Mrs R Ghai

Marlyn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Marlyn House is a care home providing personal care to 18 people at the time of the inspection. The home is registered for up to 18 people. People have access to their own bedroom along with communal spaces including lounges and gardens.

People's experience of using this service and what we found
People did not always receive safe care, as care plans and risk assessments were not always in place. When events or incidents had occurred, these were not always documented, and it was unclear what action had been taken. There was no evidence lessons were learnt when things went wrong. Infection control procedures were not always followed to ensure the spread of infection was reduced. There were safeguarding procedures in place however these were not always followed to ensure people were protected from potential harm.

The systems in place were not effective in identifying areas of improvement and often there were no audits in place or inconsistently completed. Documentation was not always available or stored where the manager or provider thought it was. Key information had also not always been documented. For example, when the someone had fallen. We were not always notified of events that had happened at the service.

We received mixed views on staffing, there was a dependency tool in place that worked out the staff levels for the home.
Improvements had been made to how medicines were managed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Where needed capacity assessments and best interest decisions were in place.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (Published 2 March 2020) and there were breaches of regulations.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to infection control, safety and medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marlyn House on our website at www.cqc.org.uk.

During this inspection we carried out a separate thematic probe, which asked questions of the provider, people and their relatives, about the quality of oral health care support and access to dentists, for people living in the care home. This was to follow up on the findings and recommendations from our national report on oral healthcare in care homes that was published in 2019 called 'Smiling Matters'. We will publish a follow up report to the 2019 'Smiling Matters' report, with up to date findings and recommendations about oral health, in due course.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 12, Safe care and treatment, regulation 13, safeguarding service users from abuse and improper treatment and regulation 17, Good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information, we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions of the 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.
Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led
Details are in our well-led findings below.

Marlyn House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by experience made telephone calls to people's friends and relatives.

Service and service type
Marlyn House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was not a registered manager in post. A new manager was in post who had started working at the home recently. They had not yet applied to register with us.

Notice of inspection
The inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since our last inspection. We also gathered feedback from the local authority.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
During our inspection we spoke with the provider, the manager and three care staff. We spoke with four people living in the home. We also spoke with eight friends or relatives on the telephone. We looked at the care records for ten people. We checked that the care they received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the home.

After the inspection.
We continue to review the information we held about the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure risks relating to the safety health and welfare of people using the service were assessed and managed. Medicines were not always managed in a safe way.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

- When incidents and accidents occurred within the home, there was no evidence reviews were taking place after these had occurred. Where care plans and risks assessments were in place for people, these had not been updated to reflect these incidents. No action had been taken to reduce the risk of these further occurring. When people had individual known risks, such as falls or absconding, there were not always care plans or risk assessments in place for this.
- Not all falls that had occurred in the home were documented. When falls had occurred and were documented, there was no evidence action had been taken to reduce the risk of further falls. The provider or manager were unable to tell us what action had been taken.
- When people had displayed periods of emotional distress, we saw not all of these incidents were documented. There was no guidance, care plans or risk assessments to show how to support people during these times.
- People were placed at an increased risk of choking. The manager told us one person required a certain diet, we saw they were eating foods that was not in line with this. There was no documentation in place stating what food the person could eat. We also saw people were not always sat in safe positions to eat, in line with their care plan. We observed one person was lying down, asleep in bed with food in their mouth. We alerted staff to this who took action.
- When people were unwell staff did not always offer people support during this time to ensure they were safe. An ambulance had been called for one person, staff did not sit with or observe this person whilst waiting for it to arrive.
- We observed that the kitchen door remained unlocked and the kitchen was unsupervised throughout, despite an incident of concern that had happened due to the door being unlocked. People continued to walk independently around the home, including in this area. This Increased the risk of this incident reoccurring. We also observed the medicine cupboard and medicine trolley were frequently unlocked with no staff in attendance. People independently walked past this area. This meant medicines were not stored safely.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Learning lessons when things go wrong
● As concerns were not being identified by the provider or manager, there were no action plans in place identifying areas of improvement or where lessons could be learnt. When incidents had occurred in the home these were not reviewed to reduce the risk of reoccurrence. Therefore, this information was also not used to ensure lessons were learnt after incidents occurred.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors, staff and people from catching and spreading infections; as we could not be assured personal protective equipment (PPE) was being effectively used in the home. Throughout the inspection on numerous occasions we had to ask staff to put their masks around their mouths and noses as they were being incorrectly worn. We saw on numerous occasions staff adjust and put on their mask when we entered the room.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw staff wearing aprons in both people's bedrooms and communal areas, we saw staff did not change every time they entered and left a bedroom.
● Where there were designated areas for aprons, we saw this was empty. This meant staff had to walk to the other side of the home to collect a clean apron.
● There was no bin located by the front door so that PPE could be disposed of when leaving the home, this meant staff and visitors would have to dispose of their PPE at the back door and walk through the home unprotected.

We have also signposted the provider to resources to develop their approach.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date

Visiting in care homes
● There were no restrictions placed on visiting and visitors could access the home freely.

Systems and processes to safeguard people from the risk of abuse
● Although there were procedures in place to manage safeguarding concerns, when incidents of potential abuse had occurred they had not always been appropriately documented, investigated or reported to the safeguarding team so that they could investigate and consider any further actions.
● Not all staff had received training in safeguarding. The manager told us 62% of staff had received this training. However, staff were able to give examples of how to keep people safe. One staff member told us, "I would report my concerns to the manager." As safeguarding referrals were not always made when needed, we therefore could not be assured procedures were understood and always followed within the home.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and recruitment
● We received mixed reviews on staffing level in the home. One person told us, "Yes there are enough staff when I need them, I can just press my buzzer and they are here in a few minutes." Another person said, "They are rushed, you have to wait sometimes, could do with more". Friends and relatives raised no concerns with staffing levels in the home.
● Staff we spoke with felt there were enough staff. One staff member said, "There are enough of us, if someone phones in sick and it can't be covered it's hard but most of the time it's enough."
● There was a dependency tool is placed that was based on people's needs, there were the correct amount of staff available based on this tool.
● We saw staff had received the relevant pre employment checks before they could start working in the home.

Using medicines safely
● Improvements had been made since the last inspection in relation to medicines. People confirmed they received their medicines when needed. A relative told us, "Yes, they are on a good amount of medication and they keep on top it".
● When people were prescribed as required medicines there was guidance in place for staff to follow.
● The records we reviewed confirmed people were receiving their medicines as prescribed.
● Staff told us, and we saw they had received training. We could not be assured all staffs competency had been checked as we were unable to locate all records for this. The one competency assessment we reviewed had been completed in 2020.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question remains inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure quality monitoring systems were effective in highlighting the shortfalls identified of which placed people at risk of receiving an inadequate service.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Continuous learning and improving care

- Audits in place were insufficient to check the quality of the service. We found audits were not consistently completed since our last inspection or in place at all. Since February 2022 we saw one audit had been completed for medicines management and one audit completed for the premises. There were no other audits in place for 2022.
- There were no audits completed on the incidents and accidents at the service. Therefore, the provider had not identified that reviews were not being completed after incidents had occurred. Furthermore, the manager and provider told us all incidents and accident forms were kept in the incident and accident file. However, we found a file which had incident and accidents forms in that had occurred in February 2022. The provider or manager was not aware these incidents had taken place. We were unable to review incident and accident forms from March and April 2022 as these could not be located.
- There were no systems in place to monitor falls. It was unclear if falls had occurred. There were no records available that monitored falls in the home and the home manager or provider were unable to confirm who had fallen and when. This lack of organisation and oversight placed people at risk of harm.
- A form was completed by a senior care staff member. This collaborated all the information recorded in a people's daily notes, for example, when they had been unwell or not eaten. There was no evidence these forms were being used to make changes or action taken when needed.
- There were no systems in place to ensure when incidents occurred, they were recorded. We were told by the home manager a person had fallen and absconded, there was no written record of this within care records.
- We viewed a medicines audit that had been completed in February 2022. This had identified a potential medicines concern; however no further information was recorded. There was no action plan in place for this. The provider or manager was unable to confirm what action had been taken and if this had been resolved.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● An external IPC audit had been completed in April 2022. This had identified areas for improvement. No action had been taken to resolve these concerns and during our inspection we found many of these concerns remained outstanding.

● We had not been notified about events in the home where people had been abusive toward each other.

● There remained no clear leadership in the home, there was no acknowledgment about the serious concerns and shortfalls we raised during our inspection.

The quality monitoring systems in place remained ineffective in identifying concerns and driving improvement within the home. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our last inspection on 11 November 2019 we issued a Notice of Proposal to impose conditions on your registration as a service provider in respect of a regulated activities. On the 7 February 2020 this was adopted to a Notice of Decision. The condition was to ensure on the last Monday of each calendar month, an action plan was sent to the commission identifying actions we asked you to take. The provider had failed to send a copy of this action plan since August 2021 despite the condition remaining in place.

This is a breach of Section 33 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not always acted in line with their duty of candour. A family member we spoke with told us they had not been informed of an incident that had occurred within the home. The provider had not always informed the local authority and CQC about events in the service.

● Other family members felt involved and updated when incidents had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was no evidence as to how people were involved with their care and the management of the service.

● Some satisfaction surveys had been completed in between January and March 2021, this information had not been used to make changes or drive improvements.

● Staff attended team meeting and had supervisions so that they could share their views.

Working in partnership with others

● There was some evidence professionals were involved with people's care, we saw people had access to and were referred to the district nurse team.

● For other people it was unclear when other professionals had been involved and reports were often unavailable for us to review. For example, we were told one person had been seen by a Community Psychiatric Nurse however no one could find the report.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

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 There were safeguarding procedures in place however these were not always followed to ensure people were protected from potential harm.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care, as care plans and risk assessments were not always in place. When events or incidents had occurred, these were not always documented, and it was unclear what action had been taken. There was no evidence lessons were learnt when things went wrong. Infection control procedures were not always followed to ensure the spread of infection was reduced.

The enforcement action we took:

We have issued a NOP to cancel this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not effective in identifying areas of improvement and often there were no audits in place. Documentation was not always be available.

The enforcement action we took:

We have issued a NOP to cancel this location