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Marsh House

Inspection report

Marsh House
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 and 29 February 2016 and was unannounced.
Marsh House provides personal care for up to 33 adults. Nursing care is not available at this location. The home is situated in a rural area close to the towns of Chorley and Leyland.
Some of the bedrooms have en-suite facilities. There is a large dining room, communal areas, hairdressing room and conservatory available for people living at the home. The grounds are well maintained with seating and patio areas. These are accessible for those who use wheelchairs and there is also a stair-lift in place. Public transport links are available and ample car parking spaces are provided.

The last inspection of Marsh House took place on 26 November 2014. At that time we found concerns in the service's arrangements to safeguard people against the risk of inadequate nutrition and hydration and arrangements to identify potential risks, in order to protect people from harm or injury. The provider was not assessing and managing risks to people using the service and the provider was failing to effectively manage people's food and fluid intake. As a result of our findings we requested the provider the provider to provide us an action plan on how they were going to meet the requirements of regulations 10, and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time.

During this inspection we reviewed actions taken by the provider to gain compliance against the two breaches from the previous inspection in November 2014.We also looked to see if improvements had been made in respect of the additional shortfalls in people's care we had identified. We found some improvements had been made in respect of choice meals and some environmental maintenance. However little in the way of improvements was found with respect to managing nutrition and hydration.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included; –the provision of person centred care, the need for consent, providing safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, receiving and acting on complaints, good governance, staffing, the lack of submission of notifications and the failure to display the rating from the last inspection in the service. You can see what action we have taken at the end of this report.

The registered manager was present throughout 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 and associated regulations about how the service is run.
At the time of this inspection there were 30 people who lived at Marsh House. We spoke with seven people living at the home, feedback varied due to some people having limited communication skills. We spent time observing care delivery and spoke with people who visited the service. People told us that they felt safe, however comments about a lack of staffing consistency infringed on the day to day experiences of care received.

We found that people were not protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at significant risk of harm and neglect. We communicated our concerns to the Local authority commissioning teams and ensured that the standard of risk management at the service was addressed by the provider before leaving the site on our first day of inspection.

We found people's safety was being compromised in a number of areas. This included how people were assisted to eat and drink, how people were supported after experiencing falls, how well medicines were administrated and how staff were trained to support people after falls.

Staff were not always following the principles of the Mental Capacity Act, 2005 for people who lacked capacity to make particular decisions. For example, the provider had not ensured that people's rights were actively assessed under the Mental Capacity Act or Deprivation of Liberty Safeguards, even though their liberty was being restricted.

We found that people's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered, placing people at risk of avoidable harm.

Although some people told us they felt safe and their privacy and dignity was respected, we saw that care was predominantly based around tasks and did not take into account people's preferences. We were concerned that some very frail people living at the home were not treated in a dignified manner by some staff. There were significant concerns around staff attitude to people's request for support at night time.

The staff did not consistently involve people in decisions made around the care they received. Care plans did not evidence involvement and observation of care confirmed concerns regarding standards of dignity and respect.

We received variable feedback from relatives; some expressed positive comments about the care provided whilst others were concerned about the high use of agency workers and inconsistency in effective communication between staff at the home.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people living at the service from risk.

Staff were not provided with effective support, induction, supervision, appraisal or training. The provider did not have effective governance systems in place to ensure that improvements could be made.

We found people's medicines were not safely managed. People were running out of medication at weekends.

We found the provider was not reporting serious injuries and allegations of abuse to Local Authority Safeguarding and to the Care Quality Commission which would have ensured appropriate oversight.

We found the service did not have effective systems to deal with complaints about care and treatment and found that the manager did not keep robust records or show how complaints were being responded to.

On our first day of inspection we found people were at extreme high of risk and harm. We required the provider to take some immediate actions to address the concerns we discovered. This included arranging for another manager to support the registered manager and making referrals to specialist professionals. On

our second visit we found the provider had put together an action plan which they had started to work on. We found some risks to people had been reduced slightly however people continued to be at high risk of unsafe care.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were no appropriate and effective systems in place to identify the possibility of risk and to prevent harm to people living at the service.

The processes in place to ensure that people received their medicines as prescribed were not robust and placed people at risk of harm.

People were not safeguarded against risk of neglect and avoidable harm.

Is the service effective?

Inadequate

The service was not effective.

People were not supported in line with the Mental Capacity Act 2005 to ensure that their ability to consent was appropriately assessed prior to decisions being made on their behalf.

Some people were unlawfully restricted.

The systems in place to ensure that people received nutrition and hydration appropriate to their needs were not robust therefore placing people at risk of choking and malnutrition.

Staff training and supervision were not effective to ensure that staff were competent and had sufficient skills to meet the needs of people they cared for.

Is the service caring?

Requires Improvement

The service was not effectively caring.

There were not appropriate and effective processes in place to make sure people were involved in discussions regarding their preferred care and treatment.

The systems and procedures operated at the home were not

designed to enable people to live their lives in the way they choose, so that they can be as independent as possible.

People were not always treated with dignity and respect and the standard of personal care people received was found to be unsatisfactory.

Is the service responsive?

Requires Improvement

The service was not responsive.

There were not appropriate and effective processes in place to make sure people's health and social care needs were properly assessed and planned.

We found peoples care needs were not appropriately planned for by the service.

The service failed to respond to peoples changing needs by ensuring amended plans of care were put in place and liaison with other health care professionals at times of deterioration in health status.

People's complaints were not dealt with effectively.

Is the service well-led?

Inadequate

There were not appropriate and effective processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care.

The service was unable to demonstrate progression since the last inspection and had not met breaches outlined in the issued warning notices.

We found that due to insufficient awareness of people's needs by the management structure people were at risk of avoidable harm.

Marsh House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 29 February 2016, both dates were unannounced.
The inspection team consisted of three adult social care inspectors on the first day and two adult social care inspectors on the second day. Before the inspection we reviewed information from our own systems which included notifications from the provider and safeguarding alerts. In particular, information we had received since our last inspection in November 2014.

We reviewed the content of the action plan for breaches issued to the provider following the previous inspection in November 2014 where two breaches were identified under the Health and Social Care Act 2008 (regulated Activities) Regulations 2010 which were in force at that time.

We gained feedback from external health and social care professionals who visited the home. As part of this we were provided with an organisational safeguarding report completed by Lancashire County Council Safeguarding Enquiries Team in January 2016 and had received regular updates from other associated professionals at the local authority.

We spent time talking with people who lived at the home and where possible their relatives, reviewed records and management systems and also undertook observations of care delivery. We spoke with seven relatives, six people who used the service, the provider, manager, regional manager, catering manager, four care staff, cook, activity co-coordinator and a visiting district nurse. We looked at six peoples care records, staff duty rosters, four recruitment files, accident and incident reports, handover sheets, management audits, medication records and quality assurance documents.

On the second day of our visit we reviewed actions that we had asked the provider to put in place to reduce risks. We found the provider was acting and had started to work on various issues that we had identified. We found some risks to people had been reduced slightly however people continued to be at high risk of unsafe

care.

Inadequate

Is the service safe?

Our findings

During our last inspection of Marsh House in November 2014, we found concerns in the service's arrangements to safeguard people against the risk of inadequate nutrition and hydration and arrangements to identify potential risks, in order to protect people from harm or injury. The provider was not assessing and managing risks to people using the service and the provider was failing to effectively manage and monitor people's food and fluid intake. As a result of our findings we requested the provider to send us a report telling us what action they were going to take to meet the requirements of regulations 10, and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time.

During this inspection we reviewed requirements outlined in the action plan issued following the inspection of the service in November 2014. We reviewed compliance against the new associated regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

Feedback from people living at the home was minimal due to limited communication abilities and dementia care needs. However we asked all people who lived at the service "Do you feel safe?" people told us they felt safe living in the service. One person we spoke to told us, "I feel safe and content". However another person told us staff did not let them know when their loved one suffered a fall and were admitted into hospital. They told us, "I had an issue with the fall she had, they did not ring me even though they have my mobile number". Another relative told us "I can come away and not be sad".

Staff did not always know how to keep people safe and how to recognise safeguarding concerns. They did not have a clear understanding of the process or procedure to raise any safeguarding concerns for people. This meant people were at risk of not being protected from safeguarding concerns, as staff were unaware of the correct procedures to follow.

We found the provider did not protect people against abuse from staff. For example some staff had been accused of shouting at people who lived at the home, refusing to help people during the night and not turning one person for 12 hours which resulted in skin damage. Although the provider was aware of these incidents they did not show how they dealt with them effectively to ensure people were safe. We found the provider had not provided these members of staff with supervision to monitor their performance after concerns were raised by relatives and people who lived at Marsh House. This meant that the provider could not be assured staff were safely providing care and treatment for people.

People were at risk of harm because the provider did not have effective processes for reporting or recording accidents or incidents and therefore could not monitor, respond to issues and reduce the risk of reoccurrence. Accidents and incidents were not always reported and people did not always receive safe care when they experienced a fall. For example a report completed by Lancashire County Council Safeguarding Team stated, "accident logs contained details of unwitnessed falls, some of which detailed 'bump to head', 'banged head on door' and 'bruising to forehead', they however did not say what care these people received.

Staff did not always make observations on people who had experienced unwitnessed falls. Support and advice was not always sought from emergency health agencies after falls. Staff we spoke with confirmed they had not received training regarding first aid. The provider also confirmed this. Therefore people were placed at risk as they could not be assured that they would receive appropriate care if they were injured.

The registered manager was unable to demonstrate how they would ensure that staff would recognise and take the required action in order to keep people safe from avoidable harm, unsafe care and/or abuse.
This was a breach of Regulation 13(1) and (2) (3) and (4)(c) (5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Risks to people from receiving care were not managed appropriately. Care plans contained risk assessments for some aspects of the care provided such as manual handling, malnutrition and pressure ulcers. However, actions to mitigate the risks were not always put in place. For example, the risk assessment for one person of developing pressure ulcers showed the risk was high but no actions had been put in place to mitigate the risk to this person of developing pressure ulcers.
Another person had been assessed as at risk of unintentional weight loss and required their nutritional needs and fluids to be managed and monitored. We however found the service had not put any measures to ensure this was happening nor did they consider referring this person to dieticians. Where risk assessments had been carried out and actions recorded to mitigate the risk these actions had not been carried out and staff did not review the care plans. For example, we found one person was being fed a pureed diet when their care plan recorded they preferred a soft mashed diet. Staff spoken with had no knowledge of the assessed needs of this person and did not recognise the risk of choking caused by feeding this person a pureed diet without an assessment from a Speech and Language Therapist. The chef told us that they had made this decision without consulting professionals.

We found one person had suffered harm due to a member of staff neglecting them during the night. This person was in the last few weeks of their life. Records indicated that no care or change of position was provided for a 12 hour period resulting in a breakdown of skin on their buttocks. The Registered Manager told us this member of staff was disciplined and under supervision however we did not find evidence of the supervision. This meant people continued to be exposed to risk of neglect from poor care practice from the member of staff in question.

This was a breach of Regulation 12(1) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider was using unlawful restraint on one person. The plan of care for this person showed that consent for all aspects of their care had been signed by the registered manager. There was no evidence of the person's relatives being involved. This person's care included some aspects which could have been restrictive, such as the use of bedrails. However, there was no capacity assessment in place and no evidence that best interest decisions had been made through specific meetings and discussions between all those involved in this person's care.

We viewed the care plan of another person and noted consent for all aspects of their care had been signed by a family member. There was no confirmation as to whether this was legally valid and no capacity assessment was on file for this individual. This meant the provider was imposing an illegal restriction on this person.
This was a breach of Regulation 13(1) and (2) (3) and (4)(c) (5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found systems for identifying and managing risks at service level were present, however these were not

robust and not effectively put into practice which meant that the systems did not help to anticipate risks within the service. For example we found there was a system for auditing medication errors which was being completed by staff however the registered manager was not using this to create action plans on how the errors would be avoided or corrected. For example we found one person went for four days without their medication to relieve their pain as the service had not supported this person to ensure they had enough medication to last the weekend. Inspectors found the GP and the pharmacy had been contacted however the provider had not ensured stocks were checked in time. This had a significant impact on this person's health and wellbeing.

When we visited twelve days later we found another person's medication had run out over the weekend. This meant that the provider was not putting effective procedures to learn from mistakes which meant people continued to be exposed to risk of going without medication.
We found that medicine management systems were not robust, placing people at risk of not receiving their medicines as prescribed. For example we found the provider failed to identify omissions in medicine administration, lack of effective medicine stock management and a lack of information to support administration of 'as and when required' treatments were evident. For example care plans relating to the administration of medicines contained PRN (as required) documents but these did not adequately detail when a person should receive their PRN medicines. For some people we found there were no care plans for "as and when medication" PRN. For example one person has who was prescribed a spray for the treatment of their angina did not have a care plan to reflect when and how this medication should be administered.

Medication audits were being completed by staff however there was no evidence to show that the issues they found during the audits were being used to correct the errors. We spoke to the registered manager who told us they were not checking the audits and had not picked the issues raised within audits. This highlighted that people were at risk of not receiving their medicines as prescribed. We requested that the manager made safeguarding referrals for two people at the home in regards to medicine management; the manager was unable to explain why internal auditing systems were not able to pick up medications that were running out.

Inspectors found two people who managed their own medication had not been assessed to ensure they could safely manage the medication. This meant the provider did could not ascertain if people were taking their medication safely. On our second visit we did not find improvements or reduction of risks on medication management, we found the provider has not put measures to reduce the risks identified on our first visit.

This was a breach of Regulation 12 (2) (g) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether the service had sufficient staff to meet people's needs. On the day of inspection we found there were sufficient numbers of staff. Some people told us that there was sufficient staff to meet their needs. One person said, "They always come on time." However, another person told us when they pressed their call bell for a staff member; "I can wait between 15 to 30 minutes for a response." This meant that people may not receive the support they needed in a timely manner and in case of an emergency could compromise people's safety.

A relative we spoke to told us "I think they need more staff. They always seem short staffed".
Concerns had also been raised to us by care professionals regarding staffing numbers at the service prior to our inspection. They cited an example of where paramedics attended the home during the night and found two members of staff supporting thirty people.

We spoke to one member of staff who told us they felt under pressure due to low staffing levels especially in the mornings due to an increase in a number of people who required support from two carers. A system to assess when more staff were needed was in place however this was not being used effectively. We found it was last updated when there were two people who had high levels of needs however on inspection day we found there were six people who required two carers and the number of staff needed had not changed. We spoke with the provider regarding the system they used to determine staffing levels. They were unable to demonstrate to us how this worked to meet people's changing needs and how they assessed that the staff on each shift had the appropriate experience and skills to meet people's needs safely.

We found the service was frequently using agency staff to cover night shifts. We spoke to the registered manager who told us they were in the process of recruiting regular night staff and had been struggling to recruit due to the location of the service. They were however actively recruiting and advertising.
This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service did not always follow safe recruitment practices. For example, on the first day of inspection we found one member of staff had started induction at 07.30 am and finished induction at 10.23am on the day of our inspection. This member of staff was scheduled to work before they received a disclosure and barring service check. We asked if there had been any risk assessments carried out to ensure this person was safe to work with vulnerable adults and the registered manager informed us, the deputy manager had arranged this and they were not aware of this arrangement. This meant the provider did not always follow safe recruitment procedures that are meant to protect vulnerable adults.
This was a breach of Regulation 19(1) (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the personnel records of another four members of staff. We found that these were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS).

People did not have plans in place for staff to follow should there be an emergency. We found some people did not have Personal Emergency Evacuation Plans (PEEPs). We found the PEEPs that were in place to be very generic and not reflecting people's individual needs and support they required. The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise for example, in the case of fire or flood. The absence of PEEPs meant that staff had not assessed how people would be supported in the case of emergencies in the home therefore putting people at risk.
This was in breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

We asked people who lived at the service if they felt staff were competent and suitably trained to meet their needs, feedback varied; One relative told us "They are excellent" and "They have worked miracles on my mother's condition". Another relative gave positive feedback saying, "I cannot fault the care". However another relative told us they were not confident with the staff and were in the process of trying to move their relative to another home.

We asked visiting health care professionals for feedback. A visiting district nurse told us, "There have been some improvements", "They do not protect themselves adequately by evidencing the care they provide" and "We are constantly asking them to record turn charts and food charts on every visit". Another professional told us "They do not seem to follow recommendations".

The Mental Capacity Act 2005 (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the provider was not working in line with the key principles of MCA. This included insufficient management of DoLS. For example we found the Registered Manager did not follow the principles of Code of Practice for MCA and DoLS when she applied for DoLS for one person. The mental capacity assessment was carried out six days after the DoLS application has been submitted to the local authority. This person's mental capacity should have been completed before the application was completed. This meant that the registered manager did not take consideration of whether this person was capable of making their own decisions or not.

The Registered Manager did not have evidence to show how they were managing applications that had been made to the Local Authority. For example they had applied for an urgent DoLS authorisation on more than twelve months earlier however no follow up had been made by the provider. Another example was that of an application that the registered manager had completed in 2014 which they had not sent to the Local Authority and thought they had done.

Records showed that arrangements to obtain consent from people who lived at the home were inconsistent. Staff did not obtain valid consent from people who lived at the home.

We spoke to staff and the registered manager and we found they did not have sufficient knowledge of

mental capacity and Deprivation of Liberties.

We looked at training records and found staff and the Registered Manager had not attended training to help them understand the principles of the Mental Capacity Act 2005.

We found that the registered person had not ensured people's rights were always protected, because consent had not been obtained through best interest decision making processes prior to the provision of specific areas of care.
This was a breach of regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014

Staff did not receive supervision regularly. Staff were only supervised when they had undergone disciplinary action. We found the provider had not put measures in place to monitor staff whose performance was causing concerns to people who lived at Marsh House. For example two members of staff who had been found to have neglected people at night, were left to continue working nights with limited supervision and oversight. This exposed people who lived at Marsh House to risks of neglectful care and meant that the provider was not ensuring people's needs were being met by effectively. On our second visit on 29 February we found the provider has acted and changed one member of staff's working pattern to ensure they could supervise their performance. This helped reduce risks at night however the other staff member was still working on the night shift.

We found training was not considered for key areas at the service, for example moving and handling training, safeguarding, mental capacity managing nutrition and first aid training. We found only four out of 21 members of staff had first aid training which was also out of date. This was regardless of the fact that there had been a significant number of falls and accidents. The need for first aid training had been identified by the local authority in November 2015.

We found that staff had not received training in safeguarding adults from abuse. Three staff spoken with during the inspection demonstrated a lack of knowledge and understanding of safeguarding procedures and their roles within both provider and national safeguarding procedures. This meant the provider was failing to analyse the requirements of the service to provide staff with necessary training to meet the needs of people they cared for. The provider had failed to ensure staff were appropriately trained.
This was a breach of regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found the provider did not have suitable arrangements for ensuring service users were protected against the risks of inadequate nutrition and hydration. We deemed this to have had a high impact on people. As a result of our findings we asked the provider to send us a report that said what action they were going to take to meet the requirements of this regulation.

During this inspection we reviewed compliance against the new associated regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

On the morning of the first day of inspection we examined nutritional intake records for six people and found that people were at significant risk of malnutrition and dehydration. People were not appropriately assessed and when people had lost a substantial amount of weight and referrals to external professionals such as their GP and, or Dietician were not undertaken.

During the inspection we observed this person being fed by a carer who was sitting in position which meant that the person was having to turn to look behind their shoulder to reach for the spoon from the carer as the carer was sitting behind them. This meant that the person was put at risk of choking. The carer advised they were sitting behind the person as they were blind. We spoke to the provider before we left to ensure all staff responsible for assisting this person to eat did so in a dignified manner.

We highlighted the risk of choking to the registered manager on the first day of inspection and requested them to inform the local authority safeguarding team. We looked at several care records relating to nutritional risk management and individual preferences and found evidence of inadequate risk assessment and involvement procedures in all the records we viewed. This meant that people had not been appropriately supported to maintain their individual nutritional and hydration needs. For example when people had lost weight actions had not been taken to protect the individual from further weight loss or malnutrition. Care plans were reviewed and carers recorded "no change in needs" when they had weighed people and evidenced weight loss three consecutive months.

We observed one person ate their breakfast very quickly. This person continued to scrape the empty bowl for more than 15 minutes. We saw that staff did not ask this person whether they needed some more porridge or something else to eat , we intervened and they gave the person another bowl which they ate quickly again indicating that they were hungry. We also found staff were not asking people if they wanted more food. This person had difficulty communicating their needs to staff and relied on staff anticipating their needs however we found staff did not pay attention to this person's signals. This meant staff were not able to respond to people' nutritional needs and signals from people who lived with dementia.

Nutritional care records we looked at had conflicting information from the care that people were receiving. For example one person's care plan stated that, "I can eat and drink independently and like staff to cut my food". We found this person needs someone to feed them and was cared for in bed. We found one person's care plan continued to say they required their drinks to be thickened however this person had been seen by Speech and Language therapist, (SALT) and no longer needed their drinks thickening. We spoke to the registered manager who told us they had been informed this by SALT however they had not shared the letter with carers and change the care plan. This meant that this person and other people were at risk of receiving unsafe or inadequate care and support.

We asked the provider to raise safeguarding alerts for people we found to be at risk of malnutrition and or choking and we informed Lancashire County Council safeguarding team that we believed this inadequacy was endemic throughout the service.

The provider had failed to ensure that people's nutritional and hydration needs were met. This was a breach of regulation 14 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed what the provider had done to reduce the risks on people on our second visit and found they had started to weight people, assess risk of malnutrition using nationally recommended tools and referring people who were at most risk to dieticians.

People's views on meals varied. One person told us "we get two choices at all meals". Another person gave us a different view "Not happy with the food it is all pre-packed". And "Puddings are lovely."

Another person told us their family raised concerns as they were having chicken everyday however when they spoke to the chef they now get a variety and they are asked what they want to eat.
There were menus displayed visibly within the service and drinks were observed to be available in

communal areas.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us, "I think they are amazing" and "They are very considerate and caring". Another person said "They are all very good, they do a very hard job and they are rushed off their feet" and "Yes I think they are all very nice". Another person said "most staff are kind, some are sharp when they speak".

Another person told us that although they found the care staff to be kind and helpful, they often appeared to be rushing and rarely had time to just have a chat. This person told us "I wish someone could spend 10 minutes with her", "There is not enough time for carers to do this" and "They are always short staffed".

We spoke to a visiting professional who told us "Care and compassion does not always show from carers". And "I think they do need to work around personal hygiene".

A member of staff told us "We have six people who needs double ups and staff numbers have not changed" and "Sometimes we just need 5 minutes". They also told us, "It puts pressure on staff as we are constantly on the go". However, another person told us that although they found the care staff to be kind and helpful, they often appeared to be rushing and rarely had time to just have a chat. "There is not enough time for carers to do this". And "They are always short staffed". Three people who lived at the home told us they had to wait for longer periods at night for staff to respond to their call bells. This meant that people did not always get timely care.

During the inspection we looked at staff's records and we found there were a number of incidents where people who lived in Marsh House had complained about carers speaking to them "sharply". One person had requested to be assisted to sit on the commode however a carer had refused to assist this person. This carer was accused of speaking to people in a manner that has been described by people who live as the service as "sharp". We saw records that the provider had kept of this member of staff and evidenced that they had been aware of the member of staff's behaviour.

We found one more carer had been reported for shouting at a resident. A relative of this person reported this to Lancashire County Council as a safeguarding alert.

People told us "Day staff are nice however night staff are not so nice". One person told us "I do not feel safe when that carer is on duty at night". We discussed these concerns with the provider and they took some action to change this member of staff's work pattern.

The provider had failed to provide dignified care that respected people's autonomy and independence. This was a breach of regulation 10 (1) (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. Plans of care we saw outlined the importance of respecting

people's privacy and dignity and promoting their independence. A staff member we spoke to told us how they would respect people's dignity. They told us "I knock on doors "However, we established that prior to our inspection the Local Authority Safeguarding Team had carried out enquiries after concerns night staff were waking people up at 06.00am.These examples did not promote a caring approach towards those who lived at Marsh House.

We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance. We saw evidence people were asked about their views regarding meals. The provider was carrying out surveys regularly to ask people for their suggestions.

We looked at care records for six people and found that people were not involved in the care planning process. We asked people if they had been given the opportunity to be involved in writing their care plans and one person told us, "I was not aware I had a care plan." A relative of one person told us "I have not formally sat down to do it however they always keep me informed as I visit frequently".

We did not find any evidence of involving people who live at the service in decisions made about the general running of the home. This meant people's voice was not always heard and their opinions could not shape how their care was delivered. We asked the manager if resident meetings were held and she explained that meetings were now scheduled.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to.
We got mixed answers from people. One relative told us, "They are good in some way but, I cannot say, they are the best". We asked relatives if they felt their loved ones needs and wishes were responded to. A relative told us, "They are excellent". And, "My mum tells me how well they look after her". Another relative told us, "I have raised issues about the smells; sometimes the cleaner does not get time to empty the commode.

We looked at how the service provided person centred care. We found little evidence of person centred care. We found the care being provided was not person centred and care files we analysed were not written in a way that ensured care and treatment of service users was appropriate, met their needs and reflect their preference. For example we found one person's file stated they were a vegetarian and did not eat meat however we found records showing they had been given meals with meat on three occasions. There was no evidence to indicate this person had agreed to have meat dishes. This meant that care provided to this person did not reflect their personal preferences and personal beliefs and their choices were not respected.

We reviewed another file for one person who had been experiencing falls on a number of occasions, this person this person's mobility care plan had been recorded as "No change in needs" and "No change in care plan".

Another person's care plan on skin integrity was reviewed in January 2016 and stated that skin remained the same from the last assessment in January 2014 However when we looked at this person's body map we found this had eleven records of skin tears including a pressure sore. This meant that this person was left at significant risk of developing pressure sores and further skin damage as they were cared for in bed and could not manage their own skin conditions.

This was a breach of regulation 9(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014

We looked at how people were supported to follow their interests and take part in social activities. We observed that people were provided with stimulating activities to promote their wellbeing or to prevent social isolation. For example, one person told us, "We are very lucky we get to go out a lot".
We found records to demonstrate that the service considers peoples social stimulation on a frequent basis. We spoke to the activity co-ordinator who told us, "We have an activity plan, some days this is changed to go along with people's preferences".

We looked whether people were encouraged and supported to develop and maintain relationships with people that matter to them and avoid social isolation. We found people were supported to continue practicing their religious beliefs. Two people told us they get visited by their priests. Another person told us, "I go out with my family."

Relatives of people who lived at Marsh House told us they could visit anytime of the day or week and there

were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationship in their lives without restriction.

We reviewed how the service responded to complaints and found that the manager did not keep robust records or show how complaints are responded.

During the inspection we found people who lived at the home and their relatives had complained about members of staff however the manager had not responded to the complaint in line with the complaint policy and procedure. These people told us they were left unsure whether their concerns had been dealt with. Some people told us that they were aware of the complaints procedure and one relative explained "I can tell the manager at any time if I have a concern", however robust records to show how the service responds to people's concerns were not available. This meant that the service did not show how it responded to people's concerns and evidence they were listening to people.
This was a breach of regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Inadequate

Is the service well-led?

Our findings

We asked people who lived at the service and their relatives if they thought the service was well led relatives told us, "We don't have any issues" and "The manager seems knowledgeable".
We asked people who lived at the service if they would be able to speak with the manager about any concerns. People told us, "Yes, she is very kind and understanding" and "We know we can talk to her anytime". However professionals who visited the service told us "There is lack of leadership" And "There is no oversight at all".

We looked at how the service demonstrated good management and leadership. We were told that people had a lot of faith in the manager; however one person raised concern about the manager and said that they did not get the feeling their concerns were being taken seriously and dealt with.

We spoke to staff and some told us they were able to make suggestions to the provider if they found areas of improvement however we found there was no evidence of regular staff or residents meetings. One meeting had been held in May 2015 as evidence for a member of staff who was undertaking a course but not as routine practice.

We asked staff about staff meetings and they said, "These are arranged but always get cancelled". Another member of staff told us providers came to Marsh House regularly, however staff said, "They visit and speak to staff" and "They can be rude and don't listen".

We found that the service had inadequate systems in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included person centred care, medicine management, managing risk to people and nutrition/hydration, and managing staff. These issues had not been sufficiently identified or managed by the provider prior to our visit which showed that there was a lack of robust quality assurance systems in place.

In the records that we checked we found staff were undertaking audits and identifying various issues in different areas including medications errors and care files that needed to be reviewed. However we found the Registered Manager did not act on the areas that were being identified from the audits.

We looked at the audits that had been completed by the compliance manager in January 2016 and found they had recorded that staff supervision's were "on-going". However we found no evidence of supervisions in staff files or anywhere else. We asked the registered manager for these and they could not give us any evidence.

We asked the registered manager if they had identified the same areas of risk we had highlighted and we were informed that they were not aware of some of the things and had not looked at audits done by staff especially medication audits.

We found significant failures in medication stock management. The provider did not put systems in place to

ensure people who managed their own medication were assessed to ensure they were capable to manage safely. Medication audits were being undertaken however no actions were being taken to correct the identified issues. This resulted in people going without essential medication.

We found there was a lack of scrutiny and analysis following incidents accidents and falls which meant that the provider was failing to analyse incidents and accidents as they should so they could take action to prevent a reoccurrence.

We also found instances of incidents and accidents that had not been picked up and reported through management systems or safeguarding processes so people could not be confident that incidents would be properly raised and investigated. For example we looked at records and found there were six occasions where concerns had been raised by relatives and people who used the service regarding the way four members of staff responded to people's needs during the night.
We saw the registered manager was aware of these incidents however we found the provider did not put effective measures in place to ensure that these carers were supervised. We discussed this with the provider and the Registered Manager and they confirmed they knew about these incidents and they had put measures in place however they acknowledged they did not follow the measures that they had put in place themselves. This meant that the provider was failing to follow their own protocols and continued to put people at risk from staff. This had resulted in people being exposed to actual harm and receiving care which was inconsistent and did not meet their care needs.

Records we viewed and information we were given before the inspection showed that staff did not feel supported. For example one member of staff had not requested help from the manager during the night when they had two staff looking after thirty people. Staff had told Lancashire County Council safeguarding officers they felt scared to phone the manager at night as she was not happy with them doing so. The provider's regional manager had discussed this with the registered manager and reminded them of their responsibilities.

We looked to see if the registered manager understood their responsibilities. We found the registered manager did not have a clear understanding of their responsibilities and the regulations that they needed to follow. For example when we asked if they kept an action plan on areas that needed doing within the home, they told us they did not keep any action plan and that these were kept by other managers such as catering manager, maintenance manager and compliance manager. The registered manager did not have system in place to track what they needed to work on a daily basis and we found that there were no clear lines of responsibility.

We spoke to professionals who visited the service and they told us, "We are constantly asking them for turn charts". And I do not feel confident they are doing them". Professionals told us they repeated the importance of ensuring care to people with complex needs is recorded and guidance is followed however this was not happening.

One professional told us, "There is no clinical oversight" and "When we ask senior staff including deputy manager and registered manager we get the answer, I don't know".

We found the registered manager was unable to demonstrate suitable knowledge around risk management for people living in the home, with particular reference to people with significant and complex health care needs. The manager and the provider were unable to clearly demonstrate that breaches in the regulations

(November 2014), as outlined in our recommendations, had been met.

The lack of appropriate management oversight and leadership meant that the provider had failed to identify the issues that we found, which had resulted in people not having their care needs met.
On our second visit we found the provider has brought in another manager to support the registered manager to ensure they can minimise the risks we identified and keep people safe. This helped minimise risks and ensured some oversight was being provided however this was not making much difference as we found more shortcomings on who was responsible for day to day managing of the home.

The service provider had failed to ensure the good governance arrangements were in place within the service.
This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying the Care Quality Commission of reportable incidents Regulation 18(1)(2)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not provide person centre care because people's care was not assessed or planned for to ensure their needs and preferences were met.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place for medicines management.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

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 The provider did not safeguard people from abuse and avoidable harm.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of service users were not met because the provider had failed to adequately support people with their food and fluid requirements and people were not offered choices. Regulation 14(1)(4)(a)(c)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have suitable arrangements to receive and deal with complaints.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to or maintain accurate medicines records. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure that staff were suitably qualified ,supervised and competent to provide safe care.

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a higher level of breaches of regulations we will ensure action is taken to keep people safe and we will report on this in due course.