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Marsh House

Inspection report

Marsh House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 13 December 2016. We last inspected Marsh House in July 2016. At that inspection, we found that people's safety was being compromised in a number of areas. This included how people's medicines were managed, the induction of new staff and temporary staff and how staff were supported to do their job through training and supervision. It also included how risk had been assessed and the guidance that had been provided to staff to reduce the risks to people, how emergency evacuation was planned and how people were protected from the risk of infections and contamination. At the last comprehensive inspection this provider was placed into special measures by the Care Quality Commission (CQC). The special measures framework is used to help make sure that registered providers found to be providing inadequate care significantly improve. It requires there is a timely and coordinated response from a provider where CQC has judged the standard of care to be inadequate. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marsh House on our website at www.cqc.org.uk.

During this inspection 13 December 2016, we found the provider had made improvements to meet the fundamental standards inspected and had an overall rating of Requires Improvement. We saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service and found no breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However we did find that the work being done was still in its early stages and needed to be sustained to ensure a consistent delivery of safe care and treatment that could be evidenced in the longer term.

As a result of the improvements made, the service has been taken out of special measures. The service will be expected to sustain the improvements and this will be considered in future inspections. You can see what action we told the provider to take at the back of the full version of the report.

During this inspection we reviewed actions the provider told us they had taken to gain compliance against the breaches in regulations identified at the previous inspections in July 2016 and February 2016. We also looked to see if improvements had been made in respect of the breaches.
Marsh House provides personal care for up to 33 adults. Nursing care is not available at this location. The home is situated in a rural area close to the towns of Chorley and Leyland.Some of the bedrooms have en-suite facilities. There is a large dining room, communal areas, hairdressing room and conservatory available for people living at the home. The grounds are well maintained with seating and patio areas. These are accessible for those who use wheelchairs and there was a stair-lift and passenger lift in the home. Public transport links are available and there are car parking spaces for visitors and staff. At the time of this inspection there were 23 people living at Marsh House

The service had a registered manager in post and they had been in post since April 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The registered manager had notified the CQC of any incidents and events as required by regulation.

People who lived at Marsh house told us that they felt safe in the home and that there were sufficient staff available to help them when they needed this. People living and visiting the home spoke highly of the registered manager and told us they were happy with the care and treatment.

Since the last inspection in July 2016 a new pharmacy system had been introduced into the home and this had led to an improvement in the management of the medicines. Staff had also received medicines management training. Medicines were being stored and recorded appropriately including controlled drugs (medicines subject to tighter controls because they are liable to misuse). There were up to date policies and procedures in use by staff. Appropriate procedures were in place for the ordering and disposal of medicines.

We noted areas of good practice in relation to medicines management. We made some recommendations to support this continued good practice in that the registered manager sought guidance on documenting the removal of pain killing patches and on making sure that all the medicine administration charts (MARs) included details of the people's allergy status. We also noted that sprays were not always kept by the person who used them. We recommended that this be risk assessed to help ensure that they can be accessed easily in an emergency.

We found that training records indicated that all staff had now had training on safeguarding people from abuse. All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse and were aware of the procedures for reporting bad practice or 'whistle blowing 'within the organisation. We saw that the registered manager had followed the service's procedure effectively in regards to misconduct by a staff member.

We saw that all staff had completed a programme of induction training and that improvements to how the on going training of staff was managed had been made. Staff told us how they felt supported through supervision and training to fulfil their roles.

The level of staffing on the day of the inspection was sufficient to ensure that the current number of people living in the home had their needs met in a timely manner. The numbers of staff on shift during the day and night were seen to be consistent. Systems were in place for the recruitment of staff and to make sure the relevant checks were carried out before employment.

Since the last inspection the provider had been responsive and proactive in improving the systems used in the recording of information about people's needs and the planning of their care. We looked at the risk assessments in place for people and these included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition and for the management of a different conditions or specific medication. We looked at the risk assessments in place and how people would be moved in the event of fire. These had been kept under review.

Care plans we looked at did not have information about any particular preferences at the end of their life. We have made a recommendation that the service took advice from a reputable source, about end of life training for care staff and on supporting people to express their views and decisions about their care, treatment and support at the end of life.

We saw that a range of organised activities were being made available to people and that staff had been

actively involved in supporting people with activities that had been arranged. We also saw that a variety of meaningful activities had been planned for the Christmas period.

We noted that the environment within the home had not been developed to make it as enabling an environment as possible for people living with dementia. We made a recommendation about seeking guidance from a reputable source on adapting the home's environment to support the independence of the people who were living with dementia.

We saw that there were systems in place to assess the quality of the services in the home. There was a programme in use to monitor or 'audit 'service provision to identify areas of weakness and address them.

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 safe but the improvements made in this respect need to fully embed and continue to evidence that the improvements can be sustained.

Significant improvements had been made to medication administration and management to provide safe systems and use.

Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home.

Immediate action had been taken against staff in the event of any misconduct or failure to follow company policies and procedures.

Maintenance checks were being done regularly and records had been kept.

Is the service effective?

Requires Improvement

The service was being effective but the improvements made in this respect need to fully embed and continue to evidence that the improvements can be sustained.

Staff were receiving training relevant to their roles and were being supervised in their practice to promote good practice.

The service had procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests.

The manager told us that staffing levels were kept under review.

Assessments and the management of nutritional requirements had been made and people had a choice of meals, drinks and snacks.

Is the service caring?

Requires Improvement

The service was caring but the improvements made in this respect need to continue to evidence that the improvements can be sustained.

People told us that they felt they were being well cared for and we saw that the staff were being respectful and polite in their approaches.

Consideration needed to be given to help people express their views and decisions about their care, treatment and support at the end of life.

The environment was welcoming but did not fully support the independence of the people who were living with dementia.

Is the service responsive?

Requires Improvement

The service was being responsive but the improvements made in this respect need to fully embed and continue to evidence that the improvements can be sustained and a person centred approach be consistently achieved.

Care plans had been improved in detailing individual care needs and assessing risk. Assessments of individual needs and risks had been undertaken to identify people's care and support needs.

People had access to health care professionals to meet their individual health care needs.

There were varied and meaningful activities planned for people living in the home and seasonal activities for the month of December.

Complaints were being managed appropriately.

Is the service well-led?

Requires Improvement

The service was being well led but the new systems that had been implemented need to show consistency and effectiveness in the safety and quality monitoring of the service provision in the long term.

Staff told us they felt supported and listened to by the registered manager.

Incidents and accidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified.

A considerable amount of work and monitoring had been done to meet the regulations and measurable systems were being used to assess the quality of the service provided.

Marsh 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 13 December 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a pharmacist specialist advisor and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection team was also joined by an Inspection Manager for part of the day.

During the inspection we went around the home and looked at all areas used by the people living there. We spoke with ten people who lived there. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We looked in detail at the care plans and records for seven people and tracked their care. We spoke with six relatives who were visiting during the inspection.

We spoke with four members of care staff, the staff trainer and the cook. We spoke with the registered provider, the registered manager for the home and the quality consultant. The consultant was being employed by the registered provider to implement and oversee a programme of audits and quality monitoring. We also spoke with the visiting hairdresser who visited the home weekly to provide a hairdressing service to people living there.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living in the home. We observed medicines being handled and discussed medicines handling with staff. We looked at medication and records for nine people living in the home at the time of the inspection.

We looked at records that related to the maintenance of the premises, the management of the service and quality monitoring documents and records. We looked at the staff rotas for the previous month and at the recruitment records for seven staff working in the home. This included new staff. We looked at records of staff training and supervision.

Requires Improvement

Is the service safe?

Our findings

We received positive responses to questions we asked people who lived at Marsh House about safety. People told us that they felt safe in the home and there was "no bullying" at the home either from the staff or from other service users. One person told us there had been an issue in the past with someone who lived there being unpleasant but said, "They have been moved to somewhere else now".

People who lived in the home we spoke with told us they were happy with the cleanliness of the home. On the day of the inspection we found the home to be clean and free from any lingering unpleasant odours

People who lived there told us, and also relatives, that medication was given correctly and on time and that creams and eye drops were given as prescribed by their doctors. We observed one person being given medication whilst sitting at the lunch table. They were handed it in a medication pot, with a drink to help it down. The staff member checked that the person had swallowed the medication before signing the administration chart.

A visitor told us "There is not as much agency staff being used now, we see the same faces anyway". People living in the home told us that more recently there had been more staff available in the home. One person said there was, "Always sufficient staff on duty now". We were told by people that staff answered their call bells when they used them. One person said, "I don't have to wait a long time". We observed that staff responded to call bells promptly or explained to people if they could not attend straight away. The registered manager had done spot checks on response times for call bells by triggering them and doing checks on the time taken to respond. They told us that if they heard a call bell sounding for a length of time, which they deemed, was unacceptable, they would investigate further.

At the previous inspection of this service in July 2016 there had been a continued breach of Regulation 12(1) (2) (a) (b) (c) (f) (g) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. In addition, Regulation 13- Safeguarding service users from abuse and improper treatment. These breaches were in respect of safeguarding people from abuse, disciplinary systems within the home, risk assessment, emergency procedures, the management of medicines and cleanliness and infection control within the home. We had ensured that action was taken to address these concerns.

At this inspection on 13 December 2016 we found a considerable amount of work and monitoring had been done to meet the regulations. The steps that had been taken by the registered provider and the new systems that had been put in place still needed to embed into the service provision. The changes needed to continue to be monitored by the registered provider and manager and maintained in the long term to show continued improvement. The service could then show evidence of a sustained record of accomplishment over time and of consistent improvement and safe practice within the home.

At this inspection we found that training records indicated that all staff had now received training on safeguarding people from abuse. Staff we asked confirmed that they had received this training and it was up to date. All the staff we spoke with knew the appropriate action to take if they believed someone was at risk

of abuse. They were also aware of the procedures for reporting bad practice or 'whistle blowing 'within the organisation. All the staff we spoke with expressed confidence in the management team to follow up any concerns they might raise and that prompt action would be taken to make sure people were kept safe. The records and notifications to CQC indicated that prompt referrals were being made to the relevant agencies where there had been incidents that might put people at risk.

We noted during the inspection that contractual arrangements were in place for staff. These included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures. We noted the service had followed their procedure effectively in regards to misconduct by a staff member. The manager told us all staff had been issued with a code of conduct and practice.

Risks to people's individual safety and well-being were assessed and managed by means of individual risk assessments and risk management strategies. This helped ensure guidance was in place for staff on minimising risks to people's wellbeing and safety. Everyone had individualised risk assessments in their care files covering areas such as, mobility, personal care, mental health, risks of choking, nutrition, falls, the use of bed rails and moving and handling. Each risk assessment offered an overview of the person's risk, triggers and the assistance required. The registered manager told us people's risk assessments were reviewed every month by senior carers and more often if required. The risk assessments we saw were in date and held detailed information you would expect to see in such a document so that staff had clear strategies for managing individual risks and behaviours.

We looked at the risk assessments in place concerning fire safety and how people would be moved in the event of an emergency. We saw the service had contingency plans in place and personal emergency evacuation plans for people living there should people ever need to be moved to a safer area in the event of an emergency. These documents gave guidance to care staff on how people needed to be supported in an emergency including the closest fire escape to their room. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. Accidents and incidents were being recorded and where possible action taken to prevent reoccurrences.

Maintenance records showed safety checks and servicing in the home including the emergency equipment, water temperatures, fire alarm, call bells and electrical systems testing. Maintenance checks were being done regularly and records had been kept. We could see that any repairs or faults had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment. Training records indicated that staff had received recent training on health and safety in the home and fire training to help make sure they were aware of what needed to be done to keep the home a safe place to live.

At previous inspections, several issues relating to the safe management of medicine had been identified. These areas were therefore the focus of the pharmacy inspection. All the medicines administration charts and corresponding medicines were checked by the pharmacy inspector. Stock checks were also carried out. It was found that all documentation was correct and the stock corresponded to the records.

Medicines were stored within a dedicated room within medicines trolleys, appropriate cabinets and fridges. Temperature monitoring was in place and recorded. A fridge cleaning rota was in place. A new fridge had been ordered following a problem with re-setting the thermometer. The key code was handled securely and changed when staff that had knowledge of it left. Keys were only held by the senior member of staff on duty.

A competency file was in place for senior staff that had undergone medicines training. The deputy manager, who was responsible for the administration of the medicines during the inspection, had only been employed since the last inspection but was experienced in medicines administration from their previous employment. Medicines audits had taken place and issues raised had been discussed at the staff meetings. Medication errors had been investigated and appropriate actions had been taken to help prevent a reoccurrence.

The majority of the medicines were administered from a Monitored Dosage System (MDS). This system provided separate pre-filled trays of medicines for each person that was colour coded for the time of day for administration. The design of the trays also allowed individual doses to be removed so that the medicines for patients could be taken safely outside of the home if required such as on a visit to the hospital. For medicines, not within the MDS regular stock checks were in place, these were documented.

It was found that all documentation was correct and the stock corresponded to the records. Within each person's section there were support documents including the care plan, risk assessment and any supplementary administration charts. The medicine administration charts (MARs) contained pictures of the medication to allow easy identification by the staff carrying out the administration.

Controlled Drugs were stored and recorded appropriately. Controlled Drug pain patches had separate documentation that recorded their application. However, the removal of controlled drug patches was not documented, which was recommended.

Appropriate procedures were in place for the ordering and disposal of medicines. Records were in place. Up to date medicines policies were in place. There was a procedure in place to deal with frequent refusal of medicines. There was a ten-point check that was completed at the end of the medicines round to help ensure that all tasks had been completed. For anticoagulants (blood thinning medicines), the record book and details of the dosage were recorded. Variable doses of medicines were being accurately recorded and if staff had to transcribe information on to the MAR charts, then this was witnessed. This approach reflected good practice.

After the inspection in July 2016, and the issues raised by the inspection in respect of cleanliness and good hygiene, a visit was made to the home by the local authority 'Infection Prevention and Control Team' in August 2016. Their report outlined areas that the registered provider needed to improve to create and maintain a clean and hygienic environment in the home. This was regarding monitoring hygiene in the home and hand hygiene, staff training, the correct storage of items in bathrooms and the correct storage of hoist slings, having cluttered areas in the home and visible pipework that required attention. An action plan was developed for the service and we examined this during the inspection.

We found that the registered provider had acted promptly to address the issues raised and to carry out the actions required. The home now had a designated infection control lead, who was undertaking appropriate training on the topic and who fed back at staff meetings. We saw that cleaning regimes had been implemented and were monitored and that action had been taken to box in visible pipes, keep equipment clean and to upgrade sluicing facilities. This helped to maintain a clean and safe environment for people living there.

We did note during the inspection that one staff member went from person to person at a mealtime without hand washing or using appropriate protective equipment. Records indicated that staff had received recent and appropriate infection control training and food hygiene training. We discussed this with the registered manager so they could follow it up and make sure the staff member understood what they were doing wrong and checked their understanding of their training. The manager told us that hand-washing audits

were being implemented and this was an item to be discussed at the next staff meeting to help make sure all staff were clear on the need to embed the correct practices.

We looked at how the provider managed staffing levels and the deployment of staff. We requested a month's staffing rotas including the week of the inspection. We noted sickness absence was covered by staff and agency when required. The manager told us that if agency staff were needed they used the same people to provide continuity of care for the people living there. We looked at the skill mix of staff and noted senior staff were on duty day and night. Rotas indicated there were sufficient staff available for the 23 people living there. The registered manager and deputy were on duty five days a week to oversee care and senior staff on day shift across the week and at the weekend to help supervise staff. There were two waking night staff and one that slept in to provide help should more staff be needed during the night.

The manager told us that staffing levels were kept under review and were flexible in response to the needs and requirements of the people using the service. This monitoring of staffing against dependency would be essential when occupancy increased and more staff were needed to meet people's individual needs.

Several new staff had been appointed since we last visited the service. We looked at the records of nine staff members employed at the service since August 2016. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. We discussed with the registered manager the importance of ensuring reference requests were made to previous employers only rather than a work colleagues to ensure the value of information provided. We recommend that the registered manager consider current best practice and guidance, seek advice and guidance from a reputable source in this respect, and take the appropriate action to update their practices accordingly.

We discussed with the registered manager the importance of risk assessing any disclosures made and recording the outcome and decision made as a result of this. This would help to ensure robust recruitment procedures designed to protect all people who used the service and help ensure staff had the necessary skills and experience to meet people's needs were followed. Staff had been asked to verify if there had been any changes the service needed to be aware of in relation to DBS issues during their supervision.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with were able to tell us about the needs, interests and personal preferences of the people they were supporting. The visitors and people who lived there we spoke with felt that the staff were able to use all the equipment that was needed "confidently" and "skilfully. One person told that a hoist was used to aid them to move and we saw the hoist sling that was used solely for them was in their bedroom.

Relatives spoken with felt that the family was being included in the person's care and asked about their family members and their preferences. One told us, "We are kept informed about health issues and if anything has happened".

People we asked told us that the food provided was "good" and "tasty" that they always had a choice of food at mealtimes. People confirmed that they could take their meals where they wanted, for example in their room. We observed examples of personal choice regarding choice of food from the menu. Everyone we spoke with who lived there told us that there were two choices for lunch and "If you don't want either of those, you can have a sandwich or jacket potato". We also heard a staff member checking that people were happy with the choice they had made earlier in the day.

At the previous inspection of this service in July 2016, there had been a continued breach of Regulations 11 Consent, 13 safeguarding service users from abuse, 14 meeting nutritional and hydration needs and 18 staffing. We could see that significant and productive work had been done by the registered manager and staff to improve care planning, care practices and the recording and monitoring of practices to show they had met the breaches found at the last inspection. The registered provider now needed to demonstrate that this was sustainable over the long term.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). 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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At this inspection December 2016 we looked at people's records and saw that the registered manager had applied to relevant supervisory authorities for deprivation of liberty authorisations for people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible.

For one person a condition of the authorisation to have their nutritional and fluid intake and weight

monitored and this was being done. We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. Some people were not able to make some important decisions about their care or lives due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision.

The service had procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests. The records on the process that had been followed showed how relatives, health professionals and senior care staff had been involved when needed to make sure decisions were only being made in that person's best interest. The registered manager and deputy showed a clear understanding of the principles of the MCA and records indicated they were applying them in practice. Staff had received training on the MCA and those we spoke with were clear about obtaining valid consent from people or their representatives when decisions were being made in people's best interests.

We noted that the information around who held Power of Attorney for a person was being recorded so staff knew who had this in place. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs.

All of the care plans we looked at contained information on specific dietary needs, preferences and any intolerances. All the people who lived at Marsh House had an individual nutritional assessment and that people had their weight regularly monitored for changes so appropriate action could be taken if needed. There was also information on people's dietary needs such as diabetic diets and soft meals. We saw evidence of competency spot checks being completed in regard to staff completing dietary intake charts, positional changes and weight monitoring. We could see that a nutritional assessment tool was being used and was discussed with staff during their supervision.

We could see in people's care plans that there was effective working with health care professionals and support agencies involved in people's care such as local GPs, community nursing teams, community mental health teams, chiropodists, opticians and social services. However, one person who lived in the home told us they felt "They [staff] don't always get a doctor when I feel I need one".

The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their needs. For example, referrals had been made in a timely way to the dietician. One person's weight was found to be fluctuating. They had been seen by the dietician, a care plan was in place, and the person's weight was now stabilising. Advice had also been taken on managing mental health needs and incorporating this into care plans so staff knew what the person needed to support them.

Another person assessed as at risk of choking had been seen by the speech and language therapist (SALT) and a plan was in place to help mitigate the risk. This included the requirements about thickened liquids and pureed food for people and for those who chose not to eat meat. We also spoke with the chef to check their understanding of different dietary needs and that they had information about them. We observed what was happening during meal times in the dining rooms and how people were supported as they had their lunch. There were pictorial menus that could be used to help people choose their meals for the day. We saw that staff offered people snacks and drinks and throughout the day and that fluid intake charts were being kept and were subject to checks by senior staff to make sure there were being completed correctly. Staff had received training on nutrition and food safety to help them understand their responsibilities and the risks to

people.

At the inspection in July 2016 a significant shortfall in the training that the provider required staff to complete in order to fulfil their roles had been found. We had ensured action was taken to address these concerns. At this inspection we saw there was a training matrix in place recording the training staff had done and what they needed and this indicated systematic approach was being taken to identifying training needs.

We spoke with a staff trainer who had been in post since April 2016. They explained a training analysis had been completed and training had been prioritised to ensure staff delivering care were competent in their work. She was being assisted by two other trainers. Training needs were being identified and training was being organised and records were being kept of the training done. Records showed that the programme of training that had been put in place since the last inspection had been effective in making sure all staff had training relevant to their roles.

A skills assessment had been completed with staff and short term and long term goals had been set. As a result of this all staff had received mandatory training that included MCA and DoLS. The trainer told us, "Staff can ask for training and some do, for instance we've found the MCA and DoLS has been problematic for some staff to fully understand how it works. I give one to one sessions and use every day scenarios to support them to understand it better". The trainer told us that the registered provider has been supportive in improving staff training and provided cover on the rota when staff were on a course.

We were also informed all staff had acquired a qualification such as Qualifications and Credit Framework (QCF) level 2 and 3 in care training and this had been aligned to the Care Certificate. New staff had completed the Skills for Care Common Induction standards or Care Certificate. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We looked at training records and were able to evidence staff had been trained in a wide subject range. Certificates of staff training were kept in staff files and we saw staff had their competency in subject matters checked through written assessments and observations. We discussed the importance of dating and signing these records as and when completed by both the assessor and staff member involved in the training. The manager told us they would update the record to include a box to put dates in.

Staff had been receiving supervision. The purpose of supervision was explained to staff and recorded on their supervision record. We could see issues around staff performance was being identified and addressed through supervision and an action plan had been put in place to improve staff performance. This included using spot checks on infection control measures and communication with people.

The challenge for the registered manager would be to make sure this programme remained effective and was maintained in the long term to ensure staff had the training they needed to provide effective care.

Requires Improvement

Is the service caring?

Our findings

At the inspection in July 2016 we found the registered provider had failed to provide dignified care that respected people's autonomy and independence. This was because staff had been observed to treat people in an undignified manner and because people had not been spoken to with respect. We had ensured that action was taken to address these concerns.

We spoke with people living in the home and their relatives and made observations of staff interactions throughout the day.We observed several caring and appropriate interactions between staff and people living in the home especially when assisting them to sit down or moving around the home. Some staff initiated the interactions easily, although there were also missed opportunities when interactions would have been of benefit to the service user. For example whilst people were sitting in the dining room waiting for other people sit down, then lunch could be served. Equally we also saw examples of staff giving people their full attention and offering reassurance.

We spoke with people living at Marsh House and their relatives about how they felt the staff approached them and cared for people. They told us that staff treated them with "kindness" and "consideration". However one person said "Most of the staff are OK" and "I don't want to name those that aren't".

A relative told us there is a staff member who "Has attitude problems and is bombastic". They followed this with "I have told [Registered Manager] and she has sorted it out". This indicated that the registered manager listened to what people had to say about the way staff approached them and would take steps to address any instances where people's choice or dignity were not being upheld. We spoke to the registered manager regarding this feedback about staff and they advised they were aware of who these staff were and that this was being dealt with through the service's own internal disciplinary systems and through supervision and checking competences whilst staff were working.

More than one relative told us that they felt listened to and their relative who lived in the home told us that staff respected their decision not to be involved with the activities. From our observations during the inspection, we saw that staff were conscious of preserving the dignity of the individual when assisting them with mobility. One person told us, "When I am in the hoist the staff always put a towel over me" and indicated the bottom half of their body. However on arrival at the home we could see from the car park a person getting dressed through their window. We told the registered manager about this as the person, and any staff helping them, needed to be aware they could be seen outside and might wish to draw the curtain whilst getting dressed.

We saw that people's preferences were being sought about whom they preferred to provide their personal support. One person told us they had been asked if they preferred a female or male carer for personal care and they said, "I told them I prefer a woman but will have a man". One person told us they were happy to have only one of the male carers and no other men. It had been recorded and their care plan that female staff should attend to personal care to avoid any confusion. A relative told us "When a male carer comes to assist [relative] they always ask if it is ok".

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. People told us and we saw from the records, that people were able to follow their own beliefs. All bedrooms at the home were being used for single occupancy. This meant that people were able to spend time in private if they wished to and could see their doctors, family and friends in private. Relatives of people who lived at Marsh House told us they could visit anytime of the day or week, there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationship in their lives. We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms were closed when people were receiving personal care. We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

We noted as we went around the home that there was little in the way of dementia friendly environment within the home for people living with dementia. This had not been developed to make it as enabling an environment as possible for people. Research and current good practice in dementia care (for example, Department of Health National Dementia Strategy, Kings Fund) highlight that attention needs to be given to establishing environments that enable people who are living with dementia to find their way around independently. For example, clear signs (using pictures and words) help enable people living with dementia to move around more confidently. Items like memory boxes for people to fill with personal items to help remind them and to navigate to their rooms. We recommend that the registered provider seek advice and guidance from a reputable source so they can adapt the home's environment to support the independence of the people who were living with dementia.

People had access to advocacy services and one person had an advocate to help support them. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

Training records did not show that staff had received any formal training or guidance on supporting people at the end of life. The care plans we looked at did not have information about any particular preferences a person may have at the end of their life or how they wanted to be looked after. We recommend that the service seek advice and guidance from a reputable source, about end of life training for care staff and on supporting people to express their views and decisions about their care, treatment and support at the end of life.

Requires Improvement

Is the service responsive?

Our findings

Where possible people were being supported to make their own daily choices and take part in activities outside the home as well as within it. On the day of the inspection several people who lived in the home, relatives and a staff member went out on a trip to a local garden centre and then went on to have Christmas lunch at a local restaurant. A relative told us that all the medication they needed to take for people went with them in "a special system" and that "All care has been taken with the management of the trip". We were told about previous planned trips when people had been to see Blackpool Illuminations and that there was "a trip out most Wednesdays".

Two visitors told us that there was often music and singing going on in the conservatory and that outside musical entertainers came to the home. We observed one person who broke into song frequently whilst music was being played and they appeared to enjoy the activity, even though they found it difficult to have a comprehensive conversation they could sing with enthusiasm.

A relative said to us that they "always" received a receipt when they left money with the staff for their relative's use, and also that they was kept informed what it was spent on, usually for the chiropodist, hair dresser and toiletries. We were also told by the relative that the staff, and in particular the registered manager, were "Able to manage their relative's moods", and said "[Relative] is happy in her own world" and also "Things here have changed for the better, it is 99% better than it used to be".

We reviewed how the service responded to complaints. We looked at the policies and procedures along with information provided to service users and relatives. People had been fully informed on how to make any complaints and given detailed information on how or who to contact. The procedure was on display in the entrance foyer to the home. People we spoke with confirmed they knew how to make a complaint. We asked people what they would do if they had any worries or complaints. We were told by one person "I would go to see [registered manager] if there was anything I didn't like". Relatives we spoke to told us they knew whom to complain to in the home.

We asked for and reviewed the complaints log. We found there had been some complaints recorded since out last inspection. We looked at these and found them to be complaints around staff actions and care which had a minor impact on people who used the service. We saw they had all been recorded and responded to in an appropriate manner in line with the policies and procedures of Marsh House. However, we had to look at the relevant emails, and letters to satisfy ourselves that they had been dealt in accordance with the timescales in the relevant procedures. We spoke to the registered manager about this who agreed to add this information to the actual log for ease of reference.

At the inspection in July 2016, we had reviewed compliance against the breach of Regulation 9, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014 found during the inspection in February 2016. We found improvements had been made to the care files and the way some of them had been written had reflected a person centred approach however this had not been consistent throughout the care files looked at during that inspection.

Care plans we looked at this inspection showed that assessments of individual needs and risks had been undertaken to identify people's care and support needs. Where they were able, people had signed and agreed their plans and we saw that they and their family members had been involved in reviews. Care plans were developed detailing how individual needs and conditions should be supported and met by staff. We saw in people's care plans that their health and personal support needs and preferences were clear and personal information was included. People's care plans included risk assessments for skin and pressure care, falls, moving and handling, mobility and nutrition. There were also management plans in place to support specific conditions such as asthma, mental health needs, recurring infections and the risk of social isolation for one person. There was a consistent approach being taken reviews were being done. The registered provider needs to continue to show this level of improvement in the long term to be able to continue to make progress.

We saw that care plans were being reviewed and updated to show where people's needs had changed so that staff knew what kind of support people required. For example, changes in a person's behaviour or weight or continence needs that needed to be followed up with other agencies. Care planning and risk assessment s indicated an individualised approach was being taken to planning the support and level of care a person needed. Care plans for people were being developed to focus more upon the needs of the individual and what had been agreed with them. Records indicated that people had access to health care professionals to meet their individual health care needs.

However, we did note that some staff approaches were not always as person centred as they might be to promote people's sense of wellbeing. For example we observed a staff member assisting a person to eat a meal. They were using a spoon but not always remembering to wait until the person had finished eating and had emptied their mouth before offering the next spoonful.

Because of the trip out the numbers of people at lunch in the home were reduced and there were plenty of staff assisting. We observed that it was quite some way into the meal before everyone had been offered and given a drink. One person was offered a drink when they were seated and chose a cold drink, another was told they could have a cup of tea, which did not arrive and others were not offered any drinks. Staff appeared to be focused on the tasks of getting meals out and taking trays out rather than the individual at this point in the day. Music was put on in the room halfway through the meal. Thus the mealtime experience was a less pleasurable and person centred event than it might have been.

Staff had received training on person centred care within the last 3 months and we spoke with the registered manager about the need to check the training was being embedded and followed by all staff. We could see issues around staff performance was being identified and addressed through supervision and spot checks on staff communication with people.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). People we spoke with told us they thought the home was well being managed and staff said that they enjoyed working in the home and felt supported by the registered manager. All the people we spoke with thought well of the manager and we were told that she was "approachable" and "understanding." The people who lived there and relatives we spoke with said they felt they would be able to take concerns and complaints to the registered manager and that she would take the appropriate actions.

We asked relatives about communication in the home. One visitor said they had told been to two residents' meetings and another that they had been to several meetings and that there was to be one that week and there was a poster advertising this in the home. They had found them "useful". Other visitors were also able to tell me that they had completed questionnaires to give their views on how the home was being run and if they had any comments. The results of the questionnaire showed that where people had made comments or asked for something to be changed they had been acted upon. For example providing additional chairs for people's visitor and adjusting temperatures in bedrooms to meet people's individual preferences.

At the inspection in July 2016 we found improvement from the inspection in February 2016 but that there was a continued breach of was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured the service was being well led. We had ensured that action was taken to address these concerns.

At this inspection in December 2016 we found that the improvements had continued and quality monitoring and auditing systems were being applied consistently. We saw the quality monitoring systems were being effective in identifying areas of the service that needed to continue to improve. Shortfalls identified at the previous two inspections had been systematically addressed by the registered provider and manager and monitored to help make sure they could be sustained. The registered providers had sought expert help from external consultants who were supporting them to monitor and develop service provision.

The new pharmacy system that had been introduced into the home had led to an improvement in the management of the medicines and in medicines monitoring to help prevent errors. We could see that the medication checks being done were identifying and addressing any issues found. Medication errors had been investigated and appropriate actions had been taken.

A skills assessment had been completed on staff and short term and long term goals had been set that were being monitored. The home's training advisor confirmed a training analysis had been completed and training had been prioritised to ensure staff delivering care were competent in their work. Staff training was subject to audit to help make sure all staff had received or were booked onto courses to receive the training they needed to carry out their roles. Staff had been receiving supervision and their performance was checked through spot checks and competency assessments. Staff we spoke with told us that they enjoyed their work and felt supported and "listened to" by management. We were told that staff morale was good.

We saw that the home's regional manager made regular visits to the home to check the monitoring and audits within the home. This included, checking recruitment, that staff training was up to date, looking at any complaints and checking what activities had been made available to people. They spoke with people living there and staff and checked their supervisions and looked at staffing and sickness levels and monitored the internal audits. Records were kept of the visits and the action plan and timescales for action for any outstanding issues. The person responsible to any action to improve was stated and a timescale was placed on the completion of follow up actions

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities. Incidents and accidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. Maintenance checks were being done regularly by staff and records kept. There were cleaning records to help make sure the premises and equipment were being kept clean and safe to use.

Following the inspection the registered manager provided us with an action plan from the verbal feedback given at the end of the inspection. This indicated what they had done straight away and how they were going to address the areas for continued improvement we had discussed. We spoke with the registered provider and manager during the inspection. Both were responsive to any issues raised and proposed courses of action to make necessary improvements. We discussed in detail with the registered manager the level of improvements made in the home and the challenge for the service to continue to improve and move forward.