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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 18 July 2016 and was unannounced.

The last inspection of Marsh House took place on 29 February 2016. At that time we found significant concerns in the service's arrangements to safeguard people against the risk of; not receiving person centred care, inadequate nutrition and hydration, inadequate arrangements to identify potential risks in order to protect people from harm or injury, inadequate measures to assess and consider people's consent to care, inadequate systems to identify or address issues that affected the quality of the service, poor medication management, lack of staff supervision and training, inadequate measures to deal with complaints and concerns and lack of governance and leadership.

The provider did not have suitable arrangements in place to ensure that staff were suitably qualified, supervised and competent to provide safe care and the provider was not notifying the Care Quality Commission of reportable incidents. As a result of our findings the service was put in special measures. Special measures ensure that providers found to be providing inadequate care, significantly improve and provides a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

As a result of our findings we ensured appropriate action was taken to keep people safe. We received from the provider an action plan on how they were going to meet the requirements of regulations Regulation 9 - Person centred care, Regulation 11 – Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 – Safeguarding service users from abuse and improper treatment, Regulation 14- Meeting Nutritional and Hydration needs, Regulation 16 receiving and acting on complaints, Regulation 17 – Good governance, Regulation 18 – Staffing, and Regulation 20A – Requirement as to display of performance.

During this inspection we reviewed actions the provider told us they had taken to gain compliance against the ten breaches from the previous inspection in February 2016. 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 improvements had been made in respect of receiving and acting on complaints, sending notifications to the Care Quality Commission (CQC), reporting safeguarding incidents to the local authority, seeking people's views on the quality of the service, and referring people to the local authority for deprivation of liberties authorisation.

Some minor improvements were noted with the information within people's care files and seeking support from health professionals for people involved in accidents and falls. However, little in the way of improvements was found with respect to; managing medication safely, staff performance management, staff training , management of people's risks from harm and risks of abuse and ill treatment, management of nutrition hydration, management of risks of infection and contamination, governance and quality assurance systems.

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 service had a new registered manager who had been in post since April 2016. This followed the departure of the previous manager who had been in post at the time of our inspection in February 2016. The registered manager was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The findings of this report relate to findings and evidence from March 2016 onwards when we had asked the provider to rectify the breaches in regulation.

At the time of this inspection there were 31 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.
Some people told us that they felt safe and that they noticed improvements in the care however, some people told us things had got worse. They expressed that a lack of a consistent and regular staff team had impacted on the quality of care they had received.

People were not protected against avoidable harm. Quality assurance systems at the home had continued to fail in identifying and resolving associated risk in a timely manner, therefore exposing people to significant risk of harm and neglect. We communicated our concerns to the local safeguarding team after the inspection to ensure that risks were appropriately managed for one person we identified to be at significant risk of neglect.

We found people's safety had continued to be compromised in a number of areas. This included how people's medicines were managed, induction of new staff and temporary staff, how staff were supported to do their job through training and supervision, how risk assessments had been assessed and the guidance that had been provided to staff to reduce the risks, how emergency evacuation was planned and how people were protected from the risk of infections and contamination.

Mental capacity assessments were not always completed for people who lacked capacity to make specific decisions. Staff lacked knowledge and understanding of the mental capacity act and how people should be supported. For example, the provider had not ensured that people had best interest decisions meetings if they lacked capacity. We were told that people who had been assessed as lacking mental capacity were making unwise decisions and that this was not something the home could prevent or address, regardless of the fact they lacked capacity to understand what they were doing.

People's health care needs had been assessed however, adequate risk assessments had not been developed to guide care staff. This placed people at risk of avoidable harm. Plans for safe evacuation of people had not been completed which meant people could not be assured safe evacuation during emergencies. This was the case for the most vulnerable people in the home.

Relatives told us people had been offered drinks and snacks. Especially people living with dementia and people at the end of their life. However risks of malnutrition, dehydration and personal hygiene were not sufficiently managed. People who could not eat in the dining room were left longer waiting for food. Choice was compromised by a directive by the service not to offer people a cooked breakfast after 10.30am. There were no goals in place for people who required food and fluid monitoring charts. Staff had recorded what people had drank however there was no evidence how they determined whether they had given people enough or what was a sufficient amount of fluids. This exposed people to risks of harm.

People told us they were treated with dignity and respect and we saw care staff speaking to people in a respectful manner. However, we observed incidents where people's dignity was not supported. We raised concerns regarding the home's ability to meet people's needs. People had waited for up to one hour to use the toilet and staff could not toilet people because the hoist was faulty and there was no immediate replacement hoist. This had caused significant distress to people involved.
Evidence we saw showed the home had made efforts to involve people in decisions around the care they received. However, this was not consistent and had been undermined by lack of knowledge on mental capacity and consent within the home.

Feedback from relatives was mixed. Some people felt they had seen gradual improvements in the quality of care however some relatives informed us the quality of care had further deteriorated. Relatives felt the high use of agency workers had impacted the quality of care provided. They also felt the home could do with more staff as staff looked rushed at all times. We observed call bells were ringing for long periods of time without being answered. People had complained being left on the commode for up to 45 minutes. This had been reported to us before the inspection and had been investigated by the local authority safeguarding department.

There had been an attempt to improve management systems in the home however, we found on going concerns with quality assurance, audits and oversight. The systems were not robust and had not identified some of the concerns that we found.

Staff had not been effectively supported for their roles. There was no induction in place for care staff who were new to the home. This had exposed people to actual harm. There had been a number of safeguarding incidents involving agency staff which were attributed to lack of knowledge about people's needs. There was no induction policy in place to ensure agency staff were made aware of people's needs before they started their role. We found significant shortfalls in staff training and development. This was an on going concern which the home had failed to address and had impacted the quality of care that people received.

There was no robust infection control measures within the home. Staff were observed not following infection control measures throughout the day. This included one member of staff disposing materials that had been used to clean faeces in the kitchen bin and not using gloves when cleaning soiled furniture as well as failing to wash hands. We observed staff going in and out of the kitchen without wearing aprons. There was a high risk of cross contamination. We found the home to be malodorous throughout the inspection.

We found the home to be extremely hot throughout the day, the temperature was 27 degrees Celsius. Although we noted that this was one of the hottest days of the year we found the heating had been left permanently on with the thermostat control set on 23 degrees Celsius. People who lived at the home, staff and visitors told us the environment was extremely hot. We were told people could go in the conservatory if they felt warm in other parts of the building however, regardless of an air conditioning unit being present this area was also very warm. The odours and the high temperatures had been reported by people who contacted us before this inspection.

Governance systems in the home had failed to ensure that improvements could be made and sustained. We found management were reactive rather than proactive in their way of improving the service.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included; Regulation 9 - Person centred care, Regulation 11 – Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 – Safeguarding service users from abuse and improper treatment, Regulation 14- Meeting Nutritional and Hydration needs, Regulation 17 – Good governance, Regulation 18 – Staffing.

The overall rating for this service continues to be 'Inadequate' and the service therefore in line with our guidance remains in 'Special measures'.

We are taking action to protect people due to the significant concerns found at this inspection and will report on our action when it is completed.

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

This 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.

People's safety was compromised due to a lack of robust risk assessments. Call bells had not been answered timely and people had waited for help for long periods of time.

People were at risk of harm due to unsafe practices in the administration of medicines.

People we spoke with said they felt safe using the service; however staff had not received training in safeguarding adults. Staff had exposed people to risk of actual harm, injury and neglect. People were not safeguarded against risk of neglect and avoidable harm.

There were processes for recording accidents and incidents. We saw that appropriate action had been taken in response to incidents to maintain the safety of people who used the service.

People had been exposed to the risk of infection as a result of poor infection control practices. There were malodorous smells throughout the day.

The temperature within the home was very hot and people and visitors had raised concerns about this.

Is the service effective?

Inadequate

This service was not effective.

People were at risk of harm due to neglectful practice from staff.

People were at risk of harm because their mental capacity and consent was not effectively considered.

People were at risk of harm due to lack of staff training and development. Training and induction had not been provided

before care staff started their role. Agency staff had not been supported to understand people's needs before starting their role; this had resulted in poor care and harm to people. There was evidence of staff supervisions.

People who required DoLS authorisation had been referred to the local authority for authorisations.

People were at risk of harm due because of inadequate systems to ensure that people received nutrition and hydration.

Is the service caring?

Inadequate

The service was not caring.

People's dignity had been compromised by poor practice from some staff. Some staff had encouraged others to act neglectfully towards people and to falsify care records.

People had been exposed to risk of neglect as their person care needs had not been adequately met. Personal preferences had not been followed. Standards of care were not satisfactory. People had been left waiting for help for long periods of time. Call bells were not responded to in a timely manner.

End of life planning had not been considered.

People and their relatives were pleased with the staff who supported them and the care they received. They however raised concerns about use of agency staff.

People were involved in discussions regarding their preferred care and treatment.

Is the service responsive?

Inadequate

The service was not responsive.

Care that had been provided was not tailored in a person centred manner. People's preferred choices had not always been followed.

People had been exposed to risks because the service did not have adequate, working equipment to assist people with transfers and toileting.

Care plans were not consistently person centred.

People had been referred to external professionals to ensure

their health needs were met, however this was not consistent and guidance from other professionals had not been followed.

Dependency tools for assessing staffing needs contained inaccurate information about people's needs which impacted on accurate staffing levels.

We found peoples care needs were not appropriately planned for by the service. Care records did not accurately reflect the care people had received.

People had been kept informed of the developments in the home through meetings. Relatives had been involved in reviewing care.

Complaint procedures were in place and people were aware of how to raise concerns. We saw examples of how complaints had been dealt with.

Is the service well-led?

Inadequate

The service was not well led.

There was a new registered manager who had been in post since April 2016 and had been fully registered with CQC in July 2016.

The service was unable to demonstrate significant progression since the last inspection and had not met all the breaches outlined in the action plan we issued.

We found multiple repeat breaches of regulation. People continued to be exposed to avoidable harm and some had suffered actual harm due to poor care practices from staff team who lacked knowledge and skill.

People were at risk of harm due to lack of robust audit and monitoring systems. Leadership and governance systems were still not adequately addressing the shortcomings within the service.

Staff's performance had not been sufficiently managed and staff who had put people at risk had not been supported effectively and continued to expose people to risks of actual harm and neglect.

Staff had not been adequately prepared for their roles due to lack of induction and training. Staff's request for support had not always been acted on resulting in underperformance and poor practice.

There were no 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 provider had sent notifications to CQC however some notifications had not been sent. We made a recommendation.

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 18 July 2016, and was unannounced.

The inspection team consisted of three adult social care inspectors including the lead inspector for the service.

Before the inspection, we reviewed information from our own systems, which included notifications from the provider, information received from whistle-blowers, members of the public, families of people living at the home and safeguarding alerts from the local authority. We contacted the commissioners of the service to see if they had any updates about the service.

All evidence reported in this report relate to the period from March 2016 after the first inspection in February 2016.

We gained feedback from external health and social care professionals who visited the home. We had received outcomes of safeguarding enquiries from Lancashire County Council Safeguarding Enquiries Team and regular updates from other associated professionals at the local authority. Comments about this service are included throughout the report.

Before the inspection, we reviewed the contents of the action plan for breaches issued to the provider following the previous inspection in February 2016 where ten breaches were identified under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We spent time observing and talking with people who lived at the home. We reviewed records and management systems and also undertook observations of care delivery. We spoke with eight relatives, seven people who used service, the registered manager, the providers, regional manager, and two other managers

from the organisation, the chef, four professionals who had visited the service and five care staff. We looked at five people's care records, staff duty rosters, six recruitment files, the accident and incident records, residents' daily records, handover records, records of residents', staff meetings, policies and procedures, medication and care file audits, service policies, medication records and service maintenance records.

Inadequate

Is the service safe?

Our findings

During our last inspection of Marsh House in February 2016, we found significant concerns in the provider'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. We also found the provider had failed to manage people's medication safely; people had been exposed to risk after falls, the provider did not protect people against abuse from staff and people had suffered actual harm from neglect. Risk assessments were not robust enough to mitigate any risks identified. Systems for identifying and managing risks were not effective as audits had not been acted on, the service did not always follow safe recruitment practices, staff had not received mandatory training to safeguard people and people were not assessed for safe evacuation during emergencies. We judged the safe domain as inadequate.

As a result of our findings we started to ensure appropriate enforcement action was taken to keep people safe. However the provider also sent us a report telling us what action they were going to take to meet the requirements of regulations 12 - safe care and treatment, 13 - safeguarding service users from abuse and improper treatment, regulation 14 - managing nutrition and hydration, regulation 18 - staffing, regulation 19 – fit and proper person of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in their action plan sent to us following the inspection of the service in February 2016. We reviewed compliance against regulations 12, 13, 14, and 18 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 continued breach of these regulations.

We gathered feedback from people living at the home; however this was limited due to some people's limited communication abilities and their dementia care needs. We asked those who could communicate with us whether they felt safe. People told us they were safe. One person told us, "Yes I am safe because if I was not you will know about it." And; "I worry for people living with dementia, who cannot speak for themselves." Another person told us, "I'm very happy here people are pleasant."
We spoke to a relative who told us "On the whole I'm happy. My biggest issue is the use of agency staff."

However we looked at whether staff had received training in safeguarding adults from abuse. There was a significant shortfall in staff training for safeguarding. Only five of 21 care staff had received training in this area. We found this lack of training and knowledge had resulted in a number of incidents which involved staff verbally and emotionally abusing people who used the service.

We found two incidents of abuse that we associated directly to the lack of training and knowledge. For example we found evidence a member of care staff had been recently dismissed as a result of gross misconduct. This care staff had been witnessed by other staff and visitors telling a person to 'shut up'. We looked at the training records and found they had not received safeguarding training. In another example we found another member of staff had been accused of shouting at people and swearing when asked to

assist people. This was a new concern involving a member of staff who had been previously accused of similar allegations. Records we checked showed they had not received training in dignity in care.

This evidence showed the direct impact that the lack of safeguarding training had on people living at Marsh House. It also meant people could not be assured of safe care and treatment from some of the care staff employed by the provider.

People were not protected against abuse from staff. We received ongoing concerns regarding abuse which included neglect and emotional abuse. The provider did not have effective disciplinary systems to deal with staff whose behaviour exposed people to risks. For example a member of staff had asked other staff members to falsify medication records and forge their signature as they had forgotten to sign for medication. Evidence we saw showed this member of staff had been formally suspended from administering medication however we found evidence they had administered medication while on this suspension. We asked the registered manager who informed us they were absent when this happened and that another senior manager had authorised this. This meant that the organisation's own policies had not been followed to effectively protect people.

In another incident the same member of care staff had suggested to another staff member that they did not charge batteries for a hoist so that they did not have to toilet anyone that afternoon as the hoist would be out of power. These were suggestions that we found to be encouraging neglectful practice which had a potential to expose people to abuse. Although these incidents had been reported to management by other staff, we found the response inadequate to address this behaviour; this was also compounded by the fact that the provider had previously received five complaints against this member of staff. At the time of our inspection another complaint had been made against the same member of staff. Performance management plans had been set for this member of staff and not followed through. This meant that provider had failed to put systems in place that ensured people could be protected from harm.

In another incident another member of care staff had signed that they had administered medication which had not been delivered and not in stock.

Further concerns of neglect had been reported to the local safeguarding team by a family member. One person had been left sitting on a commode for more than 45 minutes. During the inspection we observed call bells were left unanswered for long periods of time. Following the investigation on these concerns the registered manager had started to do spot checks to determine how long staff would take to respond to call bells. However during our inspection we observed this had not improved as people continued to wait for long periods of time. This meant that the provider could not be assured staff were safely providing care and treatment for people.

Risk management systems were not robust enough to support people and reduce harm. We found an example where risk assessments had been unclear and resulted in staff and the person being exposed to harm.

One part of this risk assessment directed staff not to insist on asking this person to have a wash if they refused once, however another part of the risk assessment gave opposing guidance, guiding staff to continue to ask and encourage if this person refused personal care. Evidence we saw showed that staff had continued to persuade this person to receive personal care which had resulted in a physical confrontation and attempts to harm care staff. This exposed people and staff to risk especially as the home was using agency staff who had limited awareness of people's needs.

In another example which showed staff at the home did not understand the processes of risk management, we found evidence where one person had been assessed by a senior carer as requiring close supervision due to high risk of falls. Evidence we saw showed the member of staff had brought this person from their bedroom where they felt this person was at more risk as they were alone. Staff had intended to supervise this person in the dining area; however, they left the person unsupervised to administer medication to other another person. On their return they found the person had suffered a fall and was subsequently admitted to hospital for medical attention. Although the care staff member had identified the risk around this person, they had failed to effectively reduce the risk by asking someone else to supervise the person.

Some risk management tools had been put in place to manage and reduce risks to people, however evidence we saw showed that care staff had not followed risk management guidance from professionals. The provider had failed to ensure care staff followed professional advice provided by dieticians and speech therapists to ensure people's nutritional needs and risks of choking from fluids were met.

We saw a weight monitoring chart for one person which showed for three months no weight monitoring had been undertaken. We then received an outcome of a safeguarding enquiry carried out by the local authority. Evidence we saw showed that the dietician had requested monthly monitoring of this person's weight and they had trained staff how to do this, however when the professional visited the home to review they found this had not been acted on. The dietician also noted that guidance provided by the speech and language therapist to ensure that the person's drinks are thickened had not been fully complied with. Although some drinks had been thickened the dietician reported that some drinks were found to have no thickener.

Failure to follow professional guidance on meeting this person's nutritional needs meant that the provider had failed to ensure they were effectively protected against risk of malnutrition and the risk of choking. The outcome from the safeguarding enquiry concluded that an act of neglect and acts of omission had occurred. The enquiry further raised concerns regarding risk assessments and care plans which were found to be unclear to ensure provision of safe and appropriate care.

Medicine management systems were not robust, placing people at risk of not receiving their medicines as prescribed. For example we found the deputy manager had carried out checks to identify whether people had enough medication in stock. Although they had carried out the checks and identified that one person had only one dose left for the following day which was Friday and two other people had almost run out and did not have enough for the weekend, they failed to highlight that these medications required ordering and/or had not ordered them in their capacity as the deputy manager who was in charge in the absence of the registered manager.
This was checked and picked by the registered manager on their return in line with the medication protocol agreed with CQC during the last inspection. The registered manager requested emergency prescriptions and people were provided with their medication.

Although this incident had not resulted in adverse impact on people using the service, it demonstrated lack of robust medication management systems. People could not be assured of continuity of seamless care and that their medication would be available in the absence of the registered manager, which can occur. This is the same breach of this regulation as at the previous inspection in February 2016. We had been assured by the provider that this issue had been addressed. They also informed us they now have a new medication management system which they advised will resolve this.

We found people were not always given medication as prescribed. One person was given a double dose of diazepam, which is a tranquillizing muscle-relaxant drug used mainly to relieve anxiety and agitation. Although the provider had sought medical advice, reported to safeguarding and CQC. Medical advice given

to staff demonstrated that the person had not suffered harm due to this medication error.

However the incident demonstrated that the care staff involved had failed to follow nationally accepted guidance which directs that staff should check that they are giving the medication to the right person, at the right time, right dosage and through the right route and people have the right to refuse the medication. This incident had a potential to harm the person due to overdose.

In another incident involving medication, care staff administered pain relief patches on a person without removing the old patches first. Staff had recorded that they had removed the old patches when they had not done so. This had put this person at risk of harm via an overdose. This was reported to local authority safeguarding and the findings were substantiated.

People were not observed to ensure they took their medication. One person was found not to have taken medication from the previous night. Care staff who administered the medication had left it in this person's room and not observed them taking it; this medication was signed as taken when the person did not actually take the medication. This meant people could not be assured they could receive their medication as prescribed which exposed them to risk of deterioration of their health conditions.

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 did not reflect people's individual needs and the support they required. The purpose of a PEEP 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.

We looked at how people were protected by the prevention and control of infections. We found the service did not have effective infection control measures in place.

People were exposed to significant risk of infection and cross contamination. We observed staff had not followed effective infection control measures by disposing of cleaning materials that had been used to clean human waste in the kitchen bin. We observed that they were not wearing gloves or an apron while cleaning soiled chairs and floor, and failing to wash their hands thereafter. A general mop had been used to clean a contaminated area instead of a designated red mop. We also noted care staff and managers walking in and out of the kitchen without wearing protective gear to avoid cross contamination.

On the day of inspection we found the home to be malodorous throughout the day. This issue was raised by a number of visitors and residents we spoke to. This meant people had been exposed to high risk of contamination and spread if infection. We informed the registered manager of this and they informed us that they had deep cleaned the home three times since they had been in post in April 2016. We referred the service to the local infection control team.

These issues were a continued breach of Regulation 12(1) (2) (a) (b) (c) (f) (g) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

We found two incidents where people had been exposed to actual harm as a result of failure to follow moving and handling guidance. One person had been left with bruised hands after a member of agency care staff working at the home attempted to assist them to stand up by pulling them by their hands. Staff had failed to follow guidance on moving this person which stated they required two people for transfers. In

another incident two agency care staff had been witnessed by another staff member attempting to assist one person from the floor by lifting them under their arms. The person is reported to have fallen back to the floor on each attempt. Records we saw showed this person suffered bruises. The two care staff were later advised to use the right aids to reduce injury to this person.

We asked the registered manager how they inducted and prepared agency care staff before they started their shift to ensure they were aware of people's needs. They told us there was no formal induction for staff who were new to the premises apart from being shown where the fire exits where located and a tour of the home. They added that there was a one page profile in each person's room for staff to read. We however did not feel it was practical for care staff to be expected to read people's profiles when people had called them for help or in an emergency scenario. This information could have been provided to staff as part of their induction. This meant people continued to be exposed to risk of poor care practice and improper treatment due to a lack of robust guidance.

We found one person who was significantly neglected due to a lack of personal care. This person lacked mental capacity to decide whether they could accept or refuse care. Evidence we saw showed that this person had been doubly incontinent on many occasions and had refused all attempts by staff to support them. This had resulted in this person walking in soiled clothes covered in urine and faeces, sore skin and long finger nails with dry faeces visible underneath them. This person required topical creams due to risk of skin damage however it was not possible to administer as they could not comply with the care they required.

We noted that the registered manager had referred this person to other professional agencies for assistance however without success. We however found that the care home had failed to fully comply with the contractual agreement with person and/or the local authority which required that if the home was unable to meet the a person' needs they needed to request for the contract to be terminated to ensure the local authority and families move the person without delay

Evidence we saw demonstrated that the home had known for months that they were unable to meet this person's needs however we found they had not acted decisively to use the option that was available to them and in the best interest of this person.

The failure by the provider to issue notice meant that this person was further subjected to neglectful care. Regulations require that providers should exercise their legal obligations fully when supporting people who lack mental capacity. Failure to do so constitutes neglectful care. The failure by the provider had resulted in this person and other people who lived in the home exposed to risks of infection, harm and improper treatment.

Following our inspection we shared our concerns with the local safeguarding team and asked the registered manager to contact the local authority in order to ensure all that is possible could be done to ensure this person was in the right setting. The provider issued the notice of termination as recommended by CQC during the inspection and the person was moved to another service shortly.

We found these incidents constituted repeated breaches of Regulation 13(1) and (2) (3) and (4)(c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

Staff were mainly agency staff and staff from other homes owned by the provider. People told us they were concerned about the high usage of agency staff as it affected consistency of care. We spoke to the provider

and the registered manager and they expressed the challenges they had faced recruiting staff due to the location of the home, poor transport network and also the current CQC rating of the home. We saw evidence the provider was attempting to recruit more staff and had engaged recruitment agencies to help recruit permanent staff. Interviews for potential staff were taking place the day of our inspection.

We shared our concerns that the use of agency staff was not a concern as long as staff were properly prepared for the role and induction was provided which was not the case for this service. Majority of relatives we spoke to told us that there was sufficient staff to meet people's needs. We however received complaints from some people that their loved ones had been sat waiting for help for as long as 45 minutes. We also observed call bells response times were longer during the inspection. This meant that people may not receive the support they needed in a timely manner. The registered manager assured us that they were now monitoring the response times and testing them personally by triggering the alarm bell in rooms and waiting to see how quickly staff responded.

The service followed safe recruitment procedures. Staff files we looked at 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).

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Marsh House in February 2016 we found the service had not taken effective action to ensure people's rights were always protected. This was because; consent had not been obtained through best interest decision making processes prior to the provision of specific areas of care, 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 home had failed to effectively meet people's nutritional and hydration needs and the provider had failed to assess people's mental capacity to make their own decisions about their care.

As a result of our findings we took appropriate action which we will report on in due course. The provider sent us a report telling us what action they were going to take to meet the requirements of regulation 11- consent, regulation 13 - safeguarding service users from abuse and improper treatment, regulation 14- managing nutrition and hydration and regulation 18 -staffing.

During this inspection we reviewed requirements outlined in the action plan the provider sent us following the inspection of the service in February 2016. We reviewed compliance against the regulations 11, 13, 14, and 18 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014.

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).

Progress had been made in respect of applying for DoLS authorisations for people whose care involved restrictive practice. All DoLS applications had been made for people who required them.

We found little progress had been made with respect to meeting people's nutritional needs. Staff had started to receive supervision however there was no progress in respect of staff training, we therefore found continuing concerns that the provider had not met the required standard and was in continued breach of these regulations.

At the previous inspection in February 2016 we found the provider was not working in line with the key principles of MCA. This included insufficient management of DoLS. 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. Best interest discussions had not taken place with the families or representatives for people who lacked capacity to make decisions about their health and welfare and staff had not attended training to understand the principles of the Mental Capacity Act 2005. All DoLS authorisation requests had been sent to the local authority.

Little progress had been made in respect of mental capacity assessment and seeking people's consent. For example, in two of the care plans we reviewed we found people's mental capacity had not been assessed appropriately to determine whether they could make specific decisions or not. We found family members had signed consent to dispose medication and consent to photography however in some documents the person had signed their own consent. There was no mental capacity assessment to explain whether this person could not make decisions on their own or why others had made decisions on their behalf. In another case we found no assessments of mental capacity had taken place, a lasting power of attorney (LPA) for finance and property only was in place. There was no LPA for Care and Welfare in place; however a family member had signed all consent documents. A mental capacity assessment had not been completed to demonstrate that the person had lost capacity along with no evidence of any best interest decisions. There was nothing to indicate that the LPA for finance and property could now take effect, and the named person could make decisions on the person's behalf in respect of these matters.

Other people had been assessed as lacking mental capacity for one specific decision however the same mental capacity assessment had been used for other decisions which were not related. There were no best interest decisions meetings when people had been deemed to lack mental capacity. Decisions had been made by care staff without consulting others.

Care staff and management we spoke to lacked sufficient knowledge on the principles MCA 2005. For example while discussing concerns around one person who had been assessed as lacking mental capacity to meet their own needs, the regional manager for the home commented that , this person had made unwise choices by not complying with care support. In line with MCA 2005, a person who has been assessed as lacking mental capacity cannot be described as making unwise decisions as they lack awareness of the consequences of what they would be doing.

This lack of understanding on the principles of MCA 2005 was found in our previous inspection in February 2016. We raised concerns and requested that staff are trained to enhance their knowledge and skills. We had signposted and arranged for the home's management team to be supported by people who lead on mental capacity awareness at the local authority. The provider informed us some staff had been trained and they were waiting for certificates. However during this inspection we found 77% of the care staff had not received this training.

This lack of training has been raised as a concern by the local authority's contracts monitoring department and the provider has assured that they have now acquired a trainer facilitator to provide the required training.

These failings amounted to a continued breach of regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014- Need for consent

Since starting the role in April 2016, the registered manager advised us that they were working towards providing supervision and appraisal for all staff. Staff records we reviewed showed staff had received one-to-one supervisions recently and some had been planned for other staff. We however found staff who had expressed they needed support to do their job had not been supported which had impacted on their performance. Supervision had not been effectively used as a way of identifying staff's developmental needs, but rather as a task that needed to be completed.

There was a significant shortfall in the training that the provider required staff to complete in order to fulfil their role. For example, not all staff had completed training in moving and handling. 90% of staff had not received training in food hygiene, this included the chef. 90% of staff had not received training in fire safety.

More than 86% of the staff team required training in safeguarding adults, more than 84 % of staff were not trained in infection control, including the chef More than 70% of care staff had not received an induction or training in; dementia care, end of life care, person centred care, health and safety training, mental capacity and DOLS training.

This shortfall in training had been pointed to the provider by the commissioners from the local authority in November 2015. We found this unresolved in February 2016. During our previous inspection in February 2016, the provider had made an undertaking that training needs would be met as a priority however we found this had not been the case. The lack of training and knowledge had continued to cause a significant impact on the care delivered as demonstrated in the breaches of regulation throughout this inspection. People had been placed at risk as they could not be assured that they could be supported by staff who had skills and knowledge of best practice.

This was a continued breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014-staffing, in conjunction with regulation 12 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Safe care and treatment.

During our last inspections in November 2014 and February 2016 we found the provider did not have suitable arrangements for ensuring service users were protected against the risks of inadequate nutrition and hydration.

During this inspection we found some improvements had been made. We observed people being offered a choice of meals and drinks during breakfast. People were encouraged to eat and drink and drinks were available throughout the day. We however found concerns around staff deployment during main meals. People who preferred to eat their meals in their own bedroom and those who were bed bound were served toward the end of the meal times. For example we found people had not been served lunch by 13.45hrs when lunch had started around 13.00hrs. This had left people waiting for too long before meals were served.

People's choice of meals had been compromised by the directive that had been given to staff not to serve people a cooked breakfast after 10.30 in the morning. The reason for this decision was documented as being that people would not be able to eat their lunch if they had a late breakfast. This removed people's choice to have a late breakfast and we did not see evidence to see this was discussed with people. It was felt that this was not a person centred approach.

Some people we spoke to expressed they did not like the meals at the home. People felt told us they preferred freshly cooked meals, not pre packed meals. We spoke to the registered manager and they informed us they had sent questionnaires to seek people's views. We also saw the registered manager had asked people's views using questionnaires however these had not been returned.

Evidence we saw showed the home had assessed people at risk of malnutrition and dehydration. They had maintained diet and fluid intake records and made some referrals to specialist professionals such as dieticians to ensure people received support with their nutritional needs. We however found this was not consistently being followed and staff lacked knowledge of why this was done and what to do after recording the information. For example people who had showed a significant loss of weight had not been referred to specialists and their care plans had not been updated. This was regardless the fact that staff had acknowledged the weight loss in the care records. Staff did not appear to show awareness on what to do with the information.

In another instance a person required fluid intake recording to ensure they took adequate fluids to avoid dehydration, however staff had not effectively recorded and added the total of fluids taken at the end of the day to determine whether adequate hydration requirements for this person had been achieved. We found this person had been exposed to risk and this had been reported to us before our visit. This had been made worse by the fact that people had complained about the high temperatures in the home. We shared our findings with the registered manager and recommended they refer to best practice on managing people's nutrition and hydration.

These shortfalls in meeting people's nutritional and hydration needs were a continued a breach of regulation 14 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Meeting nutritional and hydration needs

The environment was designed to meet the needs of the people living at the home. This was an improvement from our last inspection in February 2016. Many people residing there were living with dementia and the environment had been designed to take account of national guidance in relation to dementia-friendly environments. For example, colour had been used to support people with finding their way about. The doors and signs for bathrooms and toilets had been changed to colours that assisted people to navigate their way through the home safely. Bedroom and bathroom doors were easy to distinguish from the walls. Colour had been used in toilets, such a different coloured toilet seats to assist people in finding the toilet. There were points of interest, such as photographs or artworks of a size that could be easily seen.

We could see from some of the care records that people had regular input from professionals when they needed it, including the GP, district nurse, optician and chiropodist. A record template was in place to record all consultations with health or social care professionals. Some people received specialist health care input when necessary. This included input from the local community mental health team and the dietician. We spoke with a visiting health professional who said, "The staff are trying their best now and ask for support."

Inadequate

Is the service caring?

Our findings

At our comprehensive inspection of Marsh House in February 2016 we found the provider had failed to provide dignified care that respected people's autonomy and independence. This was because staff had been observed to treat people in an undignified manner. People had not been spoken to with respect and some staff had refused to assist people to use the toilet.

As a result of our findings we ensured appropriate action was taken to keep people safe which we will report on in due course. In the meantime the provider sent us a report telling us what action they were going to take to meet the requirements of regulation 10 (1) (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014- Dignity and respect

During this inspection we reviewed requirements outlined in the action plan sent to us following the inspection of the service in February 2016. We reviewed compliance against regulation 10, 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 continued breach of these regulations.

Before the inspection we received concerning information regarding the way people had been treated by staff. For example we received concerns some staff had used offensive language towards a person who had requested help. One person living in the home had started to refuse to receive personal care when certain members of care staff were on duty. This was an ongoing concern that we had raised in our last inspection. Another member of care staff had been witnessed by people visiting the home, and other carers, shouting at a resident telling them to 'shut up'; we later learnt that this care worker had been dismissed.

Another example that displayed a lack of care was a staff member who had suggested to other staff that they do not charge hoists used to assist people with transfers so that they 'do not have to toilet anyone that afternoon'. Hoists are lifting equipment that is used to transfer people who are unable to do so independently. They work with a re-chargeable battery which needs charging regularly.

The same staff member also made a request to other staff members to falsify medication records on their behalf. Other staff members disclosed this to the person in charge at the time. This was a neglectful and uncaring attitude towards people who relied on care staff for help and assistance to meet their basis needs. This was compounded by other evidence we got of people being sat on the commode for up to 45 minutes. We observed care staff taking a long time to answer call bells during the inspection which meant people had been left for lengthy periods of time waiting for help.

We spoke to the registered manager regarding the care staff whose behaviour was unprofessional and neglectful, they advised us that one of the issues had happened before they joined the home and that head office was dealing with this. The performance management systems they had in place had failed to monitor staff effectively.

This was a continued breach of regulation 13 (3) (4) (c) (d) of the Health and Social Care Act 2008 (regulated

Activities) Regulations 2014- safeguarding service users from abuse and improper treatment.

People were not effectively supported to ensure their personal hygiene had been met. We observed two people whose personal hygiene needs had not been met. One person had not been supported to ensure their oral hygiene was maintained. This person was unable to meet their own oral hygiene and had been assessed as needing assistance twice a day. Although this had been assessed we found this was not happening, the registered manager could not show us how this was being carried out. We had received concerns regarding this, we saw this person and checked their care records and we could tell that this person was in need of oral hygiene.

We observed another person who had soiled themselves during meal times. Care staff were unable to assist this person to wash and change. Records that we saw showed this had been going on for a few months and care staff had consistently attempted to support this person however this person had resisted support.

We found the home had engaged other agencies including the local authority commissioners. However they had not acted promptly in accepting that they were not in a position to meet this person's needs and that the home was not the right place for this person as their needs were not being met. The failure for the home to exercise their contractual obligation meant that they had neglected this person's needs. We shared our concerns with the registered manager and asked them to contact the local commissioners. Following the inspection we raised a safeguarding alert for this person.

This was a continued breach of regulation 10 (1) (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014- Dignity and respect

Relatives and people who lived at the home told us some staff were caring. They told us they felt listened to. They however commented on the use of agency staff and that staff seemed rushed. One person told us, "All the staff here are marvellous." Feedback from relatives we spoke to was also positive, some told us, they had seen some improvements and that they feel better that something is being done about the quality of the care.

Professionals we spoke to expressed concerns about certain care staff and their attitude towards people they care for. They told us, "Some care staff are very defensive and will not take advice lightly." We spoke to the registered manager regarding this feedback about staff and they advised they were aware of who these staff were and that this was being dealt with by their head office.

During the inspection 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. People were guided with their mobility.

We saw evidence people were asked about their views regarding meals. The provider had sent out surveys to ask people for their suggestions and people told us residents and relatives meetings had took place and people had been kept informed about the improvements that the provider had planned.

Care records that we saw, and relatives we spoke to, informed us that people were involved in the care planning process and review. One relative told us, "Yes she [registered manager] is trying to arrange a meeting to discuss the care plan." Another one said, "They invited me however I cannot make it." This meant that people had been considered for their involvement in planning for their care.

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection of Marsh House in February 2016 we found the provider had failed to provide person centred care. This was because people's records of care did not reflect the care that people were receiving and people's preferences had not been respected.

As a result of our findings we ensured appropriate action was taken to keep people safe, which we will report on in due course. In the meantime the provider sent us a report telling us what action they were going to take to meet the requirements of regulation 9 (1) (2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 - Person centred care.

During this inspection we reviewed requirements outlined in the action plan sent to us following the inspection of the service in February 2016. We reviewed compliance against the regulation 9, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014 and found some improvements had been made to the care files and the way some of them had been written had reflected some person centred approach however this was not consistent throughout the care files we looked at. We had continuing concerns that the provider had not met the required standards.

We asked people who lived at the service if they felt their needs and wishes were responded to. People told us, "I think things have changed, they are trying hard." However we found people had been exposed to risk of harm because the home did not have enough, working equipment to support people with transfers and toileting. We found the home had one working hoist which was faulty as it had developed an electrical fault. This fault had developed on Sunday and was resolved on Tuesday.

During this period people who required assistance with transfers to the toilet had reported being left waiting for the toilet for as long as one hour. Care staff had told people they could not assist as the hoist was not working. We saw a complaint and a safeguarding alert to the local authority regarding this. The registered manager or the on-call manager had not been informed of the incident on the day.

This incident had a significant impact on people who relied on staff and hoist for transfers and toileting. Two people had been left distressed. We spoke to the registered manager who informed us they had not been informed of the faulty hoist until the day after when they returned to work on Monday. They advised that they had condemned another hoist the week before and had not replaced it. Following this incident they called for repairs and bought a new hoist. We asked if there was a contingency plan for manual lifting equipment and were told there was none. The registered manager informed us they had emergency contact details for on call person and out of hours support however staff had not used this to seek support. This had resulted in the home failing to respond promptly to ensure another hoist was sourced first day of this happening.

We found the home had failed to protect people against the risk of neglect, people's rights and dignity had been violated. This meant people could not be assured they would receive prompt assistance when they needed the toilet.

This was a continued breach of regulation 15 (3) (4) (c) (d) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014- safeguarding service users from abuse and improper treatment.

We found the care that had been provided was not tailored in a person centred manner. People's preferred choices had not always been followed. Care files we reviewed were not written in a way that ensured care and treatment of people was appropriate, met their needs and reflects their preferences. For example we found one person's file stated they preferred female staff to provide them personal care, however we found some male carers had attempted to provide this person with personal care which had resulted in an incident where this person had displayed challenging behaviour.

Although this person may have had other reasons to react this way such as their mental health needs, it was possible that this was their reaction to being provided care by male workers against their preference. This meant that care provided to this person did not reflect their personal preferences and had a potential of violating their dignity.

Another person's care file did not reflect the level of support they needed. We found this person had not been eating their meals and required a lot of encouragement. We had observed this person had not eaten and had refused meals. When we asked the registered manager if they had been offered alternative meals we were informed carers had to constantly keep going to this person's room and keep offering them food. However when we looked in this person's care file we found they had been assessed as being able to maintain their nutrition independently with no problem and no mention that staff had to offer a lot of encouragement.

We also noted that this person had lost a significant amount of weight in one month. As the care file did not identify that this person needed a lot of encouragement, we felt that staff had not fully supported this person in the way the registered manager had told us. This was compounded by the fact that the service had a high usage of agency staff over the past few months who required clear guidance about what support people needed as they would not be familiar with people's requirements.

We observed one of the managers updating people's dependency assessments, these are tools that the home uses to determine the level of support that each individual needs and determine how many staff to use per day. The manager did not work in the home on a regular basis and did not provide personal care. We did not feel that this person was able to accurately determine the level of support that people required as they did not have enough knowledge about each individual's daily care needs. They were not supported by regular care staff who would be familiar with people and did not have people's daily notes that stated how people's care had been delivered over a period of time. This approach to care planning did not reflect a person centred approach and had a potential of providing an inaccurate reflection of people's need and support being inaccurately assessed resulting in poor care and outcomes as demonstrated above.

We found the above evidence amounted to a continued breach of regulation 9 (1) (c) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014 – Person-Centred care

Staff members we spoke to told us people's needs had become complex however staffing ratios had not changed. Staff told us they struggled due to staff shortages and felt that at times people had to go to bed as late as 23.00hrs and 00.00hrs until people who require two carers have been attended to. We looked at the tools that the provider use to determine people's level of needs and the number of staff required.

We found shortfalls and discrepancies with how the provider determined the number of care staff required. We looked at care records of two people and the level of support that they had been assessed as requiring,

we found information was incorrect. For example one person had been recorded as being able to 'eat without help' however during the inspection; we were told by the registered manager they needed feeding. We also went to this person's room and observed a member of staff feeding them. We found this same concern in our last inspection in February 2016 and the local authority had also expressed concerns regarding the information on another person's record before our inspection visit in July 2016.

In another example we found one person who had been exposed themselves to risk of skin breakdown, infection and neglect on more than five days a week and at time daily had been assessed as 'never exposing themselves to risk or exposing themselves to risk less than once a week'. This information was used to determine how many members of staff would be required each week. We found the provider had given people with high needs a low score which meant that the tool they used would suggest to them they needed fewer care staff. The lack of accurate information on what people required had exposed people to risk due to inadequate staffing levels. This is further supported by the observations we had regarding response times to call bells.

We discussed the issue around staffing with the registered manager who informed us they are recruiting more staff. We saw people coming for interviews on the day of our inspection.

People we spoke to told us they had been involved in meaningful day time activities. People were provided with stimulating activities to promote their wellbeing or to prevent social isolation. For example, one person told us, "We go out on trips, the manager arranges this for us." The registered manager confirmed they arranged different activities for people.

Evidence we saw showed people had been supported and encouraged to maintain relationships. People had been able to maintain contact with their families. They told us their relatives could visit anytime they wished to. We saw evidence relatives had been encouraged to come and join their loved ones for lunch.

Relatives of people who lived at Marsh House told us they could visit anytime of the day or week, 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 saw evidence some people had been referred to other professionals and there were engagements with specialist professionals. This however had not been consistent and follow up on advice from other professionals had not always been sufficient. Guidance from other professionals had not been followed in some instances. For example Doctors asking for observations and staff not doing this, and Doctors asking for certain medication to be stopped without this happening.

We found complaints had been received and dealt with and there was a complaints procedure on display in the home to provide people information on how to complain. Relatives we spoke to told us they knew who to complain to. People told us that the registered manager had acted on things that they had suggested.

Inadequate

Is the service well-led?

Our findings

There was a new registered manager who had been in post since April 2016. This followed the departure of the previous manager who had been in post at the time of our inspection in February 2016. The registered manager assumed her duties in April 2016 and is now fully registered with CQC since July 2016.

At our comprehensive inspection in February 2016 we found the provider had failed to provide appropriate management oversight and leadership. This was because the registered manager at the time had failed to provide staff with guidance and there were no robust quality assurance systems in place. The provider had failed to submit notifications to CQC and they had failed to display ratings from their last inspection.

As a result of our findings we ensured that appropriate action was taken to keep people safe and we will report on this in due course. In the meantime the provider sent us a report telling us what action they were going to take to meet the requirements of regulation 17- good governance, regulation 18 - staffing, regulation 20A – requirements as to display of performance assessments of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 and regulation 18 – notification of other incidents Care Quality Commission (registrations) Registrations 2009.

During this inspection we reviewed requirements outlined in the action plan the provider sent us following the inspection of the service in February 2016. We reviewed compliance against regulation 17, 18 and, 20A of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014 and also regulation 18 of Care Quality Commission (registrations) Registrations 2009.

We found some improvements had been made with regards to displaying of performance assessments, notifications had been sent to CQC, however not consistently. There were some minor improvements with regards to governance. However there was little in the way of improvement with regards to staffing, training and audits and quality assurance systems , this had impacted on the delivery of care and the quality of care people received. We had continuing concerns that the provider had not met the required standards.

The service had inadequate systems in place to ensure the delivery of high quality care. During the inspection we identified continued failings in a number of areas. These included person centred care, consent, medicine management, managing risk to people and nutrition/hydration, safeguarding people from abuse and managing staff, and lack of suitably qualified staff to deliver care. There were ongoing concerns that the provider had not addressed adequately in line with the action plan that they submitted.

A new medication system had been established in the home, and had been operational for more than a month on the day of this inspection. We however found medication audits had not been completed under this new system. We carried out our own audits and found a number of concerns with medication that could have been picked by an internal audit. In 15 medication administration records we saw 11 of these staff had not signed whether they had given medication or whether people had refused. This meant the provider could not assure themselves if people had received their medication as prescribed.

In another incident the registered manager had discovered on a Friday that three people did not have enough medication to go through the weekend. This was due to lack of robust medication stock management. This was a significant concern during our last inspection. Medication incidents and errors were not routinely recorded and action plans set. The service had only reported to local authority safeguarding and not completed their own incident report and actions plans. This meant that the home did not track and analyse trends around medication errors and therefore could not learn from these errors.

Improvements had not been made with quality monitoring processes. Many of the issues we identified at the last two inspections (November 2014 and February 2016) had not been addressed, such as the lack of management oversight on audits lack of action plans for concerns raised by audits. For example we found audits for medication completed and care planning had been delegated to other members of staff in line with the organisation's policy however no action plans had been devised by the registered manager. The organisation's policy states that the registered manager could delegate auditing however they were responsible for devising action plans. This meant that issues that had been identified had been left unresolved which meant that there was a likely chance failings would happen again.

We found systems for identifying and analysing risks that had been developed and some improvements had been made which allowed certain risks to be tracked and trends to be developed for incidents such as falls and other accidents. We however found this analysis had been done at a higher level and did not always translate into action within the home. For example we saw spreadsheets which recorded all accidents and incidents in the home within certain periods; it also gave details of what types of accidents, the frequency, times and place. However the evidence from the analysis had not been turned into practical action. For example, what should be done if people are falling in a particular location of the home or at a particular time of the day.

In another example we found there was a system for auditing medication errors which was not monitored adequately or implemented. We found a new medication system had been put in place which the registered manager felt was better and easier to manage. We however discovered that although the new system had been in place for over a month, it had not been audited by the registered manager. As a result we found medication errors which could have been picked up if audits had been completed. We found people's medication had not been signed for at the time of administration. This was in eight people's records that we checked. We also found an instance where medication was given at wrong times for two days however this was later discovered and corrected

In some instances we found audits had been carried out and some action plans drawn up however the action plans did not contain all the issues identified as requiring action. For example one audit identified a lack of pictorial menus for people living with dementia and the presence of malodorous smells in the dining area, however no actions plans had been put in place to address these issues. We found this to be the case in our last inspection; the provider had systems to undertake audits however these are not always used to improve the service and quality of care that people received.

This is also reflected in the action plans that the provider gave us following our inspection in February 2016. We were informed all staff training would be completed by 15 March 2016 however training had not been completed in the majority of the mandatory areas with an average of 80% of the staff team lacking training in key areas such as fire safety, food hygiene, safeguarding, and dignity in care and infection control.

We looked at audits completed for catering, laundry, dining experience, maintenance, medication, resident's finances, fire walk round, staff files and care plans. The action plans we saw did not always reflect facts, for example one training audit stated that all staff were currently on safeguarding training 12 March

2016. However during the inspection we were told that the organisation's training centre was not working out and that they had employed a trainer who was yet to start. The training matrix reflected that out of 21 staff members only five have received training in safeguarding.

Another audit stated that all files were compliant with mental capacity act and people had best interest meetings when they lacked capacity, however when we looked in care files, we found this not to be the case. This meant that the action plans could not be relied on to provide an accurate account of what the provider had intended to do or was doing.

Some of the audits that we found appeared to have been backdated. Audits had taken place and found care files had not been reviewed however information had then been added into the files after the audit to appear as if the information that the audit had identified as missing had always been there. This could be seen as an attempt to mislead the inspection team or those who monitor the home's performance.

We found the provider had failed to demonstrate the ability to analyse and learn from experiences and incidents within the service. There was no evidence of in depth analysis of why incidents had occurred in the home. For example staff who had been involved in, dismissals, abusive behaviour, neglect of service users, unprofessional behaviour and whose performance was unsatisfactory had not received induction, safeguarding, and dignity in care training. This was the case with concerns we found around poor infection control practices in the home. Staff had not received infection control training including the chef.

In another example a significant number of incidents had involved agency staff; however we did not see any evidence despite asking to show how the provider had analysed why this had happened. We observed agency workers not following the home's procedures in infection control and we had received safeguarding incidents where agency staff had tried to move people unsafely resulting in actual injuries and failed to administer medication the right way. We were told the induction process merely involved showing agency workers where fire exits were located. We found a link between lack of induction and poor service delivery. This exposed people to risk of actual harm.

We looked at the organisation's policy and procedures and found there was no induction policy for agency workers. We asked for a policy on this and we were told there was no policy. A new policy was then written on the day of our inspection. This policy did not say how the service will ensure agency workers would be made aware of people's needs on their first day to the service.

We found evidence there was inadequate support systems to ensure staff could carry out their duties effectively. We found staff did not received adequate training for their roles. Supervision records we saw showed staff had expressed they needed additional support to fulfil their role however we found this had not been acted on and staff had been questioned about their lack of knowledge and skill when they had requested support and not received it. This was evidenced by the lack of training.

Disciplinary processes at the home continued to cause concern. The provider did not have robust systems to ensure people could be protected from care staff who had been alleged and found to be abusive towards people living at Marsh House. We saw evidence of how they had dealt with one incident appropriately when allegations had been made. However, we found there were a lot of inconsistences with other care staff who caused more concerns to people. People's relatives, other care staff and visiting professionals had raised concerns.

We saw an example of one care staff who had been made suggestions that could lead to people being neglected and harmed, and evidence of staff who had falsely recorded that medication had been

administered when the said medication was not in stock. Although the provider was aware of this and had put a performance management system in place, we found this was not being followed effectively. The registered manager had not followed through with the monitoring system that had been put in place by their predecessor. This meant that there was no consistence in dealing with care staff whose behaviour and actions could pose risk to people.

We had concerns that staff had been encouraged to complete paperwork and ensure everything was recorded, however the evidence we found indicated that whilst effort had been spent on recording the actual care was not being delivered in line with what had been written. There was no robust quality assurance systems to identify if people had received the care that they were assessed as requiring.

The provider was unable to demonstrate that breaches in the regulations (November 2014 and February 2016), as outlined in our recommendations, had been met.

This was a continued breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure the service was well led.

We asked people who lived at the service and their relatives if they thought the service was well led. One relative told us, "We can see they are trying however more needs to be done." and "The manager is a doer." Another person told us, "Moral had gone down, it's not a happy atmosphere." Evidence we saw supported this claim that there was some tension within the staff team. The registered manager advised us they were aware of this and were working to resolve it.

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." One professional expressed that the new registered manager is trying, "She is trying however it takes a lot to change the culture."

Staff we spoke to expressed that they felt the new registered manager was responsive and listened however they felt their requests for additional support had not been listened to. We however noted that the registered manager and the provider had been attempting to recruit additional care staff.

Staff meetings had been held and evidence indicated service developments had been discussed with staff."

The registered manager had some understanding of their responsibilities and the regulations that they needed to follow. They understood their responsibility to follow regulations and to take responsibility of delegated tasks. We however found they did not have a full understanding of some aspects of their responsibility such as the types of incidents that are supposed to be reported to CQC and the need to analyse incidents and devise effective action plans, especially for medication issues.

The shortcomings in management and leadership meant that the provider had failed to identify the issues that we found, which had resulted in people continuing to receive poor care.

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities however notifications had not been submitted for allegations that one member of staff had encouraged others to falsify medication documents and another incident where they had suggested not charging hoists to avoid toileting people. These were reportable incidents. Failure to submit notifications can result in CQC being unable to effectively exercise its regulatory duties. We recommended that the

registered manager follows CQC guidance for providers.

The registered manager responded to our requests for information. We requested additional documents and they sent them to us the following day.