Stoke-on-Trent City Council

Marrow House

Inspection report

Forrister Street
Meir Hay
Stoke On Trent
Staffordshire
ST3 1SQ

Tel: 01782234903
Website: www.stoke.gov.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 June 2016 and was unannounced. This was the service's first inspection since registering as a service for reassessment and rehabilitation in March 2016. We found that people were not always receiving care that was safe, effective or well led. We have asked the provider to improve and will be returning to ensure the required improvements have been made.

Marrow House is registered to provide care and support for up to 21 people. There are 16 places that offer Intermediate Care and an additional five places have the facility to offer residential support for up to six weeks whilst a permanent placement is identified. At the time of this inspection 20 people were using the service. One of these people was a permanent resident.

There was a registered manager in post. 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.

People were not always safeguarded from abuse as when suspected abuse had been reported to the management this was not always acted upon and investigated. Other incidents of possible abuse had not been passed onto the management to be able to investigate.

Risks to people were not always recognised and minimised. Risk assessments had not been up dated or put in place to ensure that people were receiving care that was safe and met their needs.

People were not always supported to consent to their care and support. Some people's needs required reassessing on admission into the service to ensure that they still consented to decisions that had been made when they had been unwell and unable to consent.

People's medicines were not always managed safely. Records did not confirm whether people had had their medicine and some out of date medicine had been in use.

The provider did not have effective systems to be able to monitor the quality of the service being provided. Clear and concise records were not maintained and this resulted in people not always receiving care that was safe and effective.

People were supported to maintain a healthy diet, however records kept were not always accurate in relation to what people drank and this put people at risk.

There were sufficient suitably trained staff to meet the needs of people who used the service. They had been recruited using safe recruitment procedures. Staff felt supported and had training to fulfil their role.

People's health care needs were met. When people required health care they received it in a timely manner.

People were treated with dignity and respect and their privacy was maintained. People were encouraged to be as independent as they were able to be and staff supported people to reach their identified goals.

People's needs were assessed and regularly reviewed and they were offered choices dependent on their preferences and these were respected. People felt they were able to complain and that the registered manager was approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from abuse as although staff reported alleged abuse to the management it was not acted upon.

Medicines were not always managed safely.

Risks to people were not always assessed and action was not always taken to minimise the risk.

There were sufficient suitably trained staff to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistency effective.

People were not always being supported to consent to their care and treatment.

People were supported to eat and drink a healthy diet however records were incomplete and put people at risk.

People's health care needs were met by staff who felt supported to fulfil their roles.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People's right to privacy was upheld and their independence promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and their preferences identified

and respected.

People were involved in their care and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems the provider had in place to monitor the quality of the service were not effective.

Records maintained by the service were not always accurate and concise.

There was a registered manager in post who was respected and approachable.

Marrow 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 was undertaken by three inspectors on 14 June 2016 and was unannounced.

We reviewed information we held about the service including reading past inspection reports and notifications about significant events that the provider is required to send us.

We spoke with eight people who used the service and two visitors. We observed people's care in the communal areas. We spoke with the registered manager, assistant manager and three care staff.

We looked at four people's care records and two staff recruitments files. We looked at the way in which people's medicines were managed and the systems the provider had in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People who used the service were not always safeguarded from abuse. Although the staff we spoke with knew what to do if they suspected someone had been abused, when an incident of suspected abuse had been passed onto the senior staff, no action had been taken to investigate the concerns. We saw that one person had been admitted into the service and staff had noted 'severe bruising' to the person's body. The staff had no way of knowing how the bruises had occurred. The staff member had recorded the bruising on a 'body map' and reported it to a senior staff member however no action was taken to ascertain how the bruising had come about. This meant that this person may have been subjected to abuse and it would not be investigated. We saw in another person's care file that staff had recorded on a 'body map' that the person had several fresh and old bruising which had occurred since being in the service. No action had been taken to investigate the bruises and the safeguarding procedures had not been followed in reporting suspected abuse to the local authority.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if people's medicines were managed safely. We saw on one occasion a person had been given their pain relief medicine without there being a sufficient time gap between doses. This meant that this person was at risk of having too much medication and becoming unwell. We found that some medicine which was in use was out of date, this could mean the medicine was ineffective or not safe to use. There were several gaps in staff signatures on people's medication administration records (MAR), which had not been investigated as to whether the medicine had been administered. Several people had 'PRN' medication, which is medication they are prescribed to take when they required it such as 'pain relief'. The protocols for the administration of PRN medicines did not identify when a person may require their medication and staff did not know people well as they were only admitted for short periods of time. Most people who used the service were living with dementia or had memory difficulties and may not have been able to ask for their medicine. This information had not been sought at the time of the person's preadmission assessment and protocols had not been up dated when staff had gotten to know people and the signs and symptoms they may display when they required their PRN medicine. This meant that people were at risk of not always having their prescribed medicine at the times they needed it.

People's risks were not always assessed and minimised. We saw it was recorded on the staff handover record there had been an incident with one person and a relative. There had been no risk assessment put in place to ensure the risk of a further incident was minimised. Some people at time became anxious and aggressive towards other people who used the service. These people's risk assessments lacked personalised detail as to how to support them at these times. For example, it was recorded 'distract [person's name]' but did not state how to distract the person. When there had been an incident of aggression it was recorded in people's daily records, however the information was not easy to find and analyse in order to monitor if there had been an increase or decrease in behaviours and what worked and what didn't work for the person.

A person who used the service told us: "Yes, I feel safe here, there's always someone around to help you if

you need it". Staff we spoke with told us there were enough staff to be able to care for people safely. From our observations, people did not have to wait to have their care needs met and support was given in a timely manner. The registered manager told us that the provider was responsive and would agree to an increase in staffing levels if the needs of people who used the service required it.
We saw that safe recruitment procedures were being followed in relation to employing new staff. The provider had gained references and a DBS (Disclosure and Barring Service) formerly a CRB check, prior to employing people. There had been no new staff recently employed and we saw in the two staff files we looked at that the CRB checks had taken place many years before and had not more recently been refreshed and checked for accuracy. This meant that the information the provider held on the staff may not be reflective of their current situation.

Requires Improvement

Is the service effective?

Our findings

People who were admitted into the service had usually experienced a change in their wellbeing due to an incident/accident/stay in hospital which had resulted in a change in their needs. They required some support to rehabilitate and to be able to return home or find another permanent placement. Some people whilst being unwell had a Do Not Attempt Resuscitation (DNAR) put in place and this had come with them to the service. We saw two people who had a DNAR in the front of their care file which had not been reviewed since they had been admitted into the service. These people had been assessed as well enough to leave hospital and have a period of rehabilitation; however the DNAR's remained active in the front of their care records. The DNAR forms had no evidence that the person themselves or a legal representative had been involved in the decision around the DNAR. The provider had not recognised the person's clinical situation had changed, and so had not considered whether the DNAR decision needed to be reconsidered. The principles of The Mental Capacity Act 2005 (MCA) were not being followed because people had not consented to the DNAR's. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Deprivation of Liberty Safeguards (DoLS) is part of the MCA. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw that several people had been referred for a DoLS authorisation. The registered manager recognised that some people were being restricted of their liberty as they were unable to consent to their admission and stay at the service and had made referrals to the local authority for an authorisation of their restrictions.

Staff told us they felt supported to fulfil their role and they had sufficient training to be effective. Staff working at the service had mostly worked with the provider for a long period of time and knew the policies and procedures. However, senior staff had not acted upon an incident that had been reported to them as a possible safeguarding incident. Following the inspection the registered manager infirmed us that this would be addressed with staff member following the appropriate procedures.

We saw that one person was on restricted fluids as recommended by their GP. The records kept of this person's fluid intake were not always totalled to ensure that they were not having too much. We saw that this person had recently had tests that had shown that they were not drinking enough fluids and they were at risk. We discussed this with the registered manager who recognised the importance of clear, concise records in relation to this person's fluid intake. Kitchen staff were informed of people's dietary needs on their admission and we saw they had a list of identified special diets. People had choices of what they had to eat and told us they enjoyed the food. We observed meal times and saw that where needed people were

supported to eat in a patient and supportive manner.

People received health care support when they needed it. There were health professionals based at the service including an occupational therapist and community nurses. We saw that when people became unwell they were supported to gain treatment. One person had fallen and hurt themselves the previous evening, we saw that the staff had gained support and attended the hospital with them for treatment. They told us: "I feel better now and I have had some pain relief".

Good

Is the service caring?

Our findings

People we spoke with told us that they were happy in the home and that the staff were kind and helpful. One person told us: "I couldn't wish for a nicer place, the [staff] are smashing, they work really hard and will do anything for you". Another person told us: "I'm very happy here, the staff are lovely, kind and helpful".

The service provided at the home was usually for a limited time to help people gain their independence. This meant that most people residing in the home were there on a temporary basis. One person told us that: "I'd be happy to spend the rest of my life here; I've never met such lovely people". The staff knew people well and people were regularly asked for their opinions about the care they received so the service could improve.

We observed caring interactions between the people who used the service and the staff. A care worker danced with a person whilst they were sitting in their chair when some music came on that the person liked. We also saw staff chatting to people about the plans for their day and the visitors they were expecting.

Visitors we spoke with told us: "They [staff] are brilliant, we can't fault them". Visitors also told us they were kept informed about the care of the person who lived in the home and they felt involved in planning their care.

Peoples' privacy was respected. When people had a visitor there were areas they could go that allowed them to spend time together. One visitor told us: "I get to spend time on my own with my friend and we like using the reminiscence room to remember when we were younger".

Staff promoted peoples' independence. We observed care workers asking people if they would like to make their own cup of tea and other tasks such as washing up and dusting. The staff supported them in doing this. We saw a person being assisted to eat their lunch by a member of staff and they were patient and went at the pace of the person and did not rush them.

Good

Is the service responsive?

Our findings

Prior to their admission people had an assessment to ensure that the service was suitable for them and able to meet their needs. The information was then formulated into care plans and risk assessments for staff to follow to support people. Goals were set and staff supported people to reach these goals which included simple household tasks or remaining mobile. Weekly reviews took place involving all the professionals involved in the person's care. At the reviews progress towards the goals were discussed and plans were made for people to move onto a more permanent environment whether that be back home with care support or a residential establishment.

We saw staff knew people's individual needs and preferences. One person needed to write things down to be able to communicate and we saw staff patiently sitting with them whilst they communicated their needs. Another person required support and distraction as they were anxious. We saw staff knew how to support this person at these times and responded to their needs in a manner that helped them to remain calm.

The environment had been adapted to meet people's social and emotional needs in relation to living with dementia. We saw clear bold colours and signage to help people orientate around the service. Outside people's bedrooms were memory boxes with information about the person and the staff caring for them. There was a café/bar, reminiscence room, sensory garden, independent living kitchen and a hairdresser's salon within the service. On the day of the inspection we found several people having their hair done, followed by a reminiscence show about the local area. We saw one person who had previously been anxious, participated with the show and appeared to enjoy it.

Staff sat with people who used the service on a weekly basis to ask them if they were happy with their care, records of these meetings were kept on people's individual flies. Records we looked at stated that people were happy with their care.

There was a complaints procedure and a service user guide which informed people of the service they could expect. The registered manager told us there had been no recent complaints. A visitor told us: "I've never had a need to complain but I know if I said something wasn't quite right that the staff would take care of it"

Requires Improvement

Is the service well-led?

Our findings

This service had been opened in March 2016 and the provider was yet to conduct a formal quality inspection of the service. We found that records were not audited to identify where any required improvements were necessary. Some information had not been recorded correctly and put people at risk, for example one person on restricted fluids whose total amount drank had not been calculated and they were found to not be drinking enough to remain healthy. The registered manager was not aware of this until we pointed it out to them due to the lack of auditing of records.

There were gaps in signatures on people's medicine records which had not been identified and investigated as to whether the person had their medicine or not and we found some out of date medicine in use which had also not been identified. People were at risk of abuse as although body maps were completed by staff when they had noticed areas of concern such as bruising they either remained on the person's file unseen or were handed to a senior for action. However no action was taken and the bruising was not investigated. We saw that accidents and incidents were reported, such as falls. However no action was taken to analyse the incidents or to minimise the risk of them occurring again. This meant that the provider did not have effective systems in place to ensure that care being delivered was safe and effective.

Records we saw were disorganised and unclear. For example we saw that one person had a risk assessment which meant they were on a soft diet. However, we found another record that stated they didn't require a soft diet. A senior member of staff confirmed that the person no longer required a soft diet, but the records stated they did. We saw on another person's care record that a member of staff had reported they had broken skin, it had been recorded on the handover sheet, but the person's records were confusing and we could not see what action had been taken. This meant that people were at risk of receiving care that was not safe or effective due to the lack of governance systems the provider had in place.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff we spoke with told us that the registered manager was open and approachable. The registered manager told us they were working on making links with the local community such as a local school to support the service and so as to be able to support people who used the service to be part of and involved in their community.

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 11 HSCA RA Regulations 2014 Need for consent People were not being supported to consent to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor the quality of the service were ineffective.