Marley Court Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection took place on the 12 May 2015 and was unannounced. We last inspected Marley Court on 3 November 2014 to follow up issues found during a scheduled inspection on 18 June 2014. During the follow up inspection we found the home had made improvements to how they kept people's personal records accurate, safe and confidential. We also saw that some improvements had been made to how medicines were managed. We did however find that this area still needed some improvements and the home was non-compliant with regards to medicines management. We judged this to have a minor impact on people living at the home. We also found the home to be non-compliant with regards to supporting workers and judged this to have a moderate impact on people living at the home.

Summary of findings

We issued enforcement action via a written warning notice to the home. During this inspection we reviewed actions taken by the provider to gain compliance. We found that the necessary improvements had been made.

Marley Court is a purpose built home, which is registered to provide personal and nursing care for up to 49 older people. Accommodation is offered in single and double rooms on two floors. There are two lounge/dining rooms, one on each floor. There is a patio area at the front, and gardens at the side of the home which are accessible to people using the service. Marley Court is situated on the main A6 road from Chorley to Adlington and has large car parking facilities. There were 40 people staying at Marely Court on the day of our inspection, with four more people in hospital awaiting a return to the home.

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

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people who used the service were protected from potential harm or abuse.

Medication was administered by nurses and by senior carers. All staff who administered medicines told us they had received updated training and that their competency had been checked every six months by the deputy manager. This included agency staff who administered medication. We saw that an up to date record of the names, signatures and initials of staff competent to administer medicines had been maintained.

Our observations of medication administration showed that this was done safely. We saw nurses asked people if they needed 'as required' (PRN) medication such as pain relief before preparing and administering it. Nurses stayed with people and supported them to swallow their medicines before signing the medicine administration record (MAR).

We saw there were detailed policies and procedures in place in relation to the MCA, which provided staff with clear, up to date guidance about current legislation and good practice guidelines. We spoke with staff to check their understanding of MCA. The majority of the staff we spoke with were able to demonstrate a good awareness of the code of practice and confirmed they had received training in these areas.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff and it was evident that members of staff knew the people they were caring for well.

Care plans outlined the importance of promoting people's privacy and dignity and promoting their independence. During the inspection we observed staff interact with people living in the home in a caring manner.

We saw that people's care plans were written in a clear, concise way and were person centred. People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. We saw that timely referrals had been made to other professionals as appropriate such as GP's, dieticians and district nurses.

Advice given from other professionals was not always recorded effectively which meant that people may not be receiving the most appropriate care. We have made a recommendation about this.

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, care plan audits and infection control.

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?

Good

The service was safe.

People were protected from abuse and avoidable harm.

Our observations of medication administration showed that this was done safely.

All staff who administered medicines told us they had received updated training and that their competency had been checked every six months by the deputy manager. This included agency staff who administered medication. We saw that an up to date record of the names, signatures and initials of staff competent to administer medicines had been maintained.

Is the service effective?

Good

The service was effective.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We spoke with staff to check their understanding of MCA and DoLS. Staff we spoke to were able to demonstrate a good awareness of the code of practice and confirmed they had received training in these areas.

We observed throughout the day that people's consent was sought by staff at all times, either before entering people's rooms, when assisting people to mobilise or when assisting people with their medication. We discussed dignity, privacy and consent with staff who were all knowledgeable in these areas. Staff were able to give us practical examples of how issues such as consent were dealt with on a day to day basis.

Is the service caring?

Good

The service was caring.

People were treated in a respectful way. Staff were seen to be kind and caring. People were supported to remain as independent as possible.

We saw that advocacy services were available for people to access if they did not have relatives or friends to act as a voice for them. Details of local advocacy services were available within the 'Service User Handbook' which was available in the reception area and given to all new people entering the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People we spoke with and their relatives told us they knew how to raise issues or make complaints. We saw that the home had a complaints procedure and that it was made available to people, this was confirmed when speaking with people and their relatives.

We saw that people's care plans were written in a clear, concise way and were person centred. People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. We saw that timely referrals had been made to other professionals as appropriate such as GP's, dieticians and district nurses.

Advice given from other professionals was not always recorded effectively which meant that people may not be receiving the most appropriate care.

Is the service well-led?

Good

The service was well-led.

There was a registered manager at the service at the time of our inspection who had worked at the service for approximately eighteen months. There was also a deputy manager employed at the home who gave the registered manager support and ran the home in the manager's absence.

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, care plan audits and infection control.

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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 the 12 May 2015 and was unannounced.

The inspection was carried out by two adult social care inspector's, including the lead inspector for the service, 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.

Before the inspection visit we reviewed the information we held about the service, such as notifications informing us about significant events and safeguarding concerns.

We spoke with a range of people about the service; this included seven people who used the service, four relatives of people using the service, ten members of staff, including the registered manager, deputy manager, cook, nurses and care staff. The expert by experience spent time talking to people living at the home, relatives and observing how staff interacted with people living at the home.

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 spent time looking at records, which included nine people's care records, four staff files, training records and records relating to the management of the home which included audits for the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who supported them. One person told us, "I feel safe in here, the staff look after me really well". Another person told us, "I feel safe here, at night you just need to press the buzzer and they come and see to you, they are always checking you are alright."

In general, people we spoke with considered there were enough staff to look after the needs of people living at Marley Court but some thought the staff were busy and did not always have time to spend with them. One person told us, "Sometimes they are short of staff so they can't have things going on all the time. Twelve hours is a long time to keep going in this job and they never seem to stop". Another person said, "They help me with dressing and getting a shower and they always seem busy, sometimes when I press the buzzer to get help they take a long while to come but they always do get here." We observed staffing levels to be sufficient during our inspection to deliver the necessary care to people.

A 'Safeguarding Information board' was on display in the reception area which contained details of the homes Safeguarding and Mental Capacity Act policies. There was also a simple flow chart in place showing people, staff, and visitors to the home the process for reporting safeguarding issues. Staff we spoke with understood how to recognise abuse and report possible abuse through the homes safeguarding procedures and externally if required.

During this inspection we looked in detail at the medicine administration records and medicine supplies for six people. We spoke with two people about their medicines and observed two nurses as they administered medicines to people in the morning and at lunchtime. We also looked at medicine administration records and medicines related care plans.

Medicines had been ordered promptly because a system was in place to ensure this was done each month. Most medicines were supplied by the pharmacy packed in blister packs containing single medicines for each person. Medicines were stored securely in locked trolleys and cupboards in a locked medicine room. Daily temperature checks in the room and in the medicines fridge showed that medicines were stored safely within the recommended temperature range.

One person had recently come to live at the home and their tablets were supplied in original packaging. A repeat prescription had been requested from the person's GP but had not yet been dispensed. During our visit senior staff followed this up to ensure that the person's medication would be available for the following day.

Medication was administered by nurses and by senior carers. All staff who administered medicines told us they had received updated training and that their competency had been checked every six months by the deputy manager. This included agency staff who administered medication. We saw that an up to date record of the names, signatures and initials of staff competent to administer medicines had been maintained.

Our observations of medication administration showed that this was done safely. We saw nurses asked people if they needed 'as required' (PRN) medication such as pain relief before preparing and administering it. Nurses stayed with people and supported them to swallow their medicines before signing the medicine administration record (MAR).

Medicines not supplied in blister packs were checked and counted each time they were administered. Medicines controlled by the Dangerous Drugs Act were checked and counted each day. We observed a transdermal patch being checked by a nurse and a senior carer, administered safely to the person and then recorded by the staff both on the MAR and in an appropriate book.

Documentation for recording patch application included a body map which had been marked each time a patch was applied. This allowed staff to rotate the site a patch was applied to which optimised uptake of the medicine for the person.

We took the opportunity to check the count for several medicines at random, including some controlled medicines and the actual count matched the expected count in all cases. We checked the MAR for all 25 of the people living upstairs at the home. Photographic identification was available for all of them and allergies were recorded. Some records had handwritten notes on, for example when a medicine had been discontinued. These were not signed. Best practise is for the person writing on the MAR to date and sign any note so that any queries can be referred to them.

Good

Is the service safe?

Some medicines were prescribed to be given 'when required'. We saw that for each such medicine, there was information in the MAR showing what the medicine was for and particular, person centred information. This meant care workers and nurses had enough information to administer these medicines in a safe, consistent and appropriate way.

Some medicines which were applied topically such as creams and lotions were safely stored in people's individual bedrooms and administered by care workers. Documentation for each cream or lotion was available and we saw that administration records were up to date. Where medicines were administered via a peri-gastric (PEG) tube, we saw that a detailed care plan was in place to ensure that these medicines were administered safely.

Staff administering medicines had access to the medicines policy of the home, NICE guidelines, patient information leaflets and a copy of the British National Formulary (BNF). This helped staff to keep up to date about diverse medications and be able to respond to questions from people living in the home.

Medicines no longer required were stored and recorded safely and disposed of appropriately. Staff told us that weekly and monthly checks of medicines were carried out and action plans created and implemented if there were any shortfalls in the expected standard of medicines management.

We found the home to be clean and tidy and infection control procedures were in place and followed by staff. The home was clean and generally odour free. Bathrooms and toilets were clean and hand-wash soap and paper towels were available in every one. Lidded bins were available in each toilet. This helps staff to maintain good infection prevention and control.

Staff told us they all felt comfortable reporting any concerns, if they had any, to senior staff and understood the principles of whistleblowing.

During our inspection we looked at the personnel records of four members of staff. We found that recruitment practices were satisfactory. Prospective employees had completed application forms, including health questionnaires and had produced acceptable identification documents, with a photograph. The disclosure and barring service (DBS) had been consulted before people were employed. The DBS checks criminal conviction records, so the provider can make an informed choice about employment in accordance with risk. Staff talked us through their recruitment and told us this was thorough.

Good

Is the service effective?

Our findings

People we spoke with reported that the food in the home was good and there was always plenty to eat. We were told by one person, "There's always plenty of food, we are not short of it and I'll leave it at that". Another person told us, "They tell me what's on the menu and I pick what I want. They give you plenty of choice, I'm one for sandwiches and you can decide what you want on them. The food is very good, if you don't like what's on offer they give you a choice of something else, like soup. I have no complaints about the food, I have a good appetite and there's lots of food." Another person told us, "The cook here is very good, but I think the food here could be a bit more varied".

We observed lunch being served on both the ground and first floor dining areas. We saw that some people chose to eat their meals at dining tables and some chose to eat in easy chairs with small tables in front of them. We saw one person was served their meal and helped to eat with a spoon by one member of staff. The person needed encouragement and reassurance to eat each spoonful and this was provided by the staff in a quiet and calm manner throughout the meal. The person was frequently offered a hot drink of tea and with sensitive encouragement was helped to eat the majority of their meal.

Some people needed their food cut up for them so they could eat it, others could manage to eat, if slowly, unaided. Five people were provided with bibs to protect their clothing from spillage, but everyone used standard cutlery and crockery, although given some evident difficulties in manual dexterity and co-ordination some may have benefited from the use of special utensils and avoided their use of fingers. Those people who needed encouragement to eat and drink were given constant prompts and reminders in a calm and polite manner by the staff supervising mealtimes. People were offered choice of hot or cold drink and this was provided in appropriate containers for those who needed spouts on cups or beakers. People who requested additional portions of food or drinks were given them. People who did not want the meal or desert on offer were offered ice cream or yoghurt as an alternative. People who had needed encouragement to eat and had done so were praised by staff. We observed that food was enjoyed by all and that meals were conducted in a calm and relaxed atmosphere.

We spoke with the cook who told us that the home catered for any specialist diets, whether that be for health or religious needs. They were knowledgeable about the people in the home and knew which people's diets were monitored, for example which people needed their food to be fortified to assist them to gain weight. Nursing and care staff were also aware of which people needed assistance to eat and who had specialist needs. One carer we spoke with told us, "We go round and ask people their preferences. We have a sheet that indicates who is on a pureed diet, who is vegetarian, who needs assistance to eat etc."

The Care Quality Commission is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the MCA and the associated DoLS, with the registered manager. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw there were detailed policies and procedures in place in relation to the MCA, which provided staff with clear, up to date guidance about current legislation and good practice guidelines. We spoke with staff to check their understanding of MCA. The majority of the staff we spoke with were able to demonstrate a good awareness of the code of practice and confirmed they had received training in these areas.

We observed throughout the day that people's consent was sought by staff at all times, either before entering people's rooms, when assisting people to mobilise or when assisting people with their medication. We discussed dignity, privacy and consent with staff who were all knowledgeable in these areas. Staff were able to give us practical examples of how issues such as consent were dealt with on a day to day basis, one member of staff told us, "We all respect people's need for privacy when assisting to care needs. I don't think this has been an issue here and it isn't something I have ever seen as a problem."

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff and it was evident that members of staff knew the people they were caring for well.

Good

Is the service effective?

Staff all told us they had received regular supervision meetings with their line manager. A newer member of staff said they met their manager about every six weeks. They said their induction training had covered an introduction to safeguarding people from abuse and they had later had more in depth training about it and other topics.

Staff confirmed they had access to a structured training and development programme. This ensured people in their care were supported by a skilled and competent staff team. One member of staff told us that they sometimes could do with more notice of training events but this was an isolated comment. We saw from staff records and the homes training matrix that a lot of work had gone into staff training since the previous inspection.

Staff said they received a handover at the start of each shift. We saw that information was recorded in a daily handover sheet included the names of all the people living on each floor with brief details of concerns, mobility, mood. It also showed any GP or health professional visits that day. Staff on each floor also maintained a daily diary which included any issues or concerns as well as appointments or visits.

People reported that they had access to medical and health support from a variety of professionals as they needed it. One relative told us, “The optician comes round and does eye tests, my wife is waiting for an appointment with a specialist about her (condition)”. One person said, “I can see the doctor if I want to, I just tell a member of staff and they arrange it for me. I have my eyes tested every year and the chiropodist visits, but you pay extra for that”. Another person told us, “I’ve seen the doctor whilst I’ve been in her, arranged by the staff, I have my eyes tested and they do a regular screening test for my diabetes, they test my blood-sugar levels and they monitor what I eat”. One person who was receiving specialist care for their condition told us about how they were assisted to see specialist professionals to get help for their pain management.

Good

Is the service caring?

Our findings

During this inspection we observed good interaction between the care staff and people who lived at the home. People spoke well of the staff and considered they treated them with dignity and respect. One person said, "I'm well looked after here, they do everything for me, and whatever I ask for they will do their best to get it for me". They are great, the staff, when they are not busy they will come in and ask me how I am doing. They always speak respectfully to me and tell me what they are doing; they explain things when they come to help you". Another person told us, "They could not have done any better for me; they treat me well they really do. They explain what's happening and what they are going to do for me when they come to help me". Other comments made included; "They are pretty good here; there is not much you can fault. They try to manage as well as they can but they work hard". "They are good workers here, they do the best they can for you. The staff are very good to me, very good indeed, there are lots of poorly people in here and they have a lot to put up with, but they are always polite and respectful, everyone does their best."

People said their relatives could visit without restriction, but were advised to avoid visiting the home during mealtimes. One person told us, "There are no restrictions on visits, whatever the time of day". Another person said, "Visitors can come whenever they like".

Care plans outlined the importance of promoting people's privacy and dignity and promoting their independence.

During the inspection we observed staff interact with people living in the home in a caring manner. For example, during the medicine round a nurse took the time to enquire if the person had slept well and ask about their comfort. Staff were very knowledgeable when speaking about the individuals they cared for and it was evident during our observations that people knew the staff caring for them well.

Information was made available to staff which included areas such as dignity and respect, confidentiality and equality and diversity. Policies were in place to support all of these areas. We spoke with staff and asked them how they ensured that people's dignity and respect were maintained at all times. Staff were knowledgeable in this area and talked us through day to day issues such as assisting people with personal care, bathing and eating.

We saw that advocacy services were available for people to access if they did not have relatives or friends to act as a voice for them. Details of local advocacy services were available within the 'Service User Handbook' which was available in the reception area and given to all new people entering the home. This book had been updated in March 2015 therefore contained relevant, up to date information.

People were enabled to make end of life plans to ensure that care and support was provided in a person centred way and in line with their wishes. The home liaised closely with local palliative care and district nursing teams as well as local hospices when appropriate.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with and their relatives told us they knew how to raise issues or make complaints. We saw that the home had a complaints procedure and that it was made available to people, this was confirmed when speaking with people and their relatives. It was also on display within the home. The majority of people spoken with told us they felt confident that any issues raised would be listened to and dealt with appropriately. One person told us, "I have no complaints, but if I did I would go to the office and talk to them about it". Another person said, "If I was worried I would ask for the nurse and talk to her about it, I'd also tell my son as he deals with things for me."

We looked in detail at nine people's care plans and other associated documentation via the homes electronic care planning system and also some manual records such as turning charts and food and fluid monitoring records. We saw that people's care plans were written in a clear, concise way and were person centred. People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. We saw that timely referrals had been made to other professionals as appropriate such as GP's, dieticians and district nurses.

We looked in detail at wound care and pressure ulcer risk assessments for five people as this had been raised as an area of concern prior to the inspection by other visiting professionals. We also reviewed records of assessments and reviews made by an NHS tissue viability specialist nurse (TVN). Pressure ulcer risks had been consistently assessed every month using an electronic system however the risk was not referred to in the wound care records. All of the wound care plans we saw had last been updated in October 2014. They were comprehensive and included risk, aim and plan of care including the dressings to be used and the frequency of redressing required. Whenever a nurse had replaced a dressing, this had been recorded. The dressings used had changed over time, sometimes on advice of the TVN but this was not always updated in care plans. Occasionally nurses had recorded about the improvement or deterioration of a wound, for example, "seems to be improving." However this was not consistently or regularly done. Wounds measured at the start of treatment had not been re-measured, apart from by a TVN.

Advice given by the TVN was not always included in care plans. For example when a person with a pressure ulcer had developed new ulcers, the TVN had recommended '30% tilt' position changes. This had not resulted in a new care plan that included this advice. It was sometimes unclear why a different dressing had been used. Information recorded in the comments such as a change of dressing or frequency had not always been acted on afterwards and changes did not lead to changes in the care plans.

The home was awaiting the recruitment of an activities co-ordinator and some people commented that they would like there to be more going on in the home to occupy and stimulate them. One person told us, "We do have activities and entertainment, but not every day, and if they are short staffed it seems to get dropped". Another person said, "We had bingo, scrabble and dominoes, but we are waiting for a new lady to be appointed and we may get different things to do". Another person who had not been at the home long told us, "I've not been here long and I'm not mobile so I can't wander round and find out what's going on, there might be a notice board or something with information about what's going on. I think we could do with some art therapy and maybe the new co-ordinator can set something up." We discussed activities with the registered manager who did confirm that a new activities coordinator was being sought. We did see some evidence of activities taking place via notice boards and from speaking to people and staff but it was ad hoc.

We saw some good examples of people accessing the community. One person was able to attend the local church and take part in the social activities at the church centre at weekends and during the week. They told us, "I go to church on Sundays and to rosary and benediction on Thursdays. They order me a special taxi to get me there and back again." Some people also told us they were taken outside when the weather was suitable.

The home had a key-worker system in place which meant that each person had a named nurse and care-worker. When speaking with staff they were aware of who they were a keyworker for and were knowledgeable about the needs of those people.

We recommend that care plans and associated risk assessments are updated to reflect the latest advice from visiting professionals and to introduce a system to make all nursing and care staff aware of this advice.

Good

Is the service well-led?

Our findings

There was a registered manager at the service at the time of our inspection who had worked at the service for approximately eighteen months. There was also a deputy manager employed at the home who gave the registered manager support and ran the home in the manager's absence. People we spoke with told us they found the management and staff at the home to be approachable and helpful**.** One person told us, "Bev (Registered Manager) is a very good listener, she runs the home well."

All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We found the service had clear lines of responsibility and accountability. Most of the staff members confirmed they were supported by their manager and their colleagues. One staff member we spoke with told us, "I like working here because the staff are supportive and managers are also helpful." Another member of staff said, "People are definitely getting on better, morale is on the up" and another told us, "WE get the relevant support and training is getting better."

There were a number of systems in place to enable the provider and registered manager to monitor quality and safety across the service. These included regular audits and quality checks in all aspects of the service. This included medication audits, care plan audits and infection control.

Service contracts were in place, which meant the building and equipment was maintained and a safe place for people living at the home, staff and visitors. We saw service files in place to evidence this, which were well organised and up-to-date.

A suggestions and comments box was available in the reception area at the home so people could comment, anonymously if they wished, about the home at any time they wished. We saw that a 'Resident satisfaction survey' had taken place in March 2015. 23 responses had been returned which represented approximately 50% of the people living in the home. Responses were mainly positive, for example when people were asked if they felt safe and secure at Marley Court all the responses were good or excellent from the four possible options of poor, satisfactory, good and excellent. When asked if staff were friendly and helpful all except two people answered good or excellent. The two other people had answered satisfactory. Only three people had rated any part of the service as poor and this was mainly in relation to activities and food. Where people had given their name and given a negative response we saw that the manager's at the home had discussed the issue with the person.

An employee satisfaction survey had also been undertaken by the home and had gained 16 responses. Again the majority of comments were very positive. The family satisfaction survey had also been responded to well with ten responses. The only negative comments were regarding the lack of activities, food and décor. Two people had also cited poor communication as an issue. Again we could see that the home had contacted those people who had commented negatively. The registered manager also told us that all surveys would be collated and discussed at the next residents and family meeting.

We saw that team meetings were being held and saw evidence of this via meeting minutes. Staff we spoke with also confirmed that they attended staff meetings. We saw that the latest round of staff meetings had taken place a week prior to our visit but the notes had not yet been written up.