Mrs L Weekes and Miss J Weekes

Marley House

Inspection report

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 21 and 22 September 2015.

Marley House is registered to accommodate up to 26 people who require nursing or personal care. On the day of our visit there were 16 people living in the home.

The service did not have a registered manager. There was a home manager who had been working in the home for four months. Their application to be registered manager had been submitted and was being processed. 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.

At our last inspection of Marley House in September 2013 we had concerns about how people received support for their individual care needs, the quality of record keeping and the recruitment of staff. There were breaches related to these regulations. We asked the provider to take action and they sent us a plan detailing they would make necessary improvements by the end of November 2013.At this inspection we found they had addressed actions related to how people received support for their

Summary of findings

individual care needs and recruitment. However during this inspection we found that concerns about the quality of record keeping had not been adequately addressed. The home was not able to demonstrate through their records, how they protected people from inappropriate or unsafe care. This meant there was a continued breach of this regulation.

Some people required creams to be applied as prescribed by their GP, during this inspection there were gaps in the recording of when cream was applied for two people.

The home had received input from health and social care services after one person developed a significant pressure sore. The provider put some actions into place to reduce the risk of further incidents. However we found that some care workers did not complete repositioning charts appropriately. This meant people were not being protected sufficiently from the risk of developing a pressure sore. Senior staff did not identify this through quality monitoring.

Improvements were needed to ensure regular checks were carried out by senior staff and actions taken to ensure staff have appropriate guidance to enable them to provide people with the right care and support.

We found the provider had made some improvements since our last inspection in September 2013. The provider had implemented appropriate recruitment checks and staff were recruited safely. Improvements had been made to how people with specific nutritional needs were supported.

During this inspection there were concerns the home did not always have sufficient staff with the right skills and experience to meet people's needs. Some staff had left and some new staff had been recruited. Some new staff who had been recruited did not have previous experience in a care worker role. Seven members of staff, two relatives and a healthcare professional told us they were concerned about the home being "short staffed" and some staff not having the right skills and experience. There had been difficulties covering some shifts at short notice. The provider was aware of the problem and had taken actions to address it. They were actively recruiting and had booked agency staff to cover.

People were treated kindly and staff were caring and interacted warmly with people. People had their privacy and dignity respected. People were involved in decisions about their care and families told us they were happy with the home.

There were breaches of regulations which impacted on the quality of care that people experienced. You can see what action we have asked the provider to take at the back of the full version of the report.

Summary of findings

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. Staff and relatives told us there were not always sufficient staff. However the provider was aware of problems with staffing and was actively recruiting and had appointed new staff.

Medicines were stored safely and at the correct temperatures. Records were not always completed to indicate if a person had cream applied as prescribed by a GP

People were protected from harm and abuse because there were processes in place for recognising and reporting abuse. Staff were able to talk with us about how they recognise potential harm and abuse and what actions they would take.

Is the service effective?

Requires improvement

People did not always receive effective care. Staff did not always complete repositioning charts appropriately which meant people who were at risk of developing a pressure sore were not adequately protected.

People did not always receive care and support from staff who had the appropriate skills and experience. Some staff told us they did not have sufficient training to be able to do their job.

Staff understood the principles of the Mental Capacity Act (2005) and how to apply it to their work.

People received sufficient food and had dietary needs assessed.

Is the service caring?

Good

People were spoken to kindly and staff had a caring approach.

People were treated with dignity and respect and their privacy was protected.

Is the service responsive?

Good

People had their individual needs, like and dislikes assessed. People were being supported and encouraged to be involved in telling their life story as part of their care plan.

People and their families were involved in making decisions about their care.

People and their families were invited to meetings and were able to contribute ideas and suggestions which were responded to by the service.

People and their families knew how to raise concerns.

Is the service well-led?

Requires improvement

The service was not well led because the action plan from the previous inspection had not been fully adhered to.

Summary of findings

There were insufficient quality checks in place to monitor safe care and treatment.

Staff told us management were approachable and supportive.

Marley 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 21 and 22 September 2015 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed information we held about the service including notifications of incidents and the action plan that the provider had sent us after our previous inspection. A notification is the way providers tell us important information that affects the care people receive. At the time of the inspection a Provider Information Record (PIR) had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection and spoke with the manager about this. We contacted the contracts monitoring team and the clinical commissioning group and we spoke with two healthcare professionals.

During our inspection we looked around the home and observed how staff interacted with people and each other. In order to gain more information about the service we spoke with six people, and three people's relatives. We also spoke with the manager and seven members of staff. We looked at eight people's care records and the Medicine Administration Record's (MAR). We looked at a sample of staff records, staffing rotas, staff training records and other information about the management of the service.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. There was not always sufficient staff to meet people's needs safely. People, relatives and staff told us there had been problems with staffing. The manager told us they had four care workers on duty with one trained nurse. We saw during the month of August 2015 there had been six shifts where the number fell below this. On one shift there were three staff and on four shifts there were four staff. The manager told us there had been "a bit of blip" because they had four staff go on maternity leave. They told us when staff had gone off sick at short notice it was difficult to fill the shift. We asked the manager what the contingency was and were told staff "phone around local agencies" and ring the manager and if necessary "one of us come in." Relatives told us "they seem to be very short staffed, especially at weekends." One member of staff talked to us about times when they were short staffed and told us "it's hard for residents to have to wait." A healthcare professional told us they were worried that there was not enough staff to carry out care appropriately.

The provider was aware there had been problems and told us they were actively recruiting for staff. They had interviews the previous week but there was poor attendance from candidates. They were aware of the staffing difficulties and had made arrangements to have two agency staff on long term placement. They were on a four month contract which would cover over the Christmas period and would provide the home with some continuity and consistency. A nurse was recruited and who was due to start the day after our inspection. Staff told us they had worked extra hours to provide adequate cover, for example some staff told us they had worked 48 hours a week. One member of staff told us they put training on hold as they "did not have time for anything else."

We found the provider had made some improvements in relation to recruitment since our inspection on 29 September 2013. Our previous inspection found the home did not carry out recruitment checks in a robust and consistent way. Following the inspection the provider wrote to us and told us they would make improvements. During this inspection improvements had been made. The service carried out checks on staff before they started work which included checks with the Disclosure and Barring Service, identity checks and obtaining references in relation to their previous employment. There were checks completed of nurse registration.

Medicines were stored safely and at the correct temperatures. Nurses were required to complete training in the safe administration of medicines, those who had not yet completed it were booked for October 2015.There was a medicines policy and MAR included a list of homely remedies which could be administered and also included how people liked to take their medicines. The MAR also included an up to date photograph of the person which provided additional safety measures to ensure the right person received their medication.

There were some gaps in the recording of when people had cream applied. For example one person required cream applied to their feet twice daily, the records for one week showed it had been applied once a day. Another person was meant to have cream applied each morning, however the chart had not been signed for three days This meant the home did not demonstrate in their recording how they ensured people received safe care and treatment.

This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their risks assessed. There were a range of specific risk assessments, for example a moving and handling risk assessment and a nutritional risk assessment. Where some risks had been assessed control measures had been put in place to mitigate the risk. An example of this was people who needed support with moving had a care plan to provide guidance to staff on how to support the person safely with moving and what equipment was best suited. It included recommendations from healthcare professionals. However improvements were needed in relation to the management plan for people either at risk of a pressure sore or for people who had acquired one.

People were at reduced risk from abuse. Staff received safeguarding training as part of their induction prior to starting work in the home and were able to tell us about the types of abuse and what actions to take if they suspected abuse. There was a safeguarding policy and a multi-agency protocol available for staff. Staff told us they knew the contact details of the safeguarding team. Staff

Requires improvement

Is the service safe?

were able to tell us about the whistleblowing procedures and how they would report poor practice. People told us they felt safe and one person said "I am safe living here, I don't want to move."

Requires improvement

Is the service effective?

Our findings

People did not always receive effective care. At our last inspection on 29 September 2013 we had concerns that peoples care records were not accurate or complete. There were significant gaps in repositioning charts which put people at risk of developing pressure sores. As well as this some records in relation to people's creams had not been completed properly. At this inspection we saw the home had not made satisfactory improvements.

Before our visit we received information concerning one person who had developed a significant pressure sore. The person was seen by health care professionals. Due to concerns about the pressure sore they referred the matter to the safeguarding team. A meeting was held with the provider and health and social care professionals. The provider responded to the concerns and identified actions they would take. The manager told us this included increased supervision of staff and observational assessments by the head of care. As well as, more training, senior staff checks of repositioning charts and changes to handover sheets.

Healthcare professionals provided training to staff which included how to complete repositioning charts to reduce the risk of pressure sores and when to notify a nurse of any concerns. However one nurse told us they lacked confidence that some care workers would inform them if a person had skin redness.

While staff recorded people had been repositioned there were some gaps in the recording of which position people were in. For example one person's chart identified them on three occasions in the same 24 hour period, as being repositioned, with no indication of how. Another person required two/three hourly repositioning and there were frequent gaps for example on one particular day, six out of eight entries did not record a position. This meant that staff could not be sure how people needed to be repositioned.

People did not always receive the care which was recorded in their care plan. For example one person's care plan said two hourly repositioning. On one day there was a gap of 12 hours in which there was not a record of the person being repositioned.

Some people were identified as being at risk of not drinking enough. They were on charts to record how much they had to drink (fluid charts). We saw they were being completed by care workers, however there were no totals being added up at the end of the day. This meant it was unclear if staff were taking note of a person's fluid intake and if any action was being taken. We asked nurses about the fluid charts. We were told it was the responsibility of night staff to add up how much people had to drink. This meant that people were at risk of dehydration because the systems in place to monitor people at risk were not effective.

This was a breach of regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care from staff who had the right skills and experience. There was an induction programme for new staff. One new member of staff told us they had one day of learning by DVD and then did some "shadow shifts." They were reviewed by a manager and signed off as competent to continue working unsupervised. However some staff told us they did not receive enough training to enable them to feel confident about their work., for example one person said " Training, definitely don't feel I get enough, I just watched DVD's for six hours-didn't take it in." One member of staff told us experienced care workers had left and staff who had replaced them did not have the same skills and experience. Another member of staff told us "in some areas staff don't have the right skills." One healthcare professional told us the home "need to look at their induction." Healthcare professionals expressed concerns that some trained nurses lacked the necessary clinical skills, for example catheter care.

The manager had identified improvements were needed to staff training and had already taken some actions, for example the appointment of head of care to review training needs and to provide some face to face training in the home. The head of care told us they planned to deliver training in care planning which would include completion of care records such as repositioning charts.

Since our last inspection on 29 September 2013 the provider had made some improvements in relation to peoples nutritional assessments and care plans. Our previous inspection found that one person's diet had not been followed to meet their individual needs. Following the inspection the provider wrote to us and told us they would make improvements. During this inspection we found

Requires improvement

Is the service effective?

improvements had been made. People had their individual dietary needs assessed. Staff were able to tell us about people who were on a special diet and appropriate food was provided.

People had sufficient food and drink. People told us the food was good. One person told us "it's lovely, nice and hot." The menu was on display and people were offered a choice. If people did not want was on the menu we heard them being offered alternatives.

Staff received supervision (meeting with a manager) and there was a checklist to record when it had taken place. The manager told us they had not conducted any annual appraisals since being in post however they had planned to schedule them in. They did not give us a timeframe for completion. However we saw some staff had received an appraisal within the previous 12 months from the previous manager.

The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of individuals who have been assessed as lacking the mental capacity to make specific decisions. People living in the home had consented to live there and had been assessed as having the capacity to make this decision. The manager was aware of the Act and understood when they would need to make a decision in a person's best interests. The home had a policy on the MCA, which had recently been updated. Some staff had received training and other staff were booked for training in October 2015.

There was no one living in the home that was subject to a Deprivation of Liberty Safeguards authorisation (DoLS). These safeguards aim to protect people living in care homes and hospital being inappropriately deprived of their liberty. DoLS can only be used if there is no other way of supporting the person safely. The manager was aware of when to apply for a DoLs.

People had access to healthcare professionals. There was contact with the GP, on the day of our visit the GP had been called for two people. There was also input from the community matron, district nurses and tissue viability team. The Community Mental Health Team were also involved with one person. One visitor told us they were very happy with the care and the staff responded quickly if there were any health concerns. The Speech and Language Therapy Team had provided assessment for some people and there were regular visits from a chiropodist. Relatives had asked for a visiting dentist which was arranged.

Good

Is the service caring?

Our findings

People were treated kindly and with warmth. People and their families were complimentary about staff. One person told us “staff is very good.” Another person told us “everyone is very kind.” One relative told us “I commend them; they’ve done over and above for [person’s name].

Staff interacted with people and there was appropriate use of humour, one relative told us their loved one “has a bit of fun with staff, they get on really well.”

Staff were able to tell us about people in a way which demonstrated they knew them as individuals. For example one care worker talked about the jobs people had and how important it was to know people’s routines. Staff told us they enjoyed their work and gained satisfaction from caring for people. Some staff became upset when they talked with us; they were unhappy that some people had developed a pressure sore and told us they wanted to provide a high standard of care. Staff were motivated and wanted to improve how they worked, one care worker told us “I care a lot about the residents and want the best for them.”

Staff were respectful to people when they were supporting them with care. They ensured they had eye contact and talked with people and offered them a choice. For example we saw one person was unsure where they were meant to be for the meal. They were offered a choice and given support to be comfortable. Another person did not want a meal, staff sat with them, one to one, and talked with them, checking why they were declining. The person was offered alternatives.

One relative told us “staff really care; you can see it in their faces.”

People had their privacy and dignity respected. When people received personal care, staff used a sign on the door which indicated “care in progress”. We saw staff knocked on doors before entering and staff told us they ensure people remained “covered up” during personal care.

Good

Is the service responsive?

Our findings

People had care plans which were based on their individual health and social support needs. People and their families had contributed to their care plan, for example there was background information on the people's personal history. One person had been supported to write their "autobiography." The manager told us they were in the process of involving all people in writing their life story.

The care records included people's likes and dislikes and how people liked to carry out every day routines. For example one person preferred to stay in their room; they told us "I prefer my own space." This was reflected in their care plan. Another person liked to go for walks in the garden and this was part of their care plan.

The role of activity coordinator had been covered by two care workers. Both had specific interests which they utilised when organising activity for example one care worker provided manicures for people.

There was a weekly activity timetable which was on display. Activities took place in the afternoons for example: games, crafts, cooking and quizzes. We saw scrabble being played and there was a music entertainer. Some people responded to the activities, however not all people wanted to participate. One person told us "I like my books, that all I want to do." Their care plan identified the person liked reading and did not engage in organised activities. The manager told us people have an option about what they enjoy doing and the home responded according to what people enjoy.

It was not clear if people who remained in their rooms were offered or were provided with activities or one to one time with staff. For example one person enjoyed watching cricket and football; the manager told us staff facilitated this although it was unclear from the care records how often this happened. When staff were handing over from one shift to the next there was no information regarding people's social needs, other than one person refused to come downstairs. The emphasis was on what support people had received for their physical health needs, for example if people had eaten breakfast and lunch and if dressings had been applied.

There were quarterly meetings for people and their families; the last one was in June 2015. The manager talked about the care planning process and about gaining peoples life stories which would help to plan activities. Relatives also gave feedback, they were positive about the food. One relative requested the home arranged for a dentist to visit the home, which was arranged. One person and their relative told us they get asked for their opinion about the home and had received a questionnaire.

There was a complaints policy which was displayed on the notice board. People told us they would talk with a manager if they had any concerns and they could tell us who the manager was. One person told us "I don't have any complaints." There was a system for recording complaints and they were investigated by the manager. For example one relative complained about clothing going missing. The manager investigated the complaint, took actions and responded to the complainant. There was also a system for capturing compliments about the service for example one relative wrote in July 2015 "She came out a lot better than when she arrived." During our inspection the provider received a formal complaint from a relative which reflected concerns about the staffing levels and skills and the impact this had on their loved one. The provider told us they planned to investigate the complaint and provide a response.

Requires improvement

Is the service well-led?

Our findings

The service was not well led. This was because at our last inspection in September 2013 the provider submitted an action plan detailing how they would make necessary improvements to address breaches of regulations. At this inspection whilst there were some improvements in some areas, the provider had failed to ensure that care records were maintained and completed sufficiently to ensure the safe care and treatment of people.

There was not a registered manager in post. The provider had taken actions to improve the management of the home and had appointed a new manager and new head of care. The new manager had been in post four months and had applied to become a registered manager. The head of care was in their second week in post.

There was a limited system for ensuring there were some quality checks being carried out. The manager told us they informally check round the home. However monitoring systems were not always effective to protect people from unsafe care. For example one person who was referred to the Tissue Viability Nurse on 8 September 2015 because they had developed a grade three or four (significant) pressure sore had not been identified with any skin redness or damage in a wound audit 30 August 2015. If early changes to the skin had been identified sooner preventative measures could have been instigated.

There were some quality checks. For example there were monthly checks of slings and slide sheets, hoists, wheelchairs and infection control. We saw some actions were recorded following checks, such as a blood spills kit was ordered after the infection control audit picked up one was needed.

The manager told us they were reviewing the system of quality improvements and planned to make improvements with the support of the head of care.

There were systems for ensuring the building and equipment were safely maintained and the service employed a maintenance person. There were regular maintenance checks carried out and a record of when work was completed.

There was a system for recording accidents and incidents, which included a process of tracking the accident or incident to ensure actions, had been taken, for example following one person's fall, staff obtained advice from a healthcare professional and recommendations were followed. The persons care plan was updated to included two care workers were needed when supporting the person with personal care.

Staff told us management were supportive and approachable. One care worker told us management are "polite and take time to talk to us." Another member of staff told us they had experienced some personal life changes and management had been flexible to support them to continue working. Another care worker told us "I feel well supported, my manager listens." Most staff acknowledged the home had gone through a difficult period with staffing and this had impacted on how people were supported. However staff were optimistic new staff had been recruited and the home was improving. For example one nurse told us there was a new senior care worker and this meant care workers were getting more support and supervision. The head of care told us care is good however their needed to be "more organisation."

The provider had recognised that improvements to staffing were needed and had taken some actions. A senior care worker was appointed as well as the head of care. The manager told us their roles were to ensure people received the care and support they needed and staff were appropriately supported and supervised. The head of care told us the home had a full programme of change and their role was to ensure people received "the right care in the right way. "Staff told us there have been improvements; One member of staff told us "things are getting better."

We saw the provider had taken actions when there were concerns about staff performance. For example one member of staff received additional supervision and had a change made to their job role which was more appropriate based on their competencies.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) (2) (g) People's medicines were not always recorded properly. 12 (1) (2) (b) The acknowledged risks people faced were not consistently managed or action taken to minimise these risks.