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Marsh House

Inspection report

Marsh House
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Tel: 01772600991

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Marsh House provides personal care for up to 33 older people. At the time of our inspection there were 27 people living there. The home is situated in a rural area close to the towns of Chorley and Leyland. There is a large dining room, communal areas, hairdressing room and conservatory area. A substantial, well-maintained garden is available at the rear of the home for people's leisure. These areas are accessible to people who use a wheelchair and there is also a stair-lift in place.

There was no registered manager in place. 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 2008 and associated Regulations about how the service is run. However, we saw evidence the manager at Marsh House was in the process of registering.

At the last inspection on 13 December 2016, we rated the service as requires improvement. This was because developments undertaken by the provider needed to be embedded to demonstrate consistent good practice over time.

We additionally made recommendations for the provider to update their recruitment practices and to ensure staff received end of life care training. We further recommended the provider adapted the home's environment to support the independence of people who lived with dementia.

Marsh House is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both of which we looked at during this inspection.

During this inspection, we found the provider had sustained improvements following our last inspection. One staff member said, "Since [the new manager's] taken over it's been a different home. She's behind me and I'm flying." They had additionally taken action to meet the recommendation we made about safer recruitment practices. The management team assessed gaps in employment history to ensure candidates were suitable to work with vulnerable adults.

Furthermore, the provider had developed the environment to enhance the experiences of people who lived with dementia. Bedroom doors had photographs of people from important life events, such as a picture of an individual when they worked in a public house.

Additionally, the manager had clearly documented people's end of life care planning and related preferences. When we discussed end of life care with staff we found they had a good understanding of relevant principles.

However, care records we looked at contained limited information about the management of risks to people

from unsafe or inappropriate support. Assessments to mitigate risks, such as malnutrition and medication administration, were not always completed or in place.

We have made a recommendation about improving risk assessment to protect people from unsafe or inappropriate care.

People we spoke with told us they felt safe and comfortable at the home. Staff had safeguarding training to enhance their skills to protect people from potential abuse, inappropriate support or poor care.

We reviewed rotas and found staffing levels and skill mixes were sufficient to help people with a timely approach. The manager checked staff learning with competency testing and question sessions, which covered multiple areas including personal care, infection control and the MCA.

We noted staff gave people their medicines with a safe and patient approach. All the staff who administered medication received training and competency testing to underpin their skill and knowledge. One person said, "The staff are very effective, good with your medication."

Staff promoted lunch as a sociable occasion and ensured a welcoming atmosphere during mealtimes. They documented people's preferences and special diets, whilst frequently checking their weights and monitoring their health against any potential concerns.

During our inspection, we saw staff continuously asked people's permission before they undertook any tasks. Staff had training and understood the principles of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

When we discussed the principles of good care, staff demonstrated a good level of awareness. This was enhanced by clear involvement of people and their relatives in their care planning. One person who lived at Marsh House told us, "Very nice staff. Yes, they're kind and compassionate."

The manager and staff worked hard to understand people's backgrounds, preferences to care and how they liked to be supported. Care records we reviewed included their life histories to help employees gain a better awareness of each person.

People and staff said they felt the management team was visible about the home and the new manager was experienced and had good leadership skills. We saw records demonstrated action had been taken when the provider's wide-ranging quality assurance systems identified issues.

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

We found action had been taken to improve the safety of the home, but the service was not always safe.

Suitable and sufficient staff were employed to meet people's requirements. The provider had taken action to ensure their recruitment procedures were safe.

However, risk assessments, intended to reduce the risk of hazards at the home, were not always completed or in place.

There was a clear audit trail of medicines received, dispensed and returned to the pharmacy. Staff concentrated on one person at a time when they administered their medication.

Safeguarding information was on display in the foyer outlining contact details of organisations to raise concerns to, such as CQC and the local authority.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Good

We found action had been taken to improve the effectiveness of the home.

We found the building was spacious and appropriate for the care and support provided, including for those who lived with dementia.

People told us they enjoyed their meals and had a variety of food options.

The manager and staff ensured good standards in obtaining and recording people's consent to their care. We saw staff observed the principles of the MCA and DoLS and did not limit people's movement about the home.

Staff files we reviewed evidenced staff received a range of

training to support them in their roles.

Is the service caring?

Good

We found action had been taken to improve care at the home.

Staff encouraged people and their representatives to be involved in their care planning. The manager identified and recorded agreed long and short-term goals.

Staff reviewed and documented people's diverse needs and assisted them to maintain their different requirements. We saw they protected each person's privacy and dignity.

Is the service responsive?

Good

We found action had been taken to improve the responsiveness of the home.

The manager had improved staff understanding of people's end of life care needs through good care planning and training.

People and relatives said the home had a sociable atmosphere and they had good opportunities to keep occupied.

The manager developed care plans from information given by those who lived at Marsh House. This ensured a personalised approach to meet each individual's different requirements.

Is the service well-led?

Good

We found action had been taken to improve the leadership of the home.

People we spoke with told us the new manager was caring and led the home well. Staff commented they felt the manager and provider were supportive to them in their work.

Those who lived and worked at Marsh House had several opportunities to feed back about the quality of the service, including satisfaction surveys.

We found the manager had an extensive system to assess the quality of the service provided. Where issues were identified, we saw evidence where the manager acted to address them.

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 07 February 2018 and was unannounced. The inspection team consisted of two adult social care inspectors 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 expert by experience for the inspection at Marsh House had experience of caring for people who lived in a care home setting.

Before our unannounced inspection, we checked the information we held about Marsh House. This included notifications the provider sent us about incidents that affect the health, safety and welfare of people who lived at the home. We also contacted other health and social care organisations such as the commissioning department at the local authority and Healthwatch Lancashire. Healthwatch Lancashire is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced living at Marsh House.

Furthermore, we looked at the Provider Information Return (PIR) the provider had sent us. 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.

Additionally, we spoke with a range of individuals about this home. They included six people who lived at Marsh House, six staff members, three members of the management team and the providers. We observed care and support in communal areas and looked around the building to check environmental safety and cleanliness. This enabled us to determine if people received the care and support they needed in an appropriate environment.

We also spent time reviewing records. We examined care records of three people who lived at the home. This process is called pathway tracking and enables us to judge how well Marsh House understands and

plans to meet people's care needs and manage any risks to people's health and wellbeing. We checked the recruitment, training and support documents in relation to three staff members. We also looked at records related to the management and safety of Marsh House.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and there were enough staff to meet their requirements with a timely approach. One person who lived at Marsh House said, "I feel safe because there's always enough staff." A second person added, "Yes I feel safe."

We observed staff were calm and call bells were responded to in a timely way. We reviewed rotas and found staffing levels and skill mixes were sufficient to help people. A staff member told us, "The rotas are worked really well here." The day shift consisted of a senior and three care staff, which was reduced to a senior and two staff at night. Ancillary personnel, such as housekeeping and cooks, supported the team in assisting people to meet their needs. Another staff member commented, "I think there's enough staff. We work really well as a team and if we're short people will stay on and cover it"

Following our last inspection on 13 December 2016, we made a recommendation the provider recruited appropriate staff to maintain people's safety. This was because they had not always ensured reference requests were made to previous employers only rather than work colleagues.

We looked at staff files related to two personnel recruited over the last year and found they contained required documentation. This included references and criminal record checks from the Disclosure and Barring Service prior to the employee's commencement in post. The management team assessed gaps in employment history to ensure candidates were suitable to work with vulnerable adults. One staff member said, "I didn't start until they got my DBS and references."

Care records we looked at contained limited information about the management of risks to people from unsafe or inappropriate support. The main movement and handling risk assessment referred to medical diagnoses, any history of falls and mobility aids in use. The level of risk was measured and if concerns were identified staff implemented a 'risk reduction plan.' However, assessments to mitigate other risks, such as malnutrition and medication administration, were not always completed or in place. When we discussed this with the management team, they assured us they would develop this area of support planning to maintain people's safety.

We recommend the provider refers to current guidance, from a reputable source, about improving people's welfare by developing their care risk assessment procedures.

We found the provider had suitable systems to reduce the risk of a hazardous environment, such as health and safety checks. Where incidents occurred, staff documented these, along with any injuries, GP contact and actions taken to support the person. The form prompted staff to update care plans and risk assessments to maintain people's safety. The manager then reviewed accident forms to check control measures were effective. The manager said they assessed the occurrence and management of pressure ulcers because there had been a number of related incidents in 2017. They implemented new systems to mitigate risks, such as staff learning and working closely with healthcare services to improve procedures. They provided an example of one person being free of pressure ulcers for the first time over a long period.

This indicated how staff and management reviewed lessons learnt to improve people's safety and welfare.

On our arrival, we looked around the building and found it was clean, tidy and free of obstacles. The manager told us when bedrooms became available they redecorated them and we found they were bright and warm. Signs were displayed throughout the home about effective hand washing and soap dispensers were sensor operated to maximise infection control measures. Staff completed relevant training and made use of sufficient protective equipment. We saw staff had designated champion roles as part of the management of the home's safety, such as for fire, infection control and safeguarding. We noted hot, running water was available throughout the home and window restrictors were in place to protect people from potential harm. The home's gas and electrical safety certification was up-to-date and fire safety checks were completed.

Information was on display in the foyer outlining contact details of organisations to raise concerns to, such as CQC and the local authority. Staff had safeguarding training to enhance their skills to protect people from potential abuse or poor care. A staff member was assigned the safeguarding champion role with responsibility for ensuring good practice at Marsh House. When we discussed safeguarding principles with staff, we found they had a good awareness. One staff member told us, "We have a file, but any concerns and I'd be straight on the phone to the local authority."

We observed when staff administered medication they wore a do not disturb apron to ensure they could focus and complete procedures safely. They sat patiently with each person, explained what their medicines were and provided a drink. Following administration, the staff member signed people's records to confirm their medicines had been taken. They had a good awareness of different medication and additional information was displayed in the storage room to guide staff.

There was a clear audit trail of medicines received, dispensed and returned to the pharmacy. We found they were stored in a clean and secure environment. All staff who administered medication received training and competency testing to underpin their skill and knowledge. One staff member had the designated role of medication champion. Their responsibility included auditing of related systems and disseminating current research to staff to enhance their expertise. This ensured medication procedures were carried out using a safe and consistent approach.

We found action had been taken to improve the safety of the home. However, we have rated this key area as requires improvement because the management team and staff need to demonstrate consistent good practice over time.

Good

Is the service effective?

Our findings

Following our last inspection on 13 December 2016, we made a recommendation the provider sought advice and guidance from a reputable source to adapt the environment. This was specifically to assist those who lived with dementia. This was because the environment did not always enable people to be as independent as possible.

We looked around the building and found it was spacious and appropriate for the care and support provided. For example, the management team were focused upon developing the environment to enhance the experiences of people who lived with dementia. Bedroom doors had photographs of people from important life events, such as a picture of an individual when they worked in a public house. The intention of this was to assist them to better locate their personal space. People were also encouraged to bring in their own belongings, including furniture, pictures and ornaments. The manager told us, "We want the residents to know this is their home."

During our inspection, we observed lunchtime was a friendly occasion and people enjoyed their meals. One person told us, "The food is nutritious and on the whole mealtimes are enjoyable." Another person commented, "The chef is excellent. There's always a choice of meals." A third person stated, "The food is very nice actually."

The Food Standards Agency had awarded Marsh House their top rating of five following their last inspection. This graded the service as 'very good' in relation to meeting food safety standards about cleanliness, food preparation and associated recordkeeping. The kitchen was clean and tidy and staff documented cleaning records to evidence tasks had been completed. Staff files we looked at showed employees who prepared food completed food hygiene training.

Staff promoted lunch as a sociable occasion and ensured a welcoming atmosphere during mealtimes. For instance, they placed clean tablecloths and placemats on each table, along with ornamental decoration, glasses and serviettes. Sufficient condiments and varied sauce sachets were supplied for those with different tastes. People were offered a variety of meal options, including a choice of desert. Staff said they would implement monitoring charts, such as food and fluid intake, if they had any concerns. They documented people's preferences and special diets, whilst frequently checking their weights and monitoring their health against any potential concerns.

We found the manager and staff recorded details of other healthcare professionals involved in people's ongoing care. These included the person's GP, community and hospital specialists, social worker and community mental health nurse. We asked one person if they felt their health needs were met. They commented, "Yes, I believe they are taken care of. A nurse comes in." Staff documented visits and appointments, along with any remarks or changes made to an individual's care and treatment. Each person's bedroom contained details about other healthcare professionals involved, along with their contact information. The manager told us, "The details are there and then in the room so that staff can contact them immediately if they have concerns."

The management team had deployed a variety of systems to improve the effectiveness of the service and staff who worked there. For example, each bedroom contained discrete information and a colour-coded system to briefly outline the person's level of independence. This guided staff to the person's movement and handling support requirements. Other new protocols on display to assist staff understanding included falls prevention and medicines information.

The manager and staff ensured good standards in obtaining and recording people's consent to their care. For instance, they reviewed if a lasting power of attorney was involved and obtained confirmation of this where it was applicable. Consent was sought for a variety of decision-specific aspects of the person's support plan. This included access to mail, taking photographs, medication administration, personal care, bedrails and sharing of information. During our inspection, we saw staff continuously asked people's permission before they undertook any tasks.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager informed us they had submitted five applications to deprive people of their liberty to safeguard them. We found up-to-date records were in place, including mental capacity assessments and legally authorised deprivation records. Throughout our inspection, we observed staff did not limit people's movement and supported them to move about the home as they pleased.

Staff files we reviewed evidenced staff received a range of training to support them in their roles. This included safeguarding, person-centred care, dementia awareness, environmental and fire safety, manual handling, basic life support and food hygiene. The manager followed this up with competency testing and question sessions, which covered multiple areas including personal care, infection control and the MCA. Staff we spoke with said the provider supported them with a range of courses. One staff member told us, "The manager will get us on as much training as possible."

We found evidence staff received regular supervision to underpin their roles and responsibilities. Supervision was a one-to-one support meeting between individual staff and their line manager to review their role and responsibilities. The two-way discussion covered, for instance, a review of previous sessions, work performance, training and personal issues.

Good

Is the service caring?

Our findings

People told us they found staff were compassionate and supportive. One person commented, "The senior carer at night is very good with everybody. She talks to people and goes round to everyone." Another person said, "The staff are kind and compassionate." A third person added, "Yes, staff treat you with respect and they are kind." A fourth individual stated, "We get looked after in here. If you are upset they come and try to help."

Care files included documented evidence about people's preferences to, for example, meals, activities and care delivery. Staff encouraged people and their representatives to be involved in their care planning. For example, we found bedrooms included information to guide staff about routines for washing clothes, preferred times to get up and gender of carer. The manager told us, "The relatives are very particular, so it's important the staff follow their requests as part of the person's care." People and their relatives confirmed they were fully consulted about care delivery.

We reviewed three care files to check these focused on maintaining people's independence and reviewed their strengths. The manager had recorded how involved each person felt and identified agreed long and short-term goals. This was designed to help staff to understand how to assist individuals to develop their self-reliance. When we discussed the principles of good care, staff demonstrated a good level of awareness. One staff member told us, "Care is all about being empathetic. If you can't put yourself in their shoes, you're never going to make a good carer."

Staff reviewed and documented people's diverse needs and assisted them to maintain their different requirements. For example, they recorded each person's religion, along with details about whether they were practicing and how they wished to maintain their spirituality. One staff member explained the importance of protecting people's human rights and treating them as individuals. They added, "It's about taking your time to get to know them and who they are. I don't see the room numbers any more, I see the person." We saw equality and diversity was extended to all personnel. For example, the employee handbook outlined no staff should be subject to unlawful discrimination on the grounds of gender reassignment and sexual orientation. This intended to give staff confidence they worked in a safe and non-prejudiced environment.

We observed staff protected people's privacy and dignity throughout our inspection. For instance, staff knocked on people's doors and waited for a response before entering. A staff member had the designated responsibility of dignity champion, whose duties included acting as a role model. They were required to listen to and understand people's views, as well as to advise staff of good practice. A person who lived at Marsh House told us, "They do treat you with respect."

Staff and management supported people to help them to maintain their important relationships with family and friends. For example, they encouraged relatives to join them when they went out on social trips. We observed relatives and visitors were welcomed on arrival and offered a drink. One person told us, "Visitors can come without restrictions."

Records we looked at contained evidence people had agreed to appropriate sharing of their information to, for example, other healthcare services. We saw records were stored securely and those who lived at the home confirmed this was always the case. Information was made available to people about advocacy services if they required support to have an independent voice.

Good

Is the service responsive?

Our findings

Following our last inspection on 13 December 2016, we recommended the provider sought guidance from a reputable source about staff end of life training. This was because it had not been provided and care plans did not evidence people's preferences about their end of life support.

The manager and staff showed a good understanding of people's end of life care requirements, which included clear documentation of their preferences. They were tactful and respected where individuals did not wish to discuss such sensitive issues. When we discussed end of life care with staff we found they had a good understanding of related principles. The manager strengthened this with relevant training.

People and relatives said the home had a sociable atmosphere and they had good opportunities to keep occupied. One person told us, "The social side is good." Another person stated, "I play dominoes and bingo. I like reading and watching TV. We've had trips to Blackpool and Fleetwood."

Care plans we looked at included in-depth information about people's preferences and support requirements in relation to activities. This also covered support from staff in relation to developing their social skills. One lounge at Marsh House was designated as the 'activities room' and we saw cards, games and jigsaws were made available for people to keep occupied. A staff member said, "I sit down and play dominoes and chat with the residents. [The manager's] always saying to us, 'What about so and so over there? See if they want to do an activity.'"

Additionally, the premises contained a hair salon, which was in use on the day of our inspection visit. We saw this was promoted as a fun, sociable occasion. Well-maintained, extensive gardens were accessible to those who lived at the home to have a peaceful space and enjoy the surrounding countryside. Relatives and friends were encouraged to join people on trips out, which helped to nurture family relationships in a social setting. The provider had acquired their own minibus, which meant more activities could be provided outside of the home. One person who lived at Marsh House told us, "We go on trips. We went to the botanical gardens in Southport."

We found care records also included an assessment of each person's needs before their admission to reduce the risk of an inappropriate placement. The manager developed care plans from this information with those who lived at Marsh House. This ensured a personalised approach to meet each individual's different requirements. The manager regularly reviewed all records we looked at to guide staff to maintain each person's continuity of care.

The manager and staff worked hard to understand people's backgrounds, preferences to care and how they liked to be supported. Care records we reviewed included their life histories to help employees gain a better awareness of each person. For example, the manager checked and documented people's food likes/dislikes, drink preferences, term of address, sleep preferences and activities. The purpose of this information was to guide staff to provide a more person-centred approach to the individual's care.

Information was available to people in the foyer about how to complain about their experience of living at the home. Contact details of CQC and the local authority were provided should they wish to raise issues with those organisations. People told us they were confident any issues would be addressed. One person said, "Yes, I would feel comfortable about raising a complaint."

Good

Is the service well-led?

Our findings

People we spoke with told us the new manager was caring and led the home well. One person said, "She's very approachable." Another individual commented, "She's very dedicated."

We found Marsh House had a welcoming atmosphere and people approached staff and the manager in a relaxed manner. One person told us, "It's a lovely feeling here, like home from home. I like the atmosphere." People and staff said they felt the management team was visible about the home and the new manager was experienced and had good leadership skills.

We found people were supported to provide feedback through annual satisfaction surveys about the quality of service delivered. The provider further sent out questionnaires specific to gaining people's views about meal provision at Marsh House. One person commented, "Enjoy all meals and the dining room is lovely." However, not all responses from across the surveys were positive. Consequently, the management team told us they had established an action plan and were setting up 'resident-led' forums. The purpose of this centred upon giving people a voice and to look at how the home could improve.

Staff commented they felt the manager and provider were supportive to them in their work. One staff member said, "[The manager] is the best manager I've worked for. I feel really well supported here." We found the manager held meetings with both day and night staff. This provided opportunities for all employees to raise any issues or comment about the home's development. We reviewed minutes from the last meeting and noted areas discussed included medication, communication, staff attitude and team work. Furthermore, employees were encouraged to provide feedback and improvement ideas via a staff survey and suggestion box held in the staff room. The management team assured us if any concerns were fed back, they would act on them to improve the quality of the service.

We found the manager had an extensive system to assess the quality of the service provided. Audits covered, for example, care records, staff training and recruitment, medication, infection control, health and safety, catheter care, falls and pressure ulcers. We saw assessments were measured against a success rate to review how effective they were. For example, dignity and respect, catheter care and training had met 100% of the provider's standards. A member of the management team told us where issues were identified the system prompted the manager to set up an action plan. The intention of this was to address concerns quickly and efficiently. We saw one instance where the action plan showed a high number of falls and interventions were implemented, such as increased staffing levels. This resulted in a reduction of related incidents.

We saw a further example where staffing levels were measured against the complex needs of each person who lived at the home. The model utilised was developed in partnership with a number of organisations, including the Scottish Government and the Care Commission. A member of the management said, "The tool can track how individual resident characteristics change, as well as the trends for the home. This information is intended to help the service manager and staff to deliver good quality care…and to support decisions on the overall staffing of the home."

This demonstrated the provider worked closely with other organisations to drive up standards. The manager further engaged with other agencies to improve and develop the service. This included the local authority, advocacy, Independent Mental Capacity Assessors, healthcare professionals and community services.

The service had on display in the reception area of the home their last CQC rating, where people who visited the home could see it. This is a legal requirement from 01 April 2015.