Careconcepts Limited

Marion Lauder House

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

We undertook an inspection of Marion Lauder House on 11and 12 April 2017. The first day of inspection was unannounced which meant the provider did not know we were coming.

We last carried out an inspection at Marion Lauder House on 5 January 2016. We rated the service as requires improvement overall.

Marion Lauder House provides nursing and personal care and accommodation for up to 75 older people, some of whom are living with a diagnosis of dementia. There were 68 people living at Marion Lauder House at the time of this inspection.

The home accommodates people requiring nursing and residential care over two floors in three living units called Maple, Brookfield and Cherry. There is also a respite assessment unit that provides residential dementia care. At the time of our inspection the provider had recently renovated a bungalow in the grounds of the home and was using this for additional accommodation.

There was a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had kept us informed of safeguarding incidents and other notifiable events which had occurred in the home in line with their statutory obligations. Staff were confident in describing the different kinds of abuse and the signs and symptoms that would suggest a person they supported might be at risk of abuse. They knew what action to take to safeguard people from harm. All of the staff received regular training that provided them with the knowledge and skills to meet people's individual needs in an effective manner.

People's safety risks were identified, managed and reviewed and the staff understood how to keep people safe. There were sufficient numbers of suitable staff to meet people's needs and promote people's safety.

We looked at medication administration records (MARs) on the nursing unit and on the respite unit. Records on the nursing unit were complete and accurate. Nursing staff were recording initials when administered and using the key code on other occasions, for example when PRN medicines were not required or if medicines were refused and destroyed. The recording of medicines on the respite unit was confusing and not always accurate. The manager provided evidence that this had been addressed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and was aware of the principles of the Mental Capacity Act 2005. Staff sought people's

consent before they provided care and support. However, some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed. Where people had restrictions placed upon them to keep them safe, the staff ensured people's rights to receive care that met their needs and preferences were protected.

The environment was designed to enable people to move freely around the area of the home where they lived. There were lounges and dining areas in each unit of the home and a large activity room in a separate area of the home. This room was used to provide day care for a number of clients but it was also accessible to people living in the home if they expressed a wish to do so. There was also access to secure garden spaces from lounges on the ground floor . The physical environment of the home had undergone positive change and we saw that the residential unit in particular was stimulating and interesting for people with dementia.

People were treated with kindness, compassion and respect and staff promoted people's independence and right to privacy. Mealtimes were pleasant experiences for people, and those who needed assistance were helped by staff in a discreet and calm manner.

People, relatives and other healthcare professionals involved with the service said that the support staff were caring. On the day of our visits we saw people looked well cared for. There was a relaxed atmosphere in the home. We saw staff engaging with people, speaking calmly and respectfully to people who used the service.

Care plans we looked at confirmed that a detailed assessment of needs had been undertaken by the registered manager or a nurse before people were admitted to the service. We reviewed whether the care plans were written in a person-centred way and judged that they were. People using the service and their relatives were consulted and involved in assessments, care planning and the development of the service.

The treatment of wounds was detailed and thorough and the home had worked hard in establishing the right links and professional support. We were confident that the home was responsive to changes in people's skin and working well to reduce pressure sores.

Staff told us that they felt supported by the registered manager. Regular team meetings were also held and the service offered incentives for staff and had an employee of the month scheme. Staff were able to raise any issues or concerns at these meetings. Staff spoke highly of the management at the home.

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response. Appropriate action had been taken to address issues identified during these audits.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could continuously improve. People were signposted to the suggestions box in reception. This showed us that the home was willing to consult with all stakeholders in the service and take on board what people said.

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.

Medicines records on the nursing unit were complete and accurate. The recording of medicines on the respite unit was confusing and not always accurate.

Care records contained individualised risk assessments and risk management plans and we saw that risks had been discussed with either the person or their relative.

The provider followed a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home.

Is the service effective?

Good

The service was effective.

Staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Marion Lauder House.

People we spoke with expressed satisfaction with the food and drink provided in the home. Residents were consulted about menus and their comments were taken into account when planning menus.

The physical environment of the home had undergone positive change. The residential unit in particular was stimulating and interesting for people with dementia.

Is the service caring?

Good

The service was caring.

Staff displayed respect and admiration for people using the service and we saw that trusting relationships had formed.

People were supported to eat. Care workers were discreet and engaged with the individual they were supporting.

Staff were aware of their role and responsibilities and were able to describe the needs of individuals who used the service.

Is the service responsive?

Good

The service was responsive.

Care plans contained detailed clinical information, including identified risks, as well as information relating to people's preferences about care and support.

The treatment of wound care was detailed and thorough. The home had worked hard in establishing the right links and professional support.

Complaints were logged and dealt with according to company timescales. If people felt it necessary to make a complaint they were confident that this would be addressed.

Is the service well-led?

Good

The service was well led.

It was clear that people had confidence in the registered manager. They were a regular presence in the home.

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could continuously improve.

Marion Lauder House

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 the 11 and 12 April 2017 and was unannounced on the first day. The inspection team included an adult social care inspector, an inspection manager and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection one inspector from the inspection team was on site.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. The service had completed a provider information return (PIR) for this inspection. A PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. No concerns were raised about the service provided at Marion Lauder House. We liaised with other professionals involved with the service at the time of our inspection and received complimentary feedback about management and staff.

We spoke with nine people who used the service, eight visiting relatives and 12 members of staff, including the registered manger, two nurses, maintenance staff and the chef. There were also informal conversations with management and staff members during the two day inspection. We observed the way people were supported in communal areas and looked at records relating to the service.

Some people who used the service were unable to tell us about their care therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care. We observed care and support at

lunch time in the dining rooms and also looked at the kitchen, the laundry, a number of people's bedrooms and the outside space available for people using the service.

We reviewed five people's care records in detail. We looked at four staff recruitment files and fifteen records in relation to staff training, supervisions and appraisals.

We looked at the systems and processes in place for monitoring and assessing the quality of the service provided by Marion Lauder House and reviewed a range of records relating to the management of the service; for example medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, safeguarding records, policies and procedures, compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

When we spoke with people living at Marion Lauder House they told us they felt safe and well cared for. No one we spoke with raised any concerns about how staff treated them. When asked if they felt safe people told us, "Yes, I do. I've never felt unsafe" and "I've always felt safe here. I'm well cared for." Visitors we spoke with told us they considered their relatives to be very safe and told us, "Nobody could do better" and "He's definitely safe here. They look after him very well." We saw minutes from a relatives meeting held at the home. A relative had said in this forum, "I can sleep at night knowing my mother is being looked after, I feel reassured she is safe."

The registered manager told us that a dependency tool was used to calculate direct care hours required each week, based on the needs of the people living in the home. The Provider Information Return (PIR) stated that the home was usually staffed higher than the level suggested by the tool. On the days of our inspection there were enough staff on duty to meet people's needs. People we spoke with told us there were enough staff available when they needed help and support. People told us that staff responded to their needs in a timely manner. A visitor we spoke with told us, "They [care staff] always instantly respond to the buzzer system" and we saw that call bells were attended to in a timely manner throughout the inspection.

We looked at the staff rotas to check staffing levels were consistent and they were. The home employed domestic staff to clean the home and maintenance staff to oversee repairs and redecoration to all areas of the home. This meant that care staff were not undertaking additional duties and were available to attend to people requiring assistance with personal care needs. People using the service could be reassured that they would be kept safe, being supported by adequate numbers of staff.
We looked at the care records for five people who used the service. Care records contained individualised risk assessments and risk management plans and we saw that risks had been discussed with either the person or their relative. Care plans contained detailed guidance for staff to follow to minimise risks for people. We saw risks in relation to the use of hoists, falls and eating and drinking. Risk assessments were updated and reviewed following any incidents that occurred. Detailed risk assessments meant that there was a robust risk assessment and management strategy being followed to keep people safe from accidental harm.

For example, it had been identified that an individual's ability to mobilise with one person assisting had deteriorated. The service had reviewed the care plan, reassessed their needs and indicated that two care workers were now needed to assist with moving and handling. We saw the person's risk assessment and care plan had been updated to show this and staff we spoke with confirmed they were aware of the changes in need. We saw two crash mats and three sensor mats in rooms we looked in during our walk round the building. Sensor mats were in use during the night to alert staff if people got out of bed and crash mats were in place to reduce the risk of injury. These were in rooms of people identified as high risk of falls from the bed. We saw that both crash mats and sensor mats were safely stored under beds, so as not to pose a trip hazard during the day.

We noted that in two of the bedrooms we went in people did not have access to the nurse call system. This

was either unplugged or not within reach of the bed. This was flagged up to the registered manager who told us this would be rectified. People should have access to a nurse call alarm unless identified as high risk of strangulation, which if so, should then be reflected in the person's care plan. We checked seven other rooms and saw that people did have access to the call alarm in these rooms.

As part of our inspection, we make sure the service administers, stores and disposes of medicines appropriately. Most medicines were delivered to the service in colour coded packs that corresponded with the main administration times, for example breakfast, lunch, tea and night time. We saw that some medicines which were required as and when (PRN) were kept as 'named' stock and arrived boxed or bottled. Medicines were checked into the service by two staff members who signed and recorded the quantities received. Following checks made to a recent delivery of medicines, staff had noted that the pharmacy had sent a bottled medicine with no name sticker on it in error. The registered manager had flagged this up to the pharmacy and was meeting with them to raise their concerns. This showed us that staff were accurate when checking medicines and were confident to raise any errors or discrepancies to the manager.

We looked at medication administration records (MARs) on the nursing unit and on the respite unit. Records on the nursing unit were complete and accurate. Nursing staff were recording initials when administered and using the key code on other occasions, for example when PRN medicines were not required or if medicines were refused and destroyed. We noted one entry indicated medicines had not been administered, the relevant code had been entered and a note made overleaf. This documented that an individual's specific night time medicine had not been administered on one particular date as they were drowsy. This showed us that staff were vigilant, assessed the patient before administering medicines and did not over-medicate.

We identified discrepancies however with medicines on the respite unit as the recording of medicines on this unit was confusing and not always accurate. For example we saw a staff member had used two letters to record PRN medicines were not required. Using two letters could be mistaken for a person's initials and might indicate to other staff that PRN medicines had been taken. Only one letter should be used, as per the codes supplied on the MAR chart. It was not always recorded whether one or two PRN paracetamols had been given when this was a prescribed option.

Respite staff were recording on a different week on the MAR chart to the rest of the home as these medicines were not scheduled the same as other medicines. We brought all of this to the manager's attention who provided us with an investigation report days after the inspection. Staff had been spoken to about recording omissions and respite medicines were to be brought in line with other units to avoid confusion. We were assured that all medicines systems in the home would then operate robustly.

Each person had an up to date photograph on the front of their MARs, to assist staff with ensuring the correct person received the right medicines. People who required their PRN, had a protocol kept with their MARs. These protocols outlined to staff when PRN medicines might be needed and indicated the behaviours people might display when in pain, for example facial expressions or shouting. All staff with responsibility for administering medicines had an annual competency assessment to ensure they had retained the skills and knowledge to undertake the task. People who required their medicines to be administered covertly had a best interest decision recorded. We saw that best interest discussions involved people's relatives when applicable following an admission to the home when covert administration of medicines was in place. We were assured that all relevant persons were involved including the GP prior to any decisions being made.

Some people living at Marion Lauder House, required medicines known as controlled drugs. Controlled drugs require additional checks to be completed and are required to be stored separately in a secure unit.

We saw that two senior members of staff checked the controlled drugs at the start of each shift. This showed the service was ensuring these medicines were being stored and administered safely.

A system was in place to record all accidents and incidents, such as falls. The registered manager told us that the outcomes of accidents and incidents were analysed to see what lessons could be learnt and reduce future risk by taking preventative action. We saw from records kept at the home that when an incident occurred the service had taken appropriate action to prevent it from happening again.

We saw that the service was responding to safeguarding concerns appropriately. Where there had been a recent incident involving a resident leaving the building we saw the service had taken appropriate action by contacting the local authority and family members, as well as notifying the Care Quality Commission (CQC). The provider had collected statements and had taken appropriate action to reduce the risk of this happening again.

Any safeguarding incidents were reviewed by the registered manager and clear action plans were put in place when warranted. An incident had occurred on the day of inspection prior to our arrival. The manager had responded immediately, had identified the risks and put mechanisms in place to reduce the risk of reoccurrence. The actions and reporting of the safeguarding incident were fully completed by the end of our first day of inspection.

We looked at four recruitment files and found the provider followed a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home. Personnel files were in good order. The correct paperwork was on file in relation to the recruitment process and recruitment records for staff included proof of identity, two references and an application form.

Disclosure and Barring Service (DBS) checks were in place for those employed by the service. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. We saw that checks were undertaken to ensure that the registered nurses who worked at the service had a current registration with the Nursing and Midwifery Council (NMC), ensuring they were authorised to work as a registered nurse. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

Every person living at Marion Lauder House had a personal emergency evacuation plan (PEEP) which identified the assistance and equipment they would need for safe evacuation in the event of an emergency, for example a fire. We saw evidence of regular unannounced fire drills and staff we spoke with were able to outline the fire evacuation process. We were assured that people would be appropriately supported in the event of an emergency.
We saw ancillary staff, such as cleaners and maintenance staff, going about their duties in a friendly and professional manner. People spoke very highly about the cleanliness of the home. When asked about this, visitors told us, "They have lovely big rooms and they're very clean. The toilets are dead clean" and "I'm glad I picked here, they really look after mum and it's kept very clean". Staff we spoke with informed us there had previously been an issue with insufficient supplies of protective equipment, for example aprons and gloves, but this was now resolved. One member of staff told us, "It used to be quite bad but (Staff Name) is responsible for ordering PPE now and it's fine now." This showed us the home had taken responsive action by ensuring supplies were ordered and fully stocked. On the first day of inspection we noted that one bathroom on the residential unit was not clean. We made appropriate staff aware of this who attended to it straight away. We saw measures in place around the building to prevent cross-contamination and promote good infection control, including the availability of antibacterial hand gel on every wing and in communal

areas of the home. This helped reduce the possibility of cross infection and promoted good infection control.

Good

Is the service effective?

Our findings

People at Marion Lauder House received effective care and support which took account of their wishes and preferences. People and their relatives spoke highly about the effectiveness of the care and support and we received positive comments, "The staff are good and really get to know you." A visitor explained that their relative had been unsettled and had displayed challenging behaviours when first admitted to the home but told us staff had managed the behaviours effectively and now the person was much calmer.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection we identified a breach in Regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2104 because the provider was not working within the principles of the Mental Capacity Act 2005. At this inspection we checked to see what improvements, if any, the service had made and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the correct assessments in relation to capacity and decisions to restrict someone's liberty had been followed. Staff had received training in the MCA and followed the basic principle that people had capacity unless they had been assessed as not having it. The registered manager had a good understanding of the Mental Capacity Act and was aware of their responsibilities.

We saw some good examples of how the service was following the principles of the MCA. We saw that where people could consent to care the resident had signed the care plan accordingly. Where this was not possible care plans contained best interest decisions made in line with the MCA 2005 and in consultation with relatives and other health professionals. The registered manager was also aware of a change applicable to DoLS in relation to statements of intent being in place. This ruling had come into force in April 2017, and highlighted to us that the registered manager had quickly updated their knowledge in respect of the recent changes.
We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Marion Lauder House. We saw from training records that staff had completed an induction programme at the start of their employment. This meant that staff understood their roles and responsibilities within the home and as part of the team. All new employees including bank staff covered the Care Certificate standards and we saw that dates of training for specific standards were pre-planned and scheduled up to the middle of May. The manager had oversight for all Care Certificate training and signed this off for all on completion.

We examined the training records and spoke with eight care staff about the training on offer. Training

records showed that staff did mandatory aspects of e-learning training, for example safeguarding, medicines, health and safety and infection control, and these were up-to-date. We saw and staff told us that they were also offered more specific training, for example in falls prevention and management, tissue viability and slings and hoists training. Personal development of staff was encouraged with NVQ's and QCF's completed at level 2 and 3. This meant that people were supported by suitably trained and competent staff.

We could see that staff had received supervision sessions and these were recorded on a supervision matrix. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.

We noted that some employees had more supervisions than others and were told that these were both formal and informal sessions. If it was necessary to update on practice or discuss a specific care issue, for example wound care, then a supervision with relevant staff would be held. Staff we spoke with told us that if a supervision was requested this would be undertaken by line managers. They told us that support from managers was on going and feedback was provided on a regular basis. They felt fully supported by managers and felt any concerns they brought up would be responded to.

Relatives we spoke with expressed no concerns regarding the support provided and said they were always kept up to date with information regarding their family member.

Residents were consulted about menus during resident's meetings and the chef told us that any comments were taken into account when planning menus. We saw information was available for the chef and displayed in the kitchen in relation to the consistency of food for people and we spoke with the chef who told us about the special diets catered for, for example diabetic, halal, vegetarian and coeliac diets. They were also provided with information relating to people's specific allergies.

People we spoke with expressed satisfaction with the food and drink provided in the home and said, "The food's good, no complaints at all and the portions are big enough. The service is good too," "The food's great" and "The food's lovely here, it's very, very good." Relatives we spoke with were complimentary about the choices of food on offer and told us, "She's [person receiving a service] a coeliac so they have a special diet for her, even including gluten-free cakes" and "She can have anything she wants at any time."

We observed lunch being served in the dining room on both days of inspection. The dining rooms were spacious and were pleasantly decorated, with appropriate music playing throughout the lunch time service. People seemed to have a preferred seat, sitting with people they knew. The lunch time meal was the main meal of the day and people were presented with choices. As the majority of people living in Marion Lauder House had a diagnosis of dementia their choice for lunch was not determined until at the point of service, when they were physically presented with both plates of the hot meal options and asked to choose which they preferred.

We saw staff offered people a choice of drinks with their meal and throughout the day and staff were monitoring and recording people's' fluid and food intake where it had been identified that the person was at risk of dehydration or malnutrition. People's care records we viewed showed that people's nutritional needs were assessed and monitored to ensure their wellbeing.

We checked to see that the environment had been designed to promote people's wellbeing and ensure their safety. We were told that the physical environment of the home had undergone positive change and we saw that the residential unit in particular was stimulating and interesting for people with dementia. The corridors

had been given a 'street' feel with light grey brickwork paper applied to walls and bedroom doors made to look like front doors. The hairdressing salon had been given a 'shop' makeover, with a barber's pole and signage. On the corridor of the residential unit there were full size transfers of a post box, telephone box and a replica bus stop with a local bus timetable and seating areas. Pictures in the corridor were of Manchester and focused on times gone by, with references to railways and local areas. People we spoke with considered the décor to be a 'big improvement' and staff used the environment, for example the pictures and the décor, as a starting point for discussion.

People's care records showed that their day to day health needs were being met. People had access to a GP and district nurses visited the service on a regular basis to undertake routine treatments, such as administer insulin, change dressings and take bloods.

The home had a good relationship with health professionals, including representatives from the local nursing home service who told us they carried out weekly visits to the home and had contact with senior staff on a near daily basis. We received positive feedback from one health professional we approached who spoke highly of the home's ability to deal with people with a broad spectrum of complex needs. We judged that the service was effective in responding to deteriorations in people's health and involved other professionals in strategic reviews of care.

Good

Is the service caring?

Our findings

People and their relatives were very complimentary about the service and the calibre of staff supporting people living at Marion Lauder House. People told us, "All the staff are amazing," "I like it here, they're very kind" and "The staff are good and really get to know you." A relative we spoke with commented, "The staff are very good and very engaging."

There was a nice, relaxed atmosphere in all areas of the home. We spent time observing people in the lounges and dining areas of the home and watched the activities that were going on. We saw that people were respected by staff and treated with kindness. We observed staff treating people affectionately and heard staff speaking in a friendly manner. Staff displayed respect and admiration for people using the service and we saw that trusting relationships had formed.

One person we spoke with chose to remain in the lounge at lunch time and we saw staff deliver the meal to them. We saw staff assisting people to eat their meal and the care worker sat next to the person, explained what the meal was and chatted to them. We heard other staff ask people if they would like any assistance, for example with having their food cut up.

We observed people being supported to eat appropriately by care workers, who were discreet and engaged with the individual they were supporting. We found the mealtime experience was unhurried and relaxed, with appropriate music playing in the background and people chatting to each other or staff. We saw nice interactions between care workers and residents especially at meal times as staff tried to make the dining experience a pleasant one for residents. Staff checked if people were okay, were enjoying the meal and offered second helpings. They encouraged people who had not eaten much of the main meal and offered a rice pudding dessert to a resident knowing it was their favourite.

Some people preferred to eat the meal with their hands and this was not discouraged. People were allowed to eat independently using their preferred way of eating. At the end of the meal staff discreetly provided hand wipes for people or assisted them by cleaning their hands.

We saw that people's privacy and dignity were respected and staff provided us with examples as to how they achieved this, including by closing doors, curtains and trying to keep people covered as much as possible when providing personal care. We were assured that people were respected and had their dignity preserved when receiving personal care.

Staff were aware of their role and responsibilities and were able to describe the needs of individuals who used the service. During informal conversations, staff spoke about individual residents with knowledge of their backgrounds, likes and dislikes, as well as their current individual needs and behaviours. They demonstrated to us knowledge of an individual and gave us examples of how they respected people's rights and wishes. We observed during the SOFI that staff had time to sit and chat with residents and this benefitted people as we saw them laughing and smiling during these interactions with staff.

We heard care workers explaining to people what they intended doing and obtained permission from individuals before carrying out any tasks. We saw good examples of this during our lunch time observations. We heard care workers assisting people telling them what the food on offer was. Staff were patient in their approach and checked that people were ready to continue with eating. Care workers sought consent from people where possible before undertaking care tasks and were kind and caring in their approach.

The home participated in the six step end of life programme. The six step programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. This demonstrated that the service recognised the importance of end of life care and making plans in advance so that people could be supported to choose where they died. A professional health worker provided feedback with regards to this and complimented staff on their empathy and understanding, having managed end of life care well for a number of residents over the winter months.

Good

Is the service responsive?

Our findings

People we spoke with were complimentary about the service. One visitor explained to us how well care workers knew their relative and said, ""She does try to resist showering but the staff know her well and have a knack of knowing when to back off." This showed us that staff were responsive to people's moods and respected their space.

Care plans we looked at confirmed that a detailed assessment of needs had been undertaken by the registered manager or a nurse before people were admitted to the service. We reviewed whether the care plans were written in a person-centred way. Person-centred care indicates care is specific to the individual concerned. The provider used person-centred plans to support and involve people to make decisions about their care and their lives overall.

We looked at five care plans during our inspection. We saw that care plans contained detailed clinical information, including identified risks, as well as information relating to people's preferences about care and support. We saw one care plan based on a person's needs when sleeping. It identified that a person liked to sleep with two pillows, with the heating on number four with a window open. This was very personal to the individual and no two sleep care plans we looked at were the same and we judged that care plans were person-centred. .

Nurses in the home were allocated lead responsibilities, for example in infection control and wound management. The service had recruited a nurse who had opted to take on the lead role in the home for wound management. The home had allocated a separate room for wound care and we saw detailed information displayed on a white board about

Where it was identified a person had a wound this was body mapped and tracked. The service then sought appropriate advice and involvement from the tissue viability nurse as well as ensuring the person was being cared for with the correct equipment in place, for example pressure relieving equipment. Information in relation to wounds, for example individual cleansing regimes, dressings used and timings of review, were on the whiteboard for all staff to see and be aware of.

The lead nurse had attended training undertaken by clinical commissioning group and was making plans to roll out the "React to Red" training programme to all staff. The React to Red skin campaign is the latest pressure ulcer prevention campaign to be held by tissue viability nurses.
The main message of the campaign is that by reacting to red skin over bony areas and asking for help and advice from a healthcare professional care home staff can stop red skin becoming a serious wound.

The treatment of wounds was detailed and thorough and the home had worked hard in establishing the right links and professional support. We were confident that the home was responsive to changes in people's skin and working well to reduce pressure sores. A professional we contacted confirmed this and added that the home was 'very reactive' regarding identified wounds and pressure areas. This demonstrated that the service responded to changing needs and made referrals to relevant health professionals to ensure

people's safety and wellbeing.

We spoke to staff who were able to confirm people's preferences. Staff knew the people they were supporting very well. We heard throughout the inspection examples of people being given, and making, choices about their daily lives and the support they received.

The home employed a bespoke activity co-ordinator who was on annual leave at the time of the inspection. We noted that despite the activity co-ordinator not being present, other staff continued to provide various activities for people who expressed an interest. There was a poster advertising a dementia swim session at a local pool and although no one had yet expressed an interest in this activity, staff were willing to support this. We saw that care plans detailed what people liked to do and a relative we spoke with was positive about the activities on offer, such as memory games, cards, puzzles and daily discussions, and events held at the home. Relatives we spoke with considered there was enough going on for people to get involved with and said, "I actually bought the home their own equipment for baking because they (the residents) seem to enjoy things like that. The staff always seem to be looking for ways to involve them," "Mum really enjoyed making Christmas Cards and Easter eggs. She also enjoys singing and dancing. She likes to do the Charleston" and "If it's a nice day, they go out into the garden. They've even collected blackberries in the past." There was a minibus at the home that could be used for trips out and the manager had asked for suggestions for day trips out.

We asked the manger how the service met people's spiritual needs. They acknowledged that it was difficult to get a priest to visit, but the service had used a hospital chaplain on occasions. People could request to go to church if they wished and the home would support this, although requests were not regular. The home celebrated religious festivals during the year, for example Easter and Harvest Festival. People were asked if they wanted to attend celebrations or not. We saw a timetable of scheduled events for the year, including Indian Day in January and Wimbledon in June. Links had been made with a local school and children attended the home to join in with some celebrations. This meant that the home had forged links with the community that benefitted people living at Marion Lauder House.

The home subscribed to a daily reminiscence newspaper, published 365 days a year, which offers an ever-changing range of nostalgia topics and activities, geared towards stimulating the mind and improving memory. This was printed in large print, distributed around the home on a daily basis and used by staff to generate discussion. This meant that the home looked for and invested in tools to assist staff deliver meaningful activities, encouraging residents to talk and share memories.

The provider sign-posted people to advocacy services and made referrals to best interest assessors where appropriate. For people who lacked capacity and who had no family or friend representation there was the facility to refer to an Independent Mental Capacity Advocate (IMCA). IMCAs are specialist advocates who provide safeguards for adults when they lack capacity to make some important decisions.

Units dealt with their own individual complaints with oversight from the registered manager. We saw that one long standing complaint was on going at the time of our inspection. There had been a safeguarding investigation that had concluded and involvement from the coroner. We were satisfied that the home had tried to resolve this complaint as they had fully participated in all processes. We saw that other complaints were logged and dealt with according to company timescales. We were assured that people using the service and their relatives felt comfortable with all levels of management in the company. If they felt it necessary to make a complaint they were confident that this would be addressed.

We saw many examples of positive feedback sent to the home in the form of thank you cards, letters and

compliments sent via email. We saw examples of compliments from relatives of people using the service and other members of the community.

Good

Is the service well-led?

Our findings

We received positive feedback about the leadership within the home from people who used the service, relatives and staff. It was clear that people had confidence in the manager, who was a regular presence in the home. Feedback we received from a professional stakeholder was complimentary of the registered manager and the staff working there. They considered the home to be a 'valuable asset as a safe and caring environment' and could 'commission with confidence' appropriate packages of care for clients and their families.

All staff felt valued and supported by the registered manager and other senior staff. When asked their opinion about the management of the service staff members told us they were always approachable and fair and said, "[The manager] does a great job. Made it better. [They] give me confidence" and "It's run very well now. Manager has changed many things. It's better." It was apparent that staff had confidence in the registered manager and acknowledged their ability to manage the service.

There was a clear management structure in place on display and the registered manager had a hands on approach. Through speaking with the staff team, people who used the service, and the registered manager it was clear there was a strong cohesive team. It was apparent that staff enjoyed their work and one member of staff we spoke with confirmed this and said, "I love my job. I like to think I'm making a difference for people." Staff we spoke with were particularly proud of retaining the Gold Quality Standard for care, following assessment from the local authority. The Quality Standards are a set of criteria used by the local authority to judge the quality of care delivered by care homes and care agencies and to ensure they are meeting contract requirements. On the last visit the home had again been judged they were gold standard. This meant people who used the service could be confident the service they received was a good one.

Staff told us team meetings occurred on a regular basis. Staff held their own meetings on the units where they worked which the registered manager attended for a period of time to provide any company updates or information. The unit leads then continued the meetings and provided feedback to the registered manager. We saw minutes of a staff meeting held on Cherry Unit on 23 March 2017 where staff discussed rotas, fluid charts, the shift coordinator and staff benefits. These unit meetings ensured that there was less duplication and staff discussed what was relevant to their unit.

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response. Audits were in place, for example in relation to falls, health and safety and medicines administration and any identified errors or actions had been addressed. There was a dining room experience audit undertaken on a monthly basis. We saw the chef had done one on 9 February 2017 and then provided feedback for staff. In the feedback, staff were reminded to offer a second helping to residents, to remove the lids from the hot plates more quietly and to use hand wipes after the meal as these were not seen. During our meal time observations undertaken in two dining rooms at the home we observed that all of the above had been taken on board and were being done by staff.

Audits were also completed in relation to any safeguarding incidents. These were completed monthly and then reviewed to determine if there was a pattern to the incidents, for example when and where the incident had taken place. We saw actions were taken to minimise the risk of safeguarding incidents reoccurring. Care plans were updated and protection plans put in place following a safeguarding incident. Any existing relevant risk assessments were either updated or a new one formulated. This meant there were well-managed systems in place to monitor the quality of the care provided and quality audits were completed in line with company policy.

In conversation with the registered manager it was evident that they fully understood their responsibilities. The registered manager had kept us informed of safeguarding incidents and other notifiable events which had occurred in the home in line with their statutory obligations. The registered manager told us they received good support from the owners of the home who were present on our second day of inspection. They outlined plans for the continual development of the service to ensure that the changing needs of people would continue to be met through quality care and support. There were also plans to redecorate and upgrade the nursing areas of the home so that these mirrored the improvements carried out to the residential unit. We will check on this at our next inspection. They had introduced incentives for staff to raise morale, including employee of the month scheme. Successful employees were awarded a shopping voucher.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could continuously improve. Resident and relative meetings were held and minutes reflected the input from people using the service. An action plan for spring 2017 had been circulated to people who had provided feedback on the service. This provided updates on how the service had been rated and asked for further ideas, for example for activities within the home or further afield. People were signposted to the suggestions box in reception. This showed us that the home was willing to consult with all stakeholders in the service and take on board what people said.