition, fluids and medicines via an enteral feeding system. This is a flexible tube that enables fluids and liquid foods to be delivered directly into the gut. There were appropriate risk assessments and care plans in place providing very clear guidance for staff in how to provide care and manage the feeding system safely. This included care of the skin around the site of the tube and guidance on how to identify any problems or issues with the feeding system. A specialist nurse and dietician were involved and their advice was included in the person's care plan. A relative told us they were satisfied that their relation's feeding system was being well managed by the staff.

Some people were living with long term health conditions such as diabetes, Parkinson's disease and dementia. Appropriate risk assessments had been completed and comprehensive care plans guided staff in how to provide care to people safely.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had a Personal Emergency Evacuation Plan (PEEP) in place providing information about the support they would need to evacuate the building.

The provider had a robust recruitment process in place to ensure that people were supported by staff who

were suitable to work in a care setting. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files contained evidence to show where necessary, staff belonged to the relevant professional body. Documentation confirmed that nurses employed had up to date registration with the nursing midwifery council (NMC).

Staff demonstrated a clear understanding of their responsibilities with regard to safeguarding people. They were able to describe how they would recognise signs of abuse and were clear about what action they would take and who they would inform. One staff member said, "If I was worried I would always report to the manager or the nurse on duty. They would make a safeguarding alert to social services. It's our job to make sure people are safe." Another staff member said, "I would have no hesitation in reporting anything of concern." A third staff member said, "I have had the safeguarding training and I know about whistleblowing, I would always report anything worrying." Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. Records showed that appropriate actions had been taken to address safeguarding issues and alerts had been made to the local authority in line with local safeguarding arrangements and the provider's policy.

People and their relatives told us that they found the environment in both Marriott House and Marriott Lodge to be consistently clean and comfortable. People spoke highly of the domestic staff, one person said, "The cleaners do an excellent job." Another person said, "The home is always very clean." Cleaning schedules were in place and we noted that the environment in both buildings was clean with no unpleasant smells.

Good

Is the service effective?

Our findings

People and their relatives told us they had confidence in the skills and knowledge of the staff. One person said, "The staff know what they are doing." Another person said, "The care staff are very good. They will check things if they are not sure, they ask the nurse on duty- that gives me confidence in them." A third person said, "I need full time nursing care and I feel reassured that I will get it here." A relative told us, "I have found the staff to be very knowledgeable and understanding, I have total confidence in them." Another relative said, "My relation has quite complex needs. The staff are very capable and we are content with the service."

Staff told us they were receiving the training and support they needed to be effective in their role. One staff member said, "A lot of the training is on the computer now, but it's quite good and jogs your memory, I enjoy the face to face training best." Another staff member said, "I have been able to do lots of training and I've applied to do my NVQ." A third staff member said, "I'm up to date with my training and I have asked to do additional training in End of Life Care because that's a particular interest for me." A wide range of training topics were available that were relevant to the needs of people living at the home. The manager had developed links with health care professionals from Western Sussex Hospitals NHS Foundation Trust who were providing additional training for staff in nutrition and hydration. There were management systems in place to identify when staff were due to refresh their training and we saw the training diary included planned courses in relevant subjects including dementia awareness. Registered Nurses were also supported to access training relevant to their roles and told us that the clinical lead had helped them to identify areas for development. Some senior care staff, known as Care Practitioners, had received additional training in some areas, including administration of medicines and supported the nursing staff with some tasks.

Staff told us they received regular supervision and appraisals. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Staff told us that they found these meetings useful. One staff member said, "We have a carer's meeting and individual one to one sessions, both are useful for discussing how we can do things better." Another staff member said, "I have regular supervision, it's helpful to have the opportunity to talk privately because you don't always want to say things in front of the other staff." Records showed that most staff had regular supervision meetings although some were less consistent. All the staff we spoke with told us they felt well supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were

being met.

Staff had a good understanding of their responsibilities with regard to gaining consent from people. They were able to tell us about the principles of the MCA and understood why some people were subject to DoLS authorisations. Throughout the inspection we observed that staff were checking with people before providing care. For example, we heard a member of staff asking one person, "I have your cardigan here, would you like some help to put it on?" At meal time another staff member said, "Would you like me to put this apron on to protect your dress?" One staff member told us, "Even if people don't have capacity for some decisions we still need to offer them choices and check their wishes." Records confirmed that specific decisions were made in line with the legislation. For example, one person had been assessed as needing bed rails to keep them safe. As well as a risk assessment, a mental capacity assessment had been completed which determined that the person had capacity to consent to the use of the bed rails and their consent had been obtained and recorded. Some people were assessed as lacking the capacity to consent to specific decisions. Records showed how decisions made in their best interest, had been agreed. The manager had applied for DoLS applications for some people and was aware of any conditions imposed upon the authorisation. There was a system in place to ensure that DoLS applications were made when the period of authorisation expired. This ensured that people were not being deprived of their liberty without legal authorisation.

People were being supported to have enough to eat and drink. People's views on the quality of the food varied but most people and their relatives told us that they were satisfied and that the food was nice. One person said, "The food is quite good, there are usually two choices, they ask what you want on the day." Another person told us, "It's adequate, it's not fine dining." A third person said, "It's excellent, I am a good eater so I should know. They've got a good chef." A relative said, "The kitchen staff are very good and accommodating. The food always looks nice." Other people were less positive, one said, "The food is basic and bland," another commented that the meat was often tough. One person told us they didn't like the food and staff had been worried because they were losing weight. However, they went on to say that a member of staff had spent time talking about what sorts of food they would prefer. The person said, "They bought some tins of custard and rice pudding and put my name on them. If I don't want what is on offer I have one of them. It was a really good idea." People told us that if they didn't want the meal on offer an alternative was agreed and provided. One person said, "They'll make you something else, it's usually nice."

We observed the lunch time meal in both Marriott House and Marriott Lodge. In the main dining areas the tables were set attractively and people were asked where they would like to sit. Staff offered people a choice of drinks including fruit juices, squash, sherry and wine. There was a menu on each table and we observed staff explaining what the choices were. Some people were having their meals in their bedrooms, staff told us this was either because the person was not well enough to come to the dining room or it was their choice to eat in their room. Staff members were allocated to take meals to people's bedrooms. A staff member directed this process, giving clear information, including how much support each person needed with their meal. We observed that staff were following these instructions. People were supported with their food patiently and they were not being rushed.

Staff demonstrated a good knowledge of people's different dietary needs. For example, staff were aware that some people had food allergies, and knew which people were currently having their intake of food and fluid monitored, due to risks associated with nutrition and hydration. People were weighed regularly and where they were found to have unplanned weight loss they were referred to health care professionals for further assessment. Details of advice provided by Speech and Language Therapists (SALT) and Dieticians were included within people's care plans. For example, one person had been prescribed fortified drinks when they were found to have lost weight over two consecutive months and their care plan had been

updated accordingly.

People and their relatives told us that they were supported to access the health care services they needed. One person said, "If you need the doctor they arrange it." Another person said, "I see the doctor or sometimes the nurse. I might ask about seeing an optician to get stronger glasses." A third person told us, "I have to attend clinic appointments and they sort it out for me, transport and someone to come with me because I can't go on my own now."

People and their relatives told us that staff were proactive in seeking on-going health care support. Some people were living with long term conditions such as Parkinson's Disease. One relative said, "The staff here made contact with the specialist nurse, and they are also looking into physiotherapy. They (staff) are always willing to listen to me, they recognise that I have a lot of expertise about the condition." Records showed that appropriate referrals were made to health care professionals including, Tissue Viability Nurse, (TVN), Dietician, Specialist nurses, SALT, GP, Optician, Chiropodist and Dentist. We spoke with a visiting health care practitioner who told us that they found staff to be helpful and knowledgeable about the people they were caring for. They said staff followed the instructions they left, communicated well and were proactive in identifying concerns. Staff described positive relationships with visiting health care professionals.

The home had been adapted to support people who needed equipment, such as wheelchairs, to move around. People told us they were able to access the garden and move around the house freely. The general standard of decoration around the home was poor with chipped wood and peeling paint in places. One staff member told us, "We need to have some of the doors widened and more storage space, the place looks a bit shabby now." One person told us that there were maintenance issues saying, "There have been problems with the plumbing and heating and there was a flood. All the carers worked their socks off, they were wonderful." The manager told us that the heating and plumbing issues were in the process of being resolved and we observed that work was being undertaken to make improvements. The manager said that the home was due to undergo a refurbishment programme in the new year and the provider was committed to making substantial improvements. They said, "The ground floor will be completely transformed, the programme is called the 'Wow factor' and it will take some time but the home will be refurbished to a high standard."

Requires Improvement

Is the service caring?

Our findings

Most people and their relatives spoke highly of the care they received and described positive relationships with staff members. One person told us, "They are a very nice group of girls, I call them my grand-daughters." Another person said, "I have known some of the carers four or five years and we're mates." A third person told us, "I have always got along with the staff, they are perfect." Another person said, "They are very kind to me." Relatives also told us that staff were caring, one relative said, "I'm very satisfied with the care I have received and for my husband." Another relative said, "The carers are fantastic." However, despite these positive comments we found some areas of practice that needed to improve.

People's dignity was not always protected because staffing levels meant that call bells were not always answered quickly and sometimes staff were rushing to complete care tasks. For example one person said, "The staff are often pushed for time and have to rush. They do their best but I don't like to bother them too much." One relative described the impact upon their relation as degrading, they told us, "Yesterday my (relation) had to wait for the carers, we were asking them and they kept saying "We'll be there as soon as we can." It's not their fault, they are running from floor to floor but it's not fair on the people." Staff told us that they were aware that some people had to wait to receive the care they needed. One staff member said, "Sometimes we are rushing people, it's a job to get through everything we need to do so there is an impact."

Some people told us that not all the staff were kind and caring, one person said, "There are some good ones (staff), and some are not so good. They do what has to be done but don't look beyond that. For example, if you ask for something they say OK but then don't come back." Another person said, "Some of them should not be carers because they are abrupt." They went on to explain how they felt one particular staff member had a bullying attitude. A third person said, "Sometimes they are not kind," and described a situation where a care worker had spoken sharply to them. One relative told us that they had heard a staff member telling their relation, who was living with dementia, to stop ringing their call bell. They said, "The carer came in and was horrible, she said, "Take your finger off that." I think it was an agency worker." We asked people if they had raised their concerns with the manager, one person said, "It's not really worth it, all the other staff are very good," another person said, "I'm not that bothered really." A relative said, "I would like the manager to know but not until my relation has left the home in case of any repercussions." We brought these comments to the attention of the manager and the deputy manager who said that they would take appropriate action in line with their safeguarding policy. Since the inspection the provider has confirmed that the local authority were informed of these concerns and actions have been taken to ensure people's safety.

Our observations were that most staff members were caring in their approach to people. However we also noted some less positive interactions, for example, during meal time most staff were seen chatting to people and offering help and support, however some staff took a very task focussed approach. One person had their meal placed in front of them without any acknowledgement from the staff member. Another person was being supported with their meal in their bedroom but the staff member was not speaking to the person and their interactions were task focused. A third person, who was living with dementia, was sitting alone in a lounge area of the home and although staff were seen walking past the person, none of them

acknowledged their presence or stopped and spoke to them. One person was observed to be in their room when lunch was being served. They said they were waiting for a staff member to bring them to the dining room however when we asked a staff member, they told us that the person had been forgotten. They were later observed eating their meal in the dining area but most other people had finished eating.

People and their relatives told us that most of the staff were kind and caring in their approach however not all interactions between staff and people were consistently positive and people's dignity was not always protected. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that they had been involved in planning their care. One person said, "They wanted to know how I like things done." A relative said, "When my (relation) came here for respite initially they were very thorough in the planning and we had a lot of in-put, that made it easier when it became a permanent arrangement because they already knew so much about our situation." Another relative told us, "I am here for a review today, they keep me fully involved." One person told us that they had made a decision to stay in bed and that their views had been respected. They said that staff had been clear about the risks associated with this choice but staff had accepted their right to make the decision. The care plan showed how care had been designed to meet the person's needs when staying permanently in bed.

People told us staff supported them to maintain their independence. One person said, "I am able to do most things for myself and staff do the little things that I can't." Another person said, "I can walk up and down the corridor now and in the summer I was scared of going out, but now I can do a tiny walk in the garden." A third person told us, "I like to be independent and do as much as I can for myself." Staff demonstrated a clear understanding of people's individual needs and described how they supported people to maintain their independence. One staff member said, "I always offer people choices, for example what they want to wear or eat and encourage them to make their own decisions." Another staff member described how they encouraged a person to participate in an activity stressing the importance of continuing to socialise. One staff member described helping a person to rearrange the furniture in their bedroom to make it more accessible for them. They explained, "It made a big difference because they could move around independently, before they had to ring their bell if they needed something."

Staff had a firm understanding of the importance of maintaining confidentiality. One staff member said, "Sometimes the residents want to know what's going on with someone else who lives here but I wouldn't tell them anything, I usually just say I don't know." Another staff member said, "People's personal information is all locked away, to protect their privacy." We saw that people's records were kept securely in locked cabinets.

People and their relatives told us that staff were welcoming towards visitors. One person said, "They are welcoming, very much so, people can visit at any time." A staff member confirmed that visitors were always welcome and said, "We have a lifestyle kitchen here so people and their relatives can make a drink whenever they want one, or staff will make it for them." One relative told us, "I am always made to feel welcome and the nurses are so kind and understanding, the staff have treated us really well."

People's care records included end of life care plans. A staff member told us that they encouraged people to talk about and document their wishes but not everyone was prepared to talk about end of life care. They said, "It's such a personal and sensitive thing to talk about, but usually people are prepared to complete the document. Sometimes they just say, my family will deal with it when the time comes." We saw some highly personalised examples of end of life care plans with clear details about people's wishes. Others had been completed with more basic details and some noted that the person preferred not to discuss their wishes.

Staff understood the importance of providing support and reassurance to relatives of people who were approaching the end of their life. One staff member described how they put on quiet music and used gentle lighting to provide a calm and peaceful atmosphere when families were spending time together. Another staff member said, "It's so important to get the care right at the end of people's life and to support the family to be as involved as they want to be with the care."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that there was a considerable range of organised activities provided by the home. Some people spoke highly of the variety of events that were on offer including, bingo, music and quizzes. The home had dedicated staff to arrange the activities programme and to support people to attend. Volunteers were also involved in supporting the activities programme and helping people to take part. Despite this positive programme of events some people told us that they did not have enough to do and often felt bored. One person said, "The activities are very good but I don't join in because it's not my type of thing." Another person said, "I don't want to join in, it's not my scene." A third person said, "I don't do the activities, they do ask if I want to do something else but the only thing I enter into is the communion service on the first Wednesday of the month."

Our observations throughout the inspection confirmed the mixed response that people had expressed regarding available activities. Whilst there appeared to be a number of activities arranged, not everyone wanted to join in and those that did, were not all engaged with the process. For example, we observed a musical reminiscence session attended by fifteen people. An activities co-ordinator was encouraging and supporting people to be involved however no other staff were supporting the process. This meant that there was little interaction with some people who fell asleep. Another activity co-ordinator was supporting four people with a cookery session and later the same group were participating in an arts and craft session. All the people who were taking part were engaged and clearly enjoyed the activity. Other people told us that they did not want to take part as these activities did not appeal to them. Some people told us that they were bored because they were not interested in the activities on offer. One relative told us their relation, "Feels as if they are shutting down through lack of stimulation."

We asked staff how they planned activities to support the interests of all the people living at the home. They described discussing the activities programme in monthly meetings with people, but acknowledged that many people did not attend these meetings. A staff member described having individual meetings with people and discussing their needs. They said that these meetings were documented and included checking if the person would like to suggest any other activities. Some people expressed a desire to be able to go out with staff to accompany them. One person said, "I would love to go out more but I only leave here to attend hospital appointments, I can't go out on my own and staff are too busy to go with me." Another person told us that they felt they had nobody to talk to because so many other people were living with dementia and they couldn't always hold a conversation. A third person described feelings of isolation and loneliness and said that they used to enjoy going out but they weren't able to do so independently anymore. A staff member told us that they worried about some people becoming isolated. They told us, "Some people are very isolated in their rooms and never want to join in, we try and sit and have a chat with them but we are too busy to do that often." Another staff member said, "That's what we could do better here, we could be better at getting people out more. I think some people are very lonely, they don't engage and we could do more if we had time." Whilst the activities programme was meeting some people's needs, other people remained at risk of social isolation. Meeting people's need for social interaction and stimulation and supporting them to follow their interests is an area of practice that needs to improve.

People's needs were assessed before they came to live at the home and care plans were developed to support people's individual needs. The care planning process was holistic and included details of people's physical and mental health needs as well as their cultural, social and emotional requirements. Care records included information about people's life story and events and people that were important to them. Care plans were personalised and included people's likes and dislikes. For example, one care plan indicated the person's preference for a strip wash as they did not like showers or baths. Staff were aware of this, and records showed that they supported the person with this choice. Other care plans detailed people's interests and activities that they enjoyed. One care plan identified the person's previous love of singing and noted that they still enjoyed music, we noted that they took part in a music session and appeared to enjoy this interaction.

Care plans had been regularly reviewed and were updated to reflect people's current needs. For example, one person had communication difficulties and their care plan guided staff in how the person used technology to communicate their wishes. Another person was receiving end of life care and their condition had deteriorated in recent weeks. Risk assessments had been reviewed and amended to reflect changes in their care needs associated with their declining health. An updated care plan included a clear description of signs that might indicate discomfort and guided staff in what to do in these circumstances.

Some staff members demonstrated how they provided personalised care. For example, one staff member described how a person always preferred to have a cold drink and liked to watch their television with sub-titles and no sound. Another staff member described how a person had liked to ride motorbikes when they were younger and explained how they used this information to support the person to feel comfortable when using equipment to help them move. They said, "I tell them to hold on to the handle bars as if they were going up- hill on their bike." Another staff member told us that a person particularly enjoyed classical music and we noted that this was playing on the radio in their bedroom.

People and their relatives told us that they knew how to make a complaint. One person said, "I'm perfectly capable of speaking my mind." Another person said, "I would say what's wrong and what's right, but I am contented." A relative told us that they had raised a concern and it had been dealt with appropriately. Another relative said, "Everyone here is approachable, I would voice a complaint to anyone, they would all be prepared to listen." The provider had a complaints system and kept a log of all complaints that were received. This showed the nature of the issue and how it was resolved. Whilst most people told us they would feel confident to make a complaint, some people, or their relatives, told us they would not feel comfortable to do so. This was because they were not confident in how the complaint would be resolved or if there would be any repercussions from complaining. The registered manager gave us assurances that a review would be undertaken to address people's concerns and to identify ways of helping people to feel safe to raise any issues or concerns they had. We identified this as an area of practice that needs to improve.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff told us that the management of the home was generally good and that the manager was approachable. One person said, "The manager is very accommodating." Another person said, "The manager is marvellous, they sort out as much as they can for you." A third person said, "She's a very nice person, I'll be sad to see her go." Some people told us that they were not sure who the manager was. One person said, "It's changed, I never know who is in charge." Another person said, "It used to be (person's name) but I don't know who is in charge now." The registered manager had left the home in May 2017 and a new manager had been appointed but had decided not to apply to become the registered manager. They told us that they had resigned and their last week coincided with the inspection. The regional director told us that a new manager had been appointed and was due to start the week after the inspection.

Most people spoke highly of the way the home was managed. One person said, "It's well run," another person said, "It's run very smoothly, it's not chaotic." However, despite these positive comments we found some areas of practice that required improvement.

Management systems and processes were not always effective in identifying shortfalls in the quality of the service. For example, the manager and the regional director told us that a dependency tool provided an accurate indication of how many staff were needed to provide care to people. However we found that, whilst staffing levels had been consistently maintained in line with the dependency tool, there were not always enough staff to care for people safely. A report produced from the provider's call bell system showed that some people were waiting for an unacceptable length of time for their call bell to be answered. The manager told us that the report had not been regularly reviewed and this, therefore, had not been noticed. Feedback from people, their relatives and staff at the inspection indicated that there were not enough staff on duty. Notes from meetings held earlier in the year showed that staff had raised concerns about being 'Frequently short staffed.' A relatives meeting notes also showed that relatives had raised concerns about staffing levels. This shows that there was a failure of management oversight to identify shortfalls in staffing levels.

A number of audits were in place to monitor standards of care. These included internal and external audits. However not all audits were effective in identifying shortfalls. For example, a medicine audit was in place and had been undertaken regularly. However this had failed to identify that PRN (as required) medicines were not being managed consistently.

Care plans and risk assessments were detailed and up to date however staff were not always following care plans consistently and this meant that some people were exposed to avoidable risks. Management oversight had not identified that staff were not always following care plans.

Management systems and processes were not always effective and there was a lack of management oversight in identifying shortfalls in the quality and safety of services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff were clear about the management structure at the home. However, staff working at Marriott Lodge were less sure and described a lack of leadership that sometimes led to confusion. One staff member said, "There are a lot of managers, I'm not sure communication is always good between the Lodge and the House." Another staff member said, "It's not always clear who is in charge over here (Marriott Lodge)." We asked the manager to clarify the management arrangements for staff working in Marriott Lodge. They explained that the deputy manager had been mainly responsible for managing staff in Marriott Lodge but that a head of care had been appointed to take over this role. However the head of care was not yet able to fully take on their role as they were covering for staff shortages and this had prevented them from taking on their new management responsibilities. Ensuring there was clear governance and leadership in all areas of the home was identified as an area of practice that needed to improve.

Staff told us they felt well supported in their roles and that there was an open culture at the home where they were able to raise concerns and ideas. Their comments included, "The home is well run," and, "The managers know what they are doing." One staff member told us, "There is a family atmosphere here, staff are very committed to the residents." Another staff member described how some staff members who had left still returned to visit people, they explained, "Staff do really care about people, that's the best thing about working here." Staff we spoke with understood the ethos of the home describing a person centred approach and enabling people to remain as independent as possible.

The manager told us that staff had developed positive links with a number of local organisations including a local primary school, GP surgeries, Parkinson's Disease support group and a carers organisation. Staff had developed strong links with local health care organisations and told us that they benefitted from additional training. For example, a local community dietician team were providing training on management of malnutrition and enhancing people's meal time experience.

The provider undertook quality assurance surveys to gather people's views on the care provided. People and their relatives confirmed that they had been asked to complete feedback forms to gather their views. One person said, "I did complete one, but I don't know what they did about it." We saw the last completed survey from 2016 which showed the results had been measured against a national average and provided a positive overview of people's responses. The manager told us that the results of the survey for 2017 had not yet been completed but that once they had the results they would be circulated to people and their relatives and an action plan would be developed to take forward any areas for improvement. The manager said that the provider was committed to investing in the fabric of the building and making improvements to the environment. They described the planned refurbishment work that was due to begin and explained how people and their relatives would be involved the changes around the home. Some people and relatives that we spoke with were aware of the forthcoming developments, one relative said, "Apparently it will give the building the 'Wow factor'. We are all looking forward to it because some areas are looking a bit tired."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of the Duty of Candour, and understood when it would apply. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that staff always treated people in a caring way and maintained their dignity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were effective in ensuring the quality and safety of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there sufficient numbers of suitable staff to care for people