Elizabeth House (Oldham) Limited

Marland Court

Inspection report

Marland Old Road
Rochdale
OL11 4QY
Tel: 01706 638449

Date of inspection visit: 13th January 2015
Date of publication: 27/05/2015

Ratings

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

Overall summary

This was an unannounced inspection which took place on 13 January 2015.

We previously inspected this service on 4 June 2014 and found that the service had breached one of the five regulations assessed. We issued a compliance action that required the provider to make the necessary improvements in relation to the management of medicines.

We inspected this service again on 22 August 2014 to check whether the required improvements had been made and in response to information of concern we had received about staffing levels and moving and handling procedures. During this inspection we found that the service had breached two of the three regulations assessed. We issued compliance actions that required the provider to make the necessary improvements in relation to the management of medicines and records.

Marland Court is situated in Rochdale and provides accommodation and personal care to people over the age of 65. There are 24 bedrooms in total of which three are double rooms. There were 17 people living in the home at the time of our inspection.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People who used the service and the visitors we asked told us that Marland Court was a safe place to live.

Safeguarding procedures were robust and members of staff understood their role in safeguarding vulnerable people from harm.

We observed unsafe practice when two care workers transferred one person from a wheelchair to an armchair in the lounge. One of the care workers involved told us she had not received training in moving and handling procedures.

We saw that care plans lacked guidance for staff to follow about when people should be given medicines prescribed to be taken 'when required.'

Although the home was generally clean we saw that three toilets remained soiled until mid-afternoon.

We found that recruitment procedures were thorough so that people were protected from the employment of unsuitable staff.

The system in place for staff supervision and appraisal did not adequately support staff to work safely and continue their training and development.

There was no evidence to demonstrate that any of the staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who are unable to make decisions about their own care and treatment.

All the people we asked told us the meals were good. Snacks and drinks were readily available throughout the day. We found that people's weight and nutrition was monitored so that prompt action could be taken if any problems were identified.

People were registered with a GP and had access to a full range of other health and social care professionals.

People who used the service told us they received the care and support they needed. Throughout the inspection we saw that members of staff were respectful and spoke to people who used the service in a courteous and friendly manner.

We found that's people's preferences were not always considered in the daily routine. There was an expectation that most people would be up and ready for breakfast by 8am. This meant that care workers started getting people up at 5am irrespective of their wishes.

Information about people's interests and hobbies was not recorded in people's care plans. This made it difficult to engage people with a dementia in meaningful activities.

A copy of the complaint's procedure was displayed in the home. A record of complaints, any investigation and the action taken to resolve the problem was available.

The registered manager needed to be more proactive in obtaining the views of people who used the service and their representatives in order to identify areas for improvement.

The system in place for monitoring the quality of the service provided required further development. The registered manager had not identified and addressed the shortfalls we found during this inspection.

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?
The service was not always safe.

Members of staff knew the action they must take if they witnessed or suspected any abuse. However, safeguarding was not included in the induction programme for newly appointed members of staff.

Recruitment procedures were thorough and protected people from the employment of unsuitable staff.

Requires Improvement

Is the service effective?
The service was not always effective.

This was because improvements were required to ensure that staff received the training and support they needed in order to provide effective care.

Members of staff did not understand the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People who used the service told us the meals were good. At meal times members of staff chatted to people and offered appropriate help and encouragement.

Requires Improvement

Is the service caring?
The service was caring.

We saw that members of staff treated people with dignity and respect.

People who used the service told us they received all the care and support they needed.

Good

Is the service responsive?
The service was not always responsive.

This was because staff were getting people up as early as 5am and not acting in accordance with people's wishes.

The complaint's procedure was displayed in the home. A record was kept of all complaints and the action taken to resolve the issues raised.

People who used the service and their representatives had little opportunity to formally express their views about the care and facilities provided at the home.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

The system in place to monitor the quality of the service provided had failed to identify areas of the service that required improvement. Action we had asked the provider and registered manager to take at the last two inspections remained outstanding.

Although staff meetings were held infrequently members of staff told us the manager was approachable.

People who used the service told us they got on well with the registered manager.

Marland Court

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 13 January 2015 and was unannounced. During the inspection we spoke with a visiting healthcare professional, three people who used the service, two visitors, four care workers, the cook, the deputy manager and the registered manager.

The inspection team consisted of two inspectors.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made. We did not request any further information from the provider prior to this inspection. We contacted the local authority safeguarding team and the commissioners of the service to obtain their views about the service. We had also received information from an anonymous source expressing concerns that people who used the service were being assisted to get up in the morning as early as 5am. For this reason we commenced our inspection at 7.00am

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for nine people who used the service and medication administration records for 6 people. We also looked at the training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt Marland Court was a safe place to live. One person said, "I lock my door at night. I feel very safe" Another person said, "This is a nice place." The relative of one person said, "I have no concerns about this place."

We discussed safeguarding procedures with two members of staff. Both staff members had a good understanding of safeguarding procedures and were clear about the action they must take if abuse was suspected or witnessed. However, one of these staff members told us that safeguarding had not been included in the induction training she had received when she started working at the home. This information was confirmed from the training records we looked at and during discussion with the registered manager.

We looked at records of financial transactions involving people's money. The records we saw confirmed that procedures were robust and should help to protect people from financial abuse.

We looked at the care plans of nine people who used the service. These plans identified the risks to people's health and wellbeing such as falling and the formation of pressure sores. Guidance for staff to follow about how to manage identified risks in order to promote people's safety and independence were also included in the care plans.

However, soon after our arrival at the home we observed poor practice when two care workers transferred one person from a wheelchair to an armchair in the lounge. Although a moving and handling belt was used we saw that the person had difficulty weight bearing and was dragged which increased the risk of injury to both the person who used the service and members of staff. Discussion with one of the care workers confirmed that she had not received training in moving and handling procedures during induction training or at any time after her employment at the home.

At the last inspection of August 2014 we found we found a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because medicines were not always managed safely.

At this inspection we saw that medicines were stored securely which reduced the risk of mishandling. We looked at the medication administration records of 6 people who used the service and found these had been completed correctly. These records included details of the receipt and administration of medicines. A record of unwanted medication returned to the pharmacy was also available.

One person said, "They give me my medicine, always at the right time."

Some people were prescribed medicines to be taken when required for example pain killers. However, a care plan explaining whether a person was able to tell staff when they needed this medicine or the signs and symptoms they displayed if they could not was not in place. Clear directions for members of staff to follow should ensure that people received their medicine when they needed it.

We looked at the file of a member of staff appointed within the last 6 months. This file included an application form with details of previous employment and training, an interview record, two written references and evidence that a criminal records check had been obtained from the Disclosure and Barring Service. These checks helped to ensure that people who used the service were protected from the employment of unsuitable staff.

During the inspection we saw that members of staff were attentive to people's needs. One person said, "There is no messing about if I call for them. If they are busy they come and tell me they are busy with someone else and will come soon." The relative of one person said, "There's plenty of staff." Members of staff told us they were happy with the staffing levels during the day. However, the night staff said they felt under pressure to get people up and ready for breakfast at 8am.

We looked round the premises and saw that the home was generally clean with the exception of the bathrooms where three toilets were soiled and remained so until mid-afternoon. We also saw that a wheelchair used by a person who lived at the home was very dirty. There was a schedule of cleaning tasks to be undertaken daily and weekly. However, a record of when these tasks had been completed was not available. The cook kept a separate cleaning record which she signed and dated for the tasks she had completed. Areas of the home that were dirty increased the risk of infection to people who used the

Requires Improvement

Is the service safe?

service. The registered manager told us there was a vacancy for a cleaner which was currently being advertised. This meant that a cleaner was not on duty on the day of this inspection.

We saw records to demonstrate that equipment used at the home was serviced regularly. This included fire safety equipment. However, a personal evacuation plan (PEEP) had not been completed for any of the people who used the service. This meant that members of staff did not have written directions to follow about the support each person required in the event of an emergency which could put the safety of people who used the service at risk.

A business continuity plan which provided information for staff about the action they should take in the event of an emergency was in place.

Requires Improvement

Is the service effective?

Our findings

Discussion with people who used the service and their visitors confirmed that the care provided was effective. One person said, "The staff are lovely." Another person said, "They (Staff) pop in regularly to check I'm ok." Discussion with members of staff on duty confirmed that they had a good understanding of people's individual care needs. The relatives of one person told us that staff spent time with people new to the home discussing their needs and explaining the routine.

Members of Staff were observed seeking consent before supporting people with their needs. Although we saw that most people were unable to consent verbally, non- verbal signals were being interpreted appropriately. One care worker told us that she always spoke gently and clearly to people with a dementia in order to gain their consent and cooperation when assisting with personal care.

Although care plans we saw were reviewed monthly they were not always updated when the needs of the person changed. One care plan stated that the person should be given food supplements but a care worker told us these were no longer prescribed. Two care plans stated that barrier cream should be used if prescribed. There was no information about which cream this was or whether it had in fact been prescribed. Where possible people who used the service or their representative had signed their care plan to indicate their agreement with the care provided at the home. However, none of the people we asked had seen their care plan.

Lack of up to date records was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Seven of the care plans we saw included a statement about the person's mental capacity to make decisions about their own care and treatment. It was also stated that all decisions regarding daily living needs, care and treatment should be made on the person's behalf in their best interest and be least restrictive. We were not shown any records to demonstrate that any authorisations under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had been made which would legally allow staff to make such decisions for people who used the service.

Members of staff told us they had not received any training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Although the registered manager and the deputy manager told us they had received this training we were not shown any records to support this. This training is important and would provide members of staff with information about the procedure which must be followed if a person is unable to make decisions about their own care and treatment.

We found that all bedroom doors were usually kept locked and three members of staff on duty each had a master key. People who used the service could open their bedroom from the inside without the need to use a key. However, due to mobility problems or dementia most people would find it difficult to open their bedroom door unaided from the inside. Moreover, they had to ask a member of staff to unlock their door when they wanted to access their bedroom. There was no evidence in the care plans we looked at that people who used the service had consented to having their bedroom door locked. This meant that people's liberty could be restricted without a DoLS authorisation having been obtained. During our inspection we were aware that one person in their bedroom was having difficulty opening their bedroom door and called out, "Who locked me in." Although staff responded quickly this had caused some distress to the person who used the service.

Two members of staff on duty told us about the training they had received. This included moving and handling, infection control, fire prevention, dementia awareness, safeguarding adults, first aid, food safety, health and safety and nationally recognised vocational qualifications in health and social care. They said training was arranged annually to ensure they were kept up to date with current practice.

The registered manager showed us records which identified when members of staff had completed training and when further training was planned. We looked at the personnel files of three members of staff and found they contained records of the training they had completed. However, it was clear from these records and discussion with the registered manager that training for the staff team had not taken place since October 2013.

One care worker who had been employed at the home for 3 months told us that their induction training had consisted

Requires Improvement

Is the service effective?

of getting to know people who used the service and the daily routines. Although this care worker had been employed in care work several years ago she had not received any up to date training since working at the home.

One member of staff told us that she had a supervision meeting with the registered manager every six or twelve months and an annual appraisal. We looked at the supervision records for two members of staff. These records confirmed that at these meetings work related issues and training were discussed. Records showed that a supervision meeting for a new employee was scheduled for December. However, there was no record that this meeting had taken place or had been rearranged.

The lack of effective training, supervision and appraisal for staff was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we asked told us they liked the meals. One person said, “The meals are good. You have a few choices for lunch.” A relative of one person said, “The food is very, very good.”

We saw that the meal served at lunch time looked wholesome and appetising. People could choose whether to eat their meal in the dining room, lounge or their own bedroom. We saw that care workers were attentive to people’s needs and offered appropriate assistance and encouragement when necessary. People who used the service were asked about their choice of food and drinks and were also offered second helpings. The relative of one person said, “She began eating less. They put it on a smaller plate and it worked. She’s eating more.”

Although the menu was displayed in the dining room the cook said that alternatives to the menu were always available. The cook told us that snacks and drinks were available throughout the day. Fresh fruit was offered with the mid-afternoon drink to help ensure that people had a balanced diet. One person said, “There’s always plenty of juice, milk, tea and coffee whatever you want.”

We found that people’s care records included an assessment of people’s nutritional status so that appropriate action was taken if any problems were identified. This assessment was kept under review so that any changes in a person's condition could be treated promptly. People’s weight was checked and recorded monthly or more frequently if weight loss or gain needed to be monitored. When necessary advice was sought from the doctor and dietician and records of food and fluid intake were kept.

Each person was registered with a GP who they saw when needed. One person said, “They would soon have the doctor here if I needed him.” The care plans we saw demonstrated that people had access to specialists and other healthcare professionals such as dieticians, speech therapists, district nurses, podiatrists and opticians. Records were kept of all appointments and any visits from health care professionals so that members of staff were aware of people’s changing needs and any recurring problems.

Good

Is the service caring?

Our findings

People who used the service told us they liked living at the home and received the care and support they needed. One person said, “They go out of their way to help.” Another person said, “They are all very patient with us.”

We saw that members of staff spoke to people in a polite and friendly manner and addressed people by their preferred name. One person said, “You can talk to them all.” We observed care workers assisting people in a patient unhurried manner. One person said, “They are all so nice to everybody.” The relative of one person said, “The staff seem courteous and treat people with the respect they deserve.”

The care workers we spoke with understood the importance of promoting people’s privacy and dignity. We saw that people had their own bedrooms which meant they had the privacy they needed. One person said, “They (staff) always knock on the door.” However, we observed that one member of staff did not always knock on the door before entering people’s rooms.

People could choose whether to spend time in their own room or communal areas of the home. Communal rooms were spacious and suitable for a variety of leisure and cultural activities.

Where possible information about each person’s wishes regarding end of life care and resuscitation had been discussed and documented in their individual care plan. This informed staff what people wanted to happen at the end of their life.

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home.

The person and their representatives were involved in the pre-admission assessment and provided information about the person’s abilities and preferences. Information was also obtained from other health and social care professionals such as the person’s social worker. This process helped to ensure that people’s individual needs could be met at the home.

We noted that visitors were welcomed into the home and offered refreshments. People who used the service could receive their visitors in communal areas or their own room.

Inadequate

Is the service responsive?

Our findings

People who used the service told us they were given choices about care they received such as whether to have a bath or a shower. One person said she preferred to stay in her room for most of the time but staff supported her to go downstairs if she requested it.

On arrival at the home at 7am we found that 8 people were sitting in the lounge. Two of these people told us they liked to get up early and were pleased with the support they had received from staff. However, the care plan for one person who the night staff said had been up since 5am clearly stated that they liked to lie in bed until 9am. The care plan for another person indicated that they liked to get up at about 8am. This meant that the wishes of people who used the service in relation to their care and support were being ignored and the daily routine in place was institutional.

Discussion with the night staff confirmed that there was an expectation that most people would be up and ready for breakfast by 8am when the day staff came on duty. The night staff said they had started getting people up at 5am.

The cook told us that the number of people still in bed when she came on duty at 8am varied. She said that sometimes there were 2 or 3 people in bed and at other times 5 or 6. She also explained that it depended upon which care workers were on duty whether people were offered a hot drink. On the day or our inspection none of the people who were sitting in the lounge before 8am had been offered a drink.

People who used the service were not given the opportunity to make decisions about some aspects of their care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people who used the service what they did all day. One person said, “There isn’t a lot to do.” Another person said, “There are papers with puzzles in to keep your mind alive.” People who used the service also told us that bingo, quizzes and videos were organised by staff. We saw that a timetable of activities on the noticeboard included exercises, crafts, reminiscence, dancing and pampering sessions. However, we did not see any organised activities taking place during our inspection.

The care plans we looked at did not include any evidence to suggest that people had been asked about their interests and hobbies. This meant that staff did not have the information they needed in order to engage people especially those with a dementia in meaningful activities of their choice.

The registered manager told us that outside entertainers visited the home every month. Local clergy also visited regularly and offered Holy Communion to people who wished to practise their faith in that way.

A copy of the complaint’s procedure was displayed in the dining room and available in each bedroom. We looked at the record of complaints and found these were mostly about items of clothing that had been lost or the need for minor repairs such as to a wardrobe door. The records also demonstrated that appropriate action had been taken to resolve the complaints made.

Inadequate

Is the service well-led?

Our findings

The registered manager had been in post for two years and was supported by the provider who regularly visited the home. People who used the service told us they got on well with the registered manager. One person said, "The manager is lovely. She speaks to everybody." The relative of one person said, "The manager is nice. A very caring person."

The registered manager told us that people were encouraged to express their views about the care and facilities provided at the home at meetings held every 6 months. Minutes of the last meeting held in June 2014 indicated that menus, leisure activities and improvements to the home were discussed. One person told us that action had been taken as a result of their suggestions for improving the garden and menus.

People who used the service and their representatives had not been given the opportunity to complete a satisfaction survey since 2011. This meant that the registered manager did not have any recently written views of people who used the service and their representatives in order to help identify any areas for improvement.

The registered manager explained that she operated an 'open door' policy which provided the opportunity for people who used the service and members of staff to discuss any issues with her at any reasonable time.

The members of staff we spoke with had a good understanding of their roles and responsibilities.

One care worker told us the registered manager and the provider were both approachable and supportive. Staff were also aware of the management structure at the home and knew there was a designated senior care worker in charge of the home when the registered manager and deputy manager were off duty.

Members of staff were aware of and understood the whistleblowing procedure for reporting poor practice. They said they would not hesitate to report any concerns about the practise of their colleagues and were confident that any concerns would be acted upon immediately.

We were shown minutes of the last staff meeting which had been held 12 months ago. These minutes indicated that teamwork, completing charts and cleaning schedules had been discussed.

However, one member of staff told us that staff meetings took place infrequently and said that more were needed.

We found that the arrangements in place for assessing and monitoring the quality of the service provided did not cover all aspects of the care and facilities provided at the home. The registered manager did not show us any evidence to demonstrate that the prevention and control of infection or care planning were monitored.

The registered manager showed us the audits of medicines she had completed in May, June and August 2014. These audits consisted of checking the medicines for one person who used the service on each occasion. We were not shown any further evidence to demonstrate that all aspects of the management of medicines were being monitored. This included staff competence in order to ensure that correct procedures were being followed. This meant that the registered manager had not identified and addressed the shortfalls with the management of medicines we found during this inspection.

Although we saw that accidents were recorded we were not shown any evidence that these were analysed so that any trends could be identified and addressed. However, the registered manager told us that the falls team were contacted if a person had more than one fall.

The lack of a quality monitoring system was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from the risks of inappropriate care and treatment because accurate and detailed records were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who used the service were not protected from the risk of inappropriate care and treatment because decisions were made on their behalf without proper authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Suitable arrangements were not in place to ensure that members of staff received the support they needed from management to enable them to deliver safe and effective care for people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used the service were not given the opportunity to make decisions about some aspects of their care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People using the service were not protected against the risks of inappropriate and unsafe care by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to health, welfare and safety.

The enforcement action we took:
We issued warning notices.