Cumbria County Council

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

Summary of findings

Overall summary

We carried out this inspection on 29 January and 2 February 2016. The inspection was unannounced. We last inspected this service in June 2013. At that inspection we found that the provider was meeting all of the regulations that we assessed.

As part of our regulatory activity we found that the provider for the service was not registered correctly. We discussed this with Cumbria County Council and they submitted an application to correct their registration details. We carried out an assessment of Marsh House in October 2015 as part of the county council's registration application. We judged that the service was likely to be safe, effective, caring, responsive and well-led.

Marsh House provides accommodation and personal care for up to 28 older people. The home is in a residential area in Ulverston town centre. It is run by Cumbria County Council.

The home is on two floors with most bedrooms upstairs and three sitting rooms with dining areas on the ground floor. Marsh House provides permanent accommodation for people and also short term respite care.

There was a registered manager employed at the home. 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 and associated Regulations about how the service is run.

Everyone we spoke with told us this was a good service. People said they felt safe in the home and told us that the staff were "kind", "caring" and "helpful". They told us that they trusted the staff who supported them and, if they had any concerns, would be confident to speak to a staff member.

People who visited the home regularly told us that they had never seen or heard anything that caused them concern about the safety of people who lived there. A visiting health care professional said, "This is a nice home, it's a good service, people are well looked after".

We found that staff had not followed guidance about protecting a person from the risk of choking and equipment had not always been used safely. People were not safe because risks had not always been identified and managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were times when there were not enough staff to provide people's support or to support people in the event of an emergency. This was a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The systems used to assess the service had not identified the issues we found at the inspection. They had not been effective in ensuring the quality and safety of the service provided to people. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed our concerns with the registered manager of the home and they took immediate action to review the risk assessments and to increase the number of staff employed in the home during the night.

People were included in decisions about their care and maintained their independence and control over their lives.

People enjoyed the meals provided in the home and could have snacks and drinks as they wanted.

Visitors were made welcome in the home and people were able to see their friends and families as they wished.

Medicines were handled safely and the staff in the home worked well with local health care services to ensure people maintained good health.

People knew how they could complain about the service they received.

The registered manager was knowledgeable about her responsibilities under the Mental Capacity Act 2005. People agreed to the support they received their rights were protected.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to identifying and managing risks to people's safety, staffing levels and ensuring effective processes were used to monitor the quality and safety of the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

There were not always enough staff to ensure people's safety or to provide people with the support they required.

Risks were not always identified and managed properly.

People were protected against the risk of abuse.

Medicines were handled safely and people received their medicines as their doctor had prescribed.

Is the service effective?

Good

The service was effective.

People had a choice of meals and drinks that they enjoyed.

The staff in the home had completed training to give them the skills and knowledge to meet people's needs.

People agreed to the support they received and care was only provided with their consent. The registered manager was knowledgeable about her responsibilities under the Mental Capacity Act 2005 and people's rights were protected.

Is the service caring?

Good

The service was caring.

The staff in the home were kind and caring to people who lived there.

People were supported to maintain their independence and control over their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Although the care staff tried to provide the assistance that

people required, people were not always supported in a timely way.

People could receive visitors whenever they wished. Their visitors were made welcome and people were able to maintain the relationships that were important to them.

There was a formal system to receive and respond to concerns about the service. People knew how they could raise a concern if they needed to.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Although systems were in place to assess service, these had not ensured that areas requiring improvement were identified promptly.

People who lived in the home were asked for their views of the service and their feedback was used to improve the service provided.

There was a registered manager employed in the home. The registered manager took action in response to concerns raised at the time of the inspection.

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 checked 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 29 January and 2 February 2016 and was carried out by two adult social care inspectors.

Our visit to the home on 29 January was unannounced. At that visit we focused on speaking with people in the home, their visitors, care staff and visiting health care professionals. We arranged to return to the home on 2 February to look at records relating to how the home was managed.

There were 25 people living in the home at the time of our inspection. During our inspection we spoke with 14 people who lived in the home, five visitors, eight care staff, two ancillary staff, the registered manager of the home and the provider's operations manager. We observed care and support in communal areas, spoke to people in private and looked at the care records for six people. Some people who lived at Marsh House were not easily able to tell us their views about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three health care professionals who were visiting people in the home and looked at records that related to how the home was managed.

Before our inspection we reviewed the information we held about the service. We also contacted the local social work and commissioning teams to obtain their views about the service.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us that people were safe in this home. People who lived at Marsh House told us, "I feel totally safe" and said "I'm sure I'm safe". Relatives we spoke with told us, "I'm 100% confident [my relative] is safe here".

People told us that they trusted the staff in the home and would be confident to speak with them if they had any concerns about their safety. Relatives and health care professionals who visited the home regularly told us that they had never seen or heard anything that caused them concern about the safety of people in the home. One health care professional told us, "This is a nice home, it's a good service, people are well looked after".

We found that people were not protected because risks to their safety had not been identified and managed and there were not always enough staff to support people.

One person's care records showed that they had been assessed as at risk of choking. Their care plan stated that, if they chose to eat their meals in their bedroom, a member of staff had to remain with them while they had their meal. The records care staff had completed showed that there were occasions when food had been left in the person's room and a member of staff had not remained with the individual to provide support if they choked. This meant the person had been placed at risk.

Some people who lived in the home needed to use a wheelchair to help them to move around the premises. We saw that although the wheelchairs were fitted with lap belts, to protect people from falling from them, these were not used when staff assisted people to move. This meant people were at risk of falling from the wheelchairs and being injured. The care records we looked at did not show that this risk had been identified or people assessed to see if they required a lap belt to be used.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to people had not been identified and managed.

We discussed these issues with the individual staff and the registered manager. We saw that the care staff immediately sought people's permission to use the lap belts. The registered manager updated risk assessments to include the use of the lap belts. They also immediately included the use of wheelchair lap belts in the training provided to staff. The registered manager also confirmed that the guidance given to staff around supporting people at risk of choking would be reviewed immediately.

Some people who lived in the home told us that they felt there were enough staff to provide the support they required. Other people said they felt that more staff were needed. One person told us "The staff appear a bit pushed at times". Another person said, "They need more staff for all these people". A staff member we spoke with told us that at times it was difficult to care for people, especially if a lot of people had chosen to remain in their rooms on the first floor of the home. During our inspection we saw one person asked to be taken to the toilet but waited 30 minutes because the staff were busy attending to other people.

The home had hoists which staff used to assist a person off the floor if they fell. To ensure people's safety two staff were required to operate the hoists. At our inspection on 29 January 2016 we found that there were two care staff employed in the home during the night. This meant that, if someone fell and required the use of the hoist to assist them off the floor, there were no staff available to support anyone else in the home.

The home had a range of equipment for detecting and protecting people from the risk of fire. All staff had completed regular fire safety instruction including the actions to take if there was a fire in the home. A fire risk assessment had been completed and fire doors were in place to restrict the spread of a fire.

The registered manager told us that, in the event of a fire, the staff on duty would support people to move away from the fire to an area of safety. We saw that the support people would need in the event of a fire had been assessed and recorded in personal emergency evacuation plans. We found that in one area on the upper floor of the home there were two people who had been assessed as requiring the support of two staff to assist them to a place of safety in the event of a fire. We saw that there were also people who had been assessed as requiring staff to provide them with reassurance if the fire alarm sounded. The fire risk assessment stated that care staff needed to be aware that there may be circumstances where they would have to evacuate everyone from the upper floor to the ground floor of the home. We judged that staffing levels during the night were not sufficient to support and protect people in the event of an emergency.

This was a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because there were not always sufficient staff to provide people's care and to maintain their safety.

When we returned to the home on 2 February 2016 we found that the registered manager had increased the staff on duty overnight from two care staff to three.

Although we found that most areas of the home were clean and properly maintained we saw that there were areas which required minor repairs to ensure the safety of people in the home.

Windows in the home were fitted with devices to restrict how far they could be opened to reduce the risk of people falling from them. We found that two of the screws that secured the restrictor on a window on an upper landing were loose. These required attention to ensure the restrictor would continue to operate effectively. We also saw that there was a hole in the plaster of the wall of one toilet and damaged plaster in a bathroom which meant these areas would be difficult to clean thoroughly. During our inspection the registered manager reported the issues to the registered provider for repairs to be arranged.

All of the staff we spoke with told us that they were confident people at Marsh House were protected against the risk of abuse. They said they had received training in how to identify and report any concerns, including concerns about the behaviour of other staff. One staff member told us, "We know what to do if we have a concern, none of the staff here would put up with it, and we'd all report anything to the manager [registered manager] or to one of the supervisors".

The registered manager knew how to report allegations of abuse to the local safeguarding authority. She had also made required notifications about any allegations to the Care Quality Commission. From the information we received from the registered manager and from the local safeguarding authority, we could see that the registered manager took appropriate action when concerns were raised.

People told us that they received the support they required with taking their medicines. We looked at how medicines were stored and managed in the home. We saw that medicines were stored securely to prevent their misuse. Staff who supported people in taking their medicines had received training to do this safely.

The registered manager and supervisors in the home had carried out checks on how medicines were handled. These had found areas where the records around use of medicines needed to be improved. We saw that action had been taken to ensure accurate and complete records were maintained about all medicines administered in the home. The checks carried out helped to ensure people received their medicines safely and as their doctors had prescribed.

Good

Is the service effective?

Our findings

People who lived in the home told us that the staff knew the support they required and were able to provide this. We asked people if they thought the staff were well trained and they said they thought they were.

All the staff we spoke with said they completed a range of training to give them the skills and knowledge to provide the support people required. This was confirmed in the training records we looked at.

People told us that they liked the meals provided in the home. One person told us, "It's grand, you get well fed and you get lovely food". Two people said the homemade soup was always "delicious". One person said, "I always have two bowls, it's lovely".

People told us that there was always a choice of meals and we observed this during our inspection.

We saw that people were offered hot and cold drinks and snacks throughout the day. People told us that this was usual practice in the home and one person said, "You can get tea and biscuits at any time".

Some people who lived in the home were not able to make important decisions about their care and lives. We saw that the registered manager had a good understanding of their responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The 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.

Throughout our inspection we saw that people were free to make choices about their care and their lives in the home. The staff in the home asked for people's agreement before providing support and this was only given with people's permission. There was no one in the home who was subject to a DoLS at the time of our inspection and we did not see any evidence of people being restrained or deprived of their rights or of their liberty.

Marsh House provided accommodation for older people and for people living with dementia. During our visit on 29 January 2016 we saw that there was one sign on a toilet door to help people identify the room, however there were no other "dementia friendly" signs to support people to find the toilets. When we visited the home on 2 February we saw signs had been placed on all doors to toilets. This would help people living with dementia to be able to find the toilets independently.

People told us that they received the support they needed to see their doctor or other health care services. One person said, "The staff always get the doctor if you're not well". This was confirmed by visitors we spoke

with. One told us, "The staff get the doctor straight away if Mum's not well and they're very good at letting me know". A visiting health care professional we spoke with told us that the staff at Marsh House contacted them appropriately if a person needed support. They said any advice they gave was always followed. This meant people were supported to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

During our inspection we spoke at length to people who lived in the home and to their visitors. Everyone we spoke with told us that the care staff at Marsh House were "kind" and "caring". One person told us, "The staff are lovely, you couldn't ask for any better". Another person told us that the care staff were, "attentive, friendly and helpful".

People told us that they were asked about how they wanted to be supported and about the things that were important to them in their lives. They said the staff knew them well and provided support as they preferred.

People told us they were supported to maintain their independence and control over their lives. We saw that some people used equipment to help them to move around the home. The staff knew the equipment people needed and made sure this was available when they required it.

We saw that most staff treated people in a way that maintained their dignity. During our visit on 29 January we saw that one staff member did not provide support to an individual in a discreet manner, we discussed this with the registered manager of the home.

Despite the shortfalls identified during the inspection about the staffing levels during the night, people told us that the night care staff were kind and attentive to their needs. They said that, if they woke in the night and used their call bell to request staff support, the night staff usually came quickly. One person told us the night staff often made them a hot drink and a snack if they wanted this during the night.

The care staff we spoke with told us that they tried to spend time with people in the home. They said sometimes this was difficult if a number of people were being cared for in their rooms. The registered provider was introducing a system to assess staffing levels that would take into account people's level of need and the impact of the design of the building.

During both days of our inspection we found that the home was free from odours. People who lived at Marsh House told us that the home was "Always clean and fresh smelling". This was confirmed by relatives who visited the home regularly. This helped to support people's dignity. One visitor told us, "You notice that the home smells fresh and pleasant. There's never any unpleasant smell and the cleaners do a fantastic job".

We saw that the service had information available about local advocacy services that could support people to make a complaint or to express their wishes about their support. An advocate is a person who is independent of the service who can support people to share their views.

Requires Improvement

Is the service responsive?

Our findings

People who lived at Marsh House told us that they were happy living there. They told us that the staff worked very hard and that they valued the support they received. Most people said the service provided was usually responsive to their needs. However, one person told us that they were not able to join in the planned activities in the home and said they were not provided with individual support from staff to follow activities they could enjoy. Two care staff we spoke with also told us that at times it was difficult to spend time with people because there was a high workload.

During our visit on 29 January we saw that people in one dining area were waiting at the dining tables for their meal to be served. One said, "They rush you to the table and they are not ready". We also saw that one person asked the staff for support to go to the toilet but waited 30 minutes before staff responded to their request. We found although the care staff tried to provide the support that people needed, the service was not always responsive to people's needs.

We saw that one person was having difficulty eating their midday meal. Although their care plan stated that they needed assistance to eat their meals, there was no detailed information about how staff were to provide this. One staff member noticed that this person was having difficulty and requested for another care worker to provide support. We saw that the individual responded well to having the individual attention of the care worker and then enjoyed their meal.

We looked at the records held in the home. We saw that each person had a care plan that detailed the support they required from care staff and how they wanted their care to be provided. We saw that the individual, and those who knew them well, had been asked about the things that were important to them in their lives as well as about the support they required. The care plans were reviewed regularly or as people's needs changed to ensure they held up to date information for care staff to follow.

Relatives we spoke with told us that they were able to visit whenever they wanted and were always made welcome by the staff in the home. People who lived at the home confirmed that their visitors were always made welcome and said they were able to see their families and friends as they wanted.

The registered provider had a procedure for receiving and managing complaints about the services it provided. We saw that the complaints procedure was displayed in the home and was available on the registered provider's website. This meant it was available for people without having to ask the staff in the home for a copy. People could raise concerns directly with the registered provider if they did not wish to discuss them with the registered manager or staff in Marsh House. People we spoke with told us that they knew how they could complain if they needed to.

Requires Improvement

Is the service well-led?

Our findings

People who lived at Marsh House, their visitors and the health care professionals we spoke with all told us that this was a good home and said that it was well managed. People told us that they knew the registered manager and said she was "always available" if they needed to speak with her.

Two visiting health care professionals told us, "This is one of the better homes we visit, the manager is always open to our suggestions and there is a lovely atmosphere when we come." This was confirmed by the relatives we spoke with.

We saw that the registered manager had carried out checks on the service and had identified some areas where the service needed to improve. However, during our inspection we found that some risks to people had not been identified and managed and that there were not always sufficient staff to provide people's care and to maintain their safety. The checks carried out by the registered manager had not identified these issues.

This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems used to assess the service had not been effective in ensuring the quality and safety of the service provided to people.

During our visit to the home on 29 January 2016 we discussed the concerns we had found with the registered manager and with the provider's operations manager. When we returned to the home on 2 February 2016 we found that the staffing levels at night had been increased to ensure there were sufficient staff to respond to an emergency and to ensure people received the care they required. We also found that the maintenance issues we had identified had been referred to the registered provider to request the required repairs were carried out and appropriate signs had been placed on the doors to toilets to help people identify them. This showed us that the registered manager took action in response to concerns raised.

The registered provider and registered manager used formal and informal methods to gather the views of people who lived in the home. We saw that people had the opportunity to attend regular meetings where the service provided was discussed. People had also been asked to complete a survey giving their views of the service they received. We saw that, where people requested changes to the service, such as to the activities provided, these changes had been agreed. The registered manager used the views of people in the home to improve the service provided.

The care staff we spoke with told us that they felt well supported by the registered manager and care supervisors employed in the home. However two staff told us that they felt there were times when more staff were required to ensure people received the support they needed promptly. All the staff we spoke with said they knew how they could raise concerns about the behaviour or actions of other staff members. They told us that they had been informed of their responsibility to raise any concerns and said they would tell the registered manager or one of the supervisors in the home if they had any concerns about the actions of

another staff member.

Providers of health and social care services have to notify the Care Quality Commission of important events that happen in their services such as serious injuries to people or applications to deprive people of their liberty. The registered manager of Marsh House had informed us of significant events as required, this meant that we could check that action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 How the regulation was not being met: The registered provider had not ensured that risks to people were identified and managed. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The registered provider had not ensured that effective systems were in place to ensure the quality and safety of the service. Regulation 17 (1) and (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The registered provider had not ensured that there were always sufficient staff available to provide people's care and to maintain their safety. Regulation 18 (1)