Craysell Limited

Marlborough House

Inspection report

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Ratings

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

Overall summary

Marlborough House provides nursing care for up to 40 older people who are frail or living with dementia. Accommodation is provided over two floors. At the time of our inspection 24 people were using the service, two of which were living with dementia.

In September 2014 we undertook an inspection and found there were six breaches of the regulations. We took enforcement action for three of these breaches in relation to people's care and welfare, nutrition and the provider's monitoring of the service. We told the provider they needed to comply with these three regulations by 31 October 2014. We inspected the service again in November 2014 and found the provider had made the improvements to meet the requirements of these three regulations. In September 2014 we also took compliance actions for the other three breaches relating to safe management of medicine, staff support and people's records. The provider sent us an action plan telling us they would make these improvements by end of February 2015. During this inspection we checked whether the provider had taken action to address these three regulatory breaches.

Summary of findings

During this inspection we found the provider had taken action to address some of the regulatory breaches and concerns raised. There had been a delay in getting the improvement work started due to management changes. We found the provider had addressed this concern by making additional staff and management resources available to support the improvements identified. A new manager had been appointed and it was evident that increased action had been taken following the appointment of the new manager.

A range of audits and self-assessments were routinely undertaken by several senior managers across the organisation. We found these assessments and audits to be comprehensive and had supported the provider to identify similar concerns to those we found during this inspection. However, we found insufficient action had been taken to address these concerns. In the absence of a robust overarching risk based improvement plan the provider's improvement efforts had become fragmented. Individual action plans had not being completed and monitored for their effectiveness. The work that evidently had been taking place had not resulted in the required improvements.

People were supported by nursing staff to take their medicines. However, medicine administration records continued not to be completed consistently to ensure accurate information was available so staff would know that people had taken their medicines as prescribed.

People, relatives and staff acknowledged progress made to establish a stable management team in the home and spoke positively about the new manager in post at the time of our inspection. Though staff had started to receive supervision improvements were still needed to ensure the supervision and appraisal system was implemented routinely to create development plans for staff.

Recruitment practices were not sufficiently robust to protect people as far as possible from individuals who were unsuitable to deliver care to people.

People were increasingly encouraged to be involved in the planning of their care. Where people lacked the capacity to agree to the restrictions the provider placed on them to keep them safe, the provider made sure people had the protection of a legal authorisation instructing them to do so. We recommended the provider seeks guidance on how to record the best interest decisions that lead to Deprivation of Liberty Safeguards (DoLS) applications being made for people.

Staff told us the quality of care plans had improved and gave them the information they needed to know how to care for people to meet their needs and preferences.

People were cared for by staff who were kind and respectful of their needs and wishes. Their dignity was promoted through thoughtful consideration. The provider's complaints process ensured people's concerns were addressed appropriately.

People and their relatives were complimentary about the quality of care provided. They appreciated the friendliness of staff and the homely atmosphere. People were encouraged by staff to treat Marlborough House as their home. People and their relatives were increasingly encouraged to give their views about the home and their feedback was used to make improvements. The provider was preparing to send out their first quality survey to people and their relatives.

A registered manager was not in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered person'. 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 provider had appointed a new manager in January 2015 and they were completing the assessment process for becoming a registered manager with CQC.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

People were supported by nursing staff to take their medication. Medicines were not consistently recorded and thereby did not always provide accurate information to assure staff that people had taken their medicines as prescribed.

Recruitment practices were not sufficiently robust to protect people as far as possible from individuals who were unsuitable to deliver care to people. People's needs were met by sufficient numbers of staff

Risks had been assessed in relation to each individual and staff had been provided with appropriate guidance on risk management.

Requires Improvement

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

Though staff had begun to receive supervision and support to develop their skills, time was still needed to embed this process in the home. Training provided to staff had been reviewed to ensure it met the needs of people.

People received sufficient to eat and drink and a nutritious diet was available. People were supported to stay healthy and had access to health and social care professionals as required.

Where people lacked the capacity to agree to the restrictions the provider placed on them to keep them safe, the provider made sure people had the protection of a legal authorisation instructing them to do so. We recommended the provider seeks guidance on how to record the best interest decisions that lead to Deprivation of Liberty Safeguards (DoLS) applications being made for people.

Requires Improvement

Is the service caring?
The service was caring.

People got on well with their care staff and we observed staff providing support with compassion and kindness.

People's privacy and dignity were respected.

People were supported to maintain relationships that were important to them.

Good

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

Requires Improvement

Summary of findings

People's care plans were detailed and contained sufficient information to enable staff to meet their needs. Group and individual activities were available in the home and people took part in activities they enjoyed.

Staff were focused on completing the meal tasks and did not always use the opportunity to engage with people and support them to maintain their social skills.

The provider was still developing and embedding opportunities for people to give their feedback about the service. There were appropriate procedures in place for the management and investigation of complaints.

Is the service well-led?

Requires Improvement 

The service was not always well led.

The provider was creating a culture of support and a caring attitude.

Though the provider had made resources available to drive improvements this had not yet led to adequate systems of working which effectively protected people from identified risks. Quality assurance, audits and investigations identified concerns but did not always result in actions being taken to drive improvement or raise standards of care consistently.

The service did not have a registered manager but a new manager had been appointed in January 2015 and was completing the CQC registered manager assessment process. Relatives and staff spoke positively about the new manager and the improvements they had made.

Marlborough 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.

10 and 19 March 2015

This inspection took place on 6, 10 and 19 March 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience with experience of elderly care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including previous inspection reports, any concerns raised about the service and minutes of safeguarding meetings. We also looked at notifications sent in to us by the provider, which gave us information about how incidents and accidents were managed. A notification is information about important events which the provider is required to notify us by law.

We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 18 people living in the home and six relatives who visited the home on the day of our inspection to obtain their views on the quality of care at Marlborough House. In addition, we spoke with the operational manager, a director of the provider company, manager, independent trainer, independent training assessor, laundry assistant, cook, kitchen assistant, three nurses, activity co-ordinator, two team leaders and three care assistants. We also spoke with the specialist community nurse for care homes who frequently visited the home. We reviewed five people's care records. We looked at all staff training records and two staff recruitment files. We also looked at records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

At our inspection in September 2014 we found people's medicines were not always administered safely as nurses did not follow hygienic practice when giving people their medicines. Medicine records also did not provide a true and accurate record of people's medicine history so nurses would know whether people had received their medicine as prescribed. We informed the provider that improvements were needed to ensure people received their medicines safely and medicines administered were recording appropriately.

At this inspection we found improvements had been made and people received their medicines safely. We observed a nurse giving people their morning medicine. They followed good hygienic practice, did not handle the medication with their hands and used a clean spoon to place medication on people's tongues when needed. The nurse kept the medicine trolley locked in the passage when going into people's rooms to reduce the risk of people gaining access to the medication. A system was in place to record fridge temperatures daily to indicate the fridge temperature was maintained at the correct level for storing medicines. Though nurses told us the temperature reading was taken daily a record of the readings were not available from mid January 2015 onwards. Therefore, it was not always clear from the record whether medicines had been stored within the required temperature range to ensure they would remain effective.

We found some improvements had been made in the medicine recording practices since our last inspection. Nurses now signed each person's medication administration record (MAR) after medication has been given, not before, to ensure an accurate record of medicines administered. Where written changes had been made to a person's MAR, some records were now dated, signed and checked by a second member of staff for accuracy before medicines were commenced. Nurses now indicated the actual amount administered when a variable dose was prescribed so that an accurate record would be available to inform any adjustments that might be needed for future doses.

However, these improvements in medicine recording were not consistent. We found six people's MARs where incomplete. We noted some blank spaces where we would expect to see initials for administration or a code for non-administration. Recording charts to record the use of topical medicine for external use, such as creams were incomplete. One handwritten entry had not been double signed as per the provider's instruction. Nurses might not have known from these records whether people had received the correct dosage of medicine or whether their cream had already been applied, thereby, increasing the risks of errors occurring.

Though we did not find any medicine administration errors from checking medicine stock and speaking with nurses, people were at risk of harm because records relating to the administration of people's medicines were not always sufficiently robust to ensure staff would know from people's MAR that medicines had been administered as prescribed. This was an ongoing breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the home and did not have any concerns about abuse or bullying from staff. They told us they would be confident speaking to a member of staff or the manager of the service if they had concerns. Three relatives told us they did not feel confident that the front door was monitored and strangers might gain unauthorised entry to the home. Our observations found people were protected from the risks posed by unauthorised strangers in the home. On all three occasions we visited we were asked to identify ourselves and sign the visitor's book. However, the home's new draft policies did not include a procedure for ensuring visitors to the home where identified appropriately. Though staff could tell us what checks they would undertake when they allowed visitors into the home in the absence of clear written guidance some of these checks might be overlooked.

Arrangements were in place to support staff to identify and respond to abuse. Staff training records showed staff received training on safeguarding adults. Five staff confirmed this and knew who to contact if they needed to report abuse. They gave us examples of poor or potentially abusive care they had covered in training or seen in other services, which demonstrated their understanding of abuse and how it could be prevented. They were confident any abuse or poor care practice would be quickly identified and addressed at Marlborough House. The manager was aware of their legal responsibility to share safeguarding

Requires Improvement

Is the service safe?

information with CQC and the local authority, and had procedures in place to do so. At the time of our inspection the provider was waiting for the outcome of two safeguarding investigations. The provider had investigated these incidents and was working with the local authority to put plans in place to keep people safe. Policies and procedures on safeguarding where available for staff to refer to. At the time of our visit the operations manager was reviewing these policies to ensure they contained up to date information and contact details of relevant agencies.

Risks to people's safety and staff supporting them had been assessed. This included any risks due to the health and support needs of the person including the risk of falling and the risk from staff supporting people to move with the use of a hoist. Risk assessments included information about action staff needed to take to minimise the risk of harm occurring to people. Staff we spoke with had a good understanding of people's risks including what action to take if people were to choke or fall. Records showed people were monitored closely for 24 hours after a fall to ensure they had not sustained any injuries.

The provider had assessed the number of staff required to support people based on the needs of people living in the home. Staff rota's verified these levels were maintained. Banks and agency staff were used to fill staff absences. The provider was actively recruiting for permanent nursing staff and used the same agency nurses to ensure people were consistency supported by staff who knew them. Records showed the home had identified improvements were required in how staff worked during mealtimes to ensure people received their food and the support they needed when they wanted it. The provider had implemented staggered mealtimes and we saw people were not left waiting for their lunch time support. The manager was awaiting the delivery of a meal trolley to further improve staff's effectiveness over lunch time so they would not have to waste time going up and down stairs with trays. People told us in general staff responded well to their requests for assistance, though they needed to wait a bit longer sometimes over busy periods of the day. During our visits we saw two people on the ground floor having to wait a few minutes for assistance. Records showed the provider was working on improving staff's response to people's call bells and was reviewing how staff were deployed over the two floors to ensure the right staff were available when people needed them.

We looked at two staff employment records to see if the provider had followed safe recruitment procedures. The provider had completed staff employment checks before new staff began working in the home. These included criminal record checks and evidence to show the applicants had not been barred from working with vulnerable adults, at least two satisfactory references and proof of identity. However, the provider's staff recruitment checks were incomplete. Their application form requested applicants to only provide an employment history for the past seven years. They had not ensured a full employment history, including explanations of any gaps, had been received from applicants before staff were offered employment as required by law. People were not protected as far as possible from individuals who were known to be unsuitable to work with people in a care setting.

The provider did not ensure information was available for all staff to evidence their full employment history as required. This is a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People were supported to keep their skin healthy. Nurses used screening and monitoring tools to identify people's risks of developing pressure ulcers. Where people had been identified as being at risk, plans were in place to prevent pressure ulcers developing. These included supporting people to frequently change position to relief skin pressure, using air mattresses and keeping people's skin moisturised. The provider was arranging specialist wound care training for nurses to further develop their skills in developing and implementing people's wound care plans consistently and in line with good practice guidelines. At the time of our inspection no person in the home had a pressure ulcer.

At our inspection in September 2014 records did not show whether people with limited mobility had been supported to regularly change their position to relief pressure on their skin. At this inspection we found some improvements had been made and body repositioning charts were in place. However, further improvements were needed to ensure these charts could inform nurses that the repositioning plans they had in place were being implemented effectively. Two people required support to reposition every four hours. Their records showed they had been supported to reposition consistently throughout the day but not as frequently as their care plan required. Team leaders told us what action they took when gaps were identified in people's daily care records to assure themselves that people had received their care. These including repositioning people promptly when a gap has been identified, instructing and monitoring care workers to see that repositioning took place for the rest of the day. However, this corrective action had not been recorded for staff to know whether people had already been supported to reposition following the team leaders check or whether they needed to take additional action.

Staff understood the importance of supporting people to drink enough and we saw people were encouraged to drink throughout the day. Staff received training to enable them to identify people at risk of malnutrition and dehydration. Since our inspection in September 2014 improvements had been made to people's records and we saw people had been screened monthly to assess their risk of becoming malnourished. People at risk were monitored to make sure they ate and drank enough. Food and fluid charts were kept to inform staff whether people had eaten and drunk enough. These records however had not always been effective in informing staff if a person's nutrition and hydration care plan had been implemented appropriately. The records did not note a target amount of food and fluid each person had to consume to remain hydrated and nourished. Staff therefore would not know whether they needed to offer people more of less to eat and drink.

The manager told us she was reviewing the daily care records used in the home to determine whether they were fit for purpose and provided nurses with the information they required to judge whether people's care plans had been implemented effectively. This included reviewing people's repositioning, bowel, food and fluid charts.

People at risk of malnutrition were weighed weekly. Nurses met with the specialist community nurse for care homes monthly to discuss any unexplained weight loss and agreed a nutritional plan. The specialist community nurse told us the new manager informed her promptly if people required nutritional support. Staff knew who required dietary support and we saw people at risk of weight loss were offered calorific snacks throughout the day. The cook was kept informed of people's dietary needs and they were able to describe how they would improve meals that met the needs of people with diabetes and those with swallowing difficulties.

People with swallowing difficulties had been assessed by a Speech and Language Therapist (SALT) and where needed received soft and pureed diets. Staff could describe how they would support people with swallowing difficulties during meal times and we observed people being supporting to eat in line with their SALT guidelines.

People were supported with their day to day health needs. One person told us "If I need a doctor they will get one". During the morning handover meeting staff raised concerns about people's health. We saw nurses then agreed a plan of action with the manager, instructed staff if any monitoring was required and informed the GP as needed. A chiropodist routinely visited the home. People who required specialist input to maintain healthy were referred to the appropriate professionals, these included community mental health workers, the diabetic and tissue viability nurses.

When we inspected the service in September 2014 we informed the provider that improvements were needed to make sure staff received the support they required to develop their skills and undertake their roles to an

Requires Improvement

Is the service effective?

acceptable standard. Staff had not received regular supervision and appraisal. At this inspection we found some improvements had been made and the provider had created four team leader posts to ensure sufficient senior staff were available to supervise care workers. Records showed structured one to one supervisions and appraisals had been re-introduced. Staff told us they had started having supervisions and half of the staff team had received their annual appraisal since January 2015. They told us this had given them the opportunity to discuss their performance and identify any further training they required. Staff said received sufficient support and guidance to enable them to fulfil their roles. Nurses felt they would benefit from a checklist to support them to fulfil their daily monitoring tasks, for example checking MAR records at the end of a shift.

The manager had identified some team leaders required additional support to develop their supervisory skills and confidence and she was supporting them through monitoring. The manager was also introducing one to one supervision for agency nurses. Though staff had started to receive supervision improvements were still needed to ensure the supervision and appraisal system were implemented routinely and information used to create development plans for staff.

The provider had reviewed their staff training programme and had included new training content year to ensure training reflected the needs of people in the home. A new training provider had also been sourced. The new training included medicine training for nurses in March 2015 and the introduction of medicine competencies to check whether nurses could manage medicines to an acceptable standard. Nurses had also attended a skills development training day in February 2015 to refresh their skills in line with national good practice guidelines.

The provider had identified three care workers had not received sufficient supervision when initially employed and had taken action to address this shortfall. The induction programme had also been reviewed to ensure it met national Common Induction Standards. An independent training assessor told us the provider had made training available soon after the new team leaders were appointed and they were given the time and support required to undertake their care qualifications. The team leaders told us they were benefitting from this training and it had for example, improved their understanding of health and safety requirements in the home.

Care staff had a basic understanding of the key requirements of the Mental Capacity Act 2005 (MCA). Nurses and the manager had a more in depth understanding of how to protect the rights of people who might not have the capacity to consent to living at Marlborough House or the care provided. They were knowledgeable about the Deprivation of Liberty Safeguards (DoLS). This included decisions about depriving people of their liberty so they get the care and treatment they needed, where there is no less restrictive way of achieving this. The provider had identified three people were subject to a level of supervision or control that may amount to deprivation of their liberty and had made DoLS applications to the local authority. The manager was still waiting for the outcome of these three applications.

Records showed in completing the DoLS applications steps had been taken by staff to consult with people who knew the person and their circumstances well. However, records did not show what less restrictive approaches had been considered and exhausted to determine whether parts of people's care plans could be met without placing restrictions on them.

We recommend the provider seeks advice and guidance based on current best practice from a reputable source, on how to record the best interest decisions that lead to DoLS applications being made for people.

Good

Is the service caring?

Our findings

People we spoke with were happy living in the home and satisfied with the care they received from staff. Comments included ‘‘Staff are very good to me”, ‘‘This is a very good home”, ‘’Staff help me when I need it” and ‘‘I have no worries with my life here”. Relatives were also positive about staff and the care their loved ones received. One relative told us ‘‘The care workers are very happy and all say hello. They get my mum singing”.

We saw staff had built positive relationships with people. The catering and laundry staff took time to talk with people and asked after their welfare. Care staff spoke of and to people with kindness and compassion.

Staff were knowledgeable about the care people required and the things that were important to them. Where people had the need to remain useful staff gave them the opportunity to help set the tables, post letters for the home or pick up the newspaper. People were given opportunities to make decisions about their daily life and these decisions were respected. Where people chose to spend their time alone in their rooms we saw staff reminding them that activities were taking place and encouraged them to join in. When people declined to take part in communal activities staff checked on them throughout the day. People were given the opportunity to choose where they wanted their meals and what they would like to eat.

People who took pride in their appearance and required assistance to maintain this told us they were supported to use the services of the visiting hairdresser. One person told us ‘‘The hairdresser comes once a month and will also come of you need your hair done for a special occasion”.

People were asked about their religious needs and given support to practice their faith. Church services and communion was held regularly in the home. One person told us ‘‘I can see a priest if I want one”.

People’s wishes to remain part of their family and maintain their friendships were respected and encouraged. Visitors told us they were encouraged to spend time with people and have a cup of tea. One relative told us ‘‘In the summer they encourage us to sit outside with our loved ones”. People could meet with their visitors in their rooms or in communal areas. People were supported by staff to make Marlborough House their home. People’s rooms were personalised with their photos and items that were important to them. One person showed us her room and told us that it was important for her to have pretty things around. Staff we spoke with understood this and supported her to keep her room clean and tidy when she asked for help.

People were treated with respect and supported to maintain their dignity. Dignity care plans informed staff how people preferred to be addressed and how they would like to be comforted if they became distressed. We heard staff calling people by their preferred names. Staff supported people’s care needs discreetly and with sensitivity. They could explain how they would protect people’s modesty when undertaking care tasks and we saw people were given the privacy they wanted. All staff knocked before entering people’s rooms.

Staff were sensitive to people’s communication needs. A handful of people required support to make their wishes known. We saw staff gave them time to make their choices and spoke clearly and slowly at times using touch to communicate with and comfort people.

Requires Improvement

Is the service responsive?

Our findings

Each person's needs had been assessed providing staff with comprehensive information about people's needs including their skin, nutrition, sleep, personal care and mobility needs. People's needs assessments had been used to develop care plans which informed staff how to support each person. Staff we spoke with told us the care plans had improved and gave them the information they needed to meet people's needs and keep them safe.

Care plans also reflected people's preferences, likes, dislikes and wishes. For example, people could choose when they wanted to get up, how they wanted their care to be delivered and how they wanted to spend their time. However, some people had not always been supported in line with their care plan. One person preferred their light to be switched of as it shone in their eyes and on both days we found their light had been left on despite a note on the door reminding staff to put the light off when they leave the room. Their relative told us this happened repeatedly and we also saw this person's drink was placed on the wrong side of their bed and they could not reach it. People told us they generally received care that reflected their needs and preferences. Most people preferred to spend their day in their rooms and told us staff sat with them if they asked for company. During meal times we saw staff did not always initiate conversation with people. Staff were focused on completing the meal tasks and did not use the opportunity to engage with people and support them to maintain their social skills. Some people might therefore not receive the social interaction they enjoyed.

People had the opportunity to take part in activities in the home. An activity co-ordinator worked five days a week and planned activities for care workers to undertake during the weekends. Group activities took place daily, people chose what they wanted to do and activities including word games and physical exercise. The activities co-ordinator told us they had adjusted the activities programme to accommodate the needs of people who chose to spend time in their room. We saw at least three sessions a week took place during which the activity co-ordinator visited people in their room to do their nails, watch a movie or play games. She had also noticed that people were more likely to leave their rooms for celebrations or social events. An afternoon tea was added to the activity plan which staff told us was well attended. A pet therapist and musician also visited the home monthly.

There were some opportunities for people to provide feedback about their experience of the service. A residents' meeting had been held in January 2015. During the meeting people said they were happy with the staffing levels and activities in the home. The majority of concerns related to food. Some people also told us they felt the food could be more appetising. The manager had address the people's individual concerns raised about the food and the resident of the day programme also provided an opportunity for people to give their views on the food. The resident of the day programme had been introduced in December 2014 to ensure people's care plans reflected their changing needs and their preferences. The programme ensured each person's care plan was reviewed monthly and they had a meeting to discuss their views of the service. Staff spoke positively about this programme and said time was needed to ensure it was embedded in the home and relatives were given the opportunity to be involved.

One relative told us they would appreciate the opportunity to be more involved in her loved one's care planning. The provider was looking at ways in which relatives could routinely be involved in care planning and give feedback about their experience of the service. The operational manager showed us the satisfaction questionnaire that will be sent to relatives and people in the home in March 2015 to provide feedback about the quality of the service. This will be the provider's first quality survey.

People and their relatives told us they had not made any complaints about the service they received. They said if they were unhappy about anything they would let the staff know or talk to the manager. One person told us they were not satisfied with the support they received when they asked staff to clean a soiled chair. We mentioned this to the manager who ensured the appropriate support was provided. The manager was reviewing the complaints policy and once completed this would be displayed in the home to inform people about the process for making a complaint. People had a copy of the current complaints policy in their resident handbook.

We looked at how written complaints were managed by the provider. The manager told us the home had received two

Requires Improvement

Is the service responsive?

complaints since our inspection in September 2014. We found these complaints had been investigated and responded to in line with the provider's own policy. The manager told us complaints and feedback was taken seriously. Action had been taken to resolve individual complaints. We saw the provider had taken action to replace a person's missing property. The provider had identified the need to review the themes and outcomes of complaints so learning could be undertaken to improve the service as a whole and to check improvements made following feedback, had been sustained. These checks had been built into the new draft quality assurances process so people could be assured the service would improve in response to their feedback.

Requires Improvement

Is the service well-led?

Our findings

A range of audits and self-assessments were routinely undertaken by several people across the organisation. This made it difficult to identify who had overarching responsibility for quality and risk management. Actions required following these audits, were at times not clearly communicated to the manager. Written records were not always available to inform her of past investigations of significant incidents that still required improvement action. This concern had been identified by the provider's external quality assurance consultant during his visit on 26 January 2015. The manager was responsible for ensuring improvements were made to the service and the current system was not effective in providing her with all the information she required to do so.

The audit format had been reviewed to reflect the new CQC inspection methodology and to support the manager to identify potential regulatory breaches. We looked at the safeguarding, care plan, dignity and infection control audits completed in January 2015 as well as the quality monitoring visit records for November 2014, December 2014 and January 2015. The monthly quality assessment was completed by an independent consultant on behalf of the provider. We found these assessments and audits to be comprehensive and had supported the provider to identify similar concerns to those we found during this inspection.

Some action plans had been drawn up and the provider was implementing several improvement plans from different agencies and audits at the same time. However, we found insufficient action had been taken by the provider to address these concerns and some actions noted on the plans had not been completed by the target date stated. There had been some delay in progressing the action plans whilst a new manager was being recruited and the new manager was still familiarising herself with the improvements required. Though she had already taken action to improve supervision, reviewed care plans and ensured people's records were kept secure it was not always clear which outstanding actions she was expected to prioritise. The manager had started to develop a risk register to support her to prioritise actions according to risk. She told us ''There is so much to do I need to get some idea what is having the biggest impact on people, so I can prioritise that''. It was evident that the provider had made management and financial resources available to drive service improvement. However, we found in the absence of a robust overarching risk based improvement plan the provider's improvement efforts had become fragmented and action plans were not being completed and monitored for their effectiveness. The work that evidently had been taking place had not resulted in the required improvements.

For example, the provider had taken some action to address the identified breaches of regulations in the September 2014 report. However, they had been unable to make and sustain all the required improvements. The monthly quality reports from the external consultant repeatedly identified improvements were required in the medicine practice. This was similar to the concerns we again identified in relation to medication records at this inspection. Following concerns raised in September 2014 the provider had instructed nurses to check people's MAR daily and report any concerns through the incident reporting system. However, we found this had not brought about sustained improvement. Medicine records were still incomplete, and incident reports had not been completed for the omissions we found. The provider had not robustly monitored their intervention to ensure nurses had effectively implemented their instruction and people were protected against the risk of poor medicine practices. During our inspection the manager had reviewed the daily MAR checks and were monitoring whether nurses completed this check daily.

A specialist community nurse regularly visited the home to support the manager to monitor the nursing care in the home. They told us the provider responded well to her visits and the service still needed time to develop their ability to independently and robustly monitor their own clinical practice. They felt the new manager had a good understanding of what was required and they were working together to formulate a robust clinical governance system. New team leader post had been created to support the day to day monitoring of, for example, daily care records and supervise staff. However, clear systems were not in place to monitor whether the team leaders were completing their monitoring tasks as evident in the gaps we found in people's daily records.

Quality assurance processes at Marlborough House were not effective in ensuring improvements were made to the quality and safety of the service. Though the provider's audit system were effective in identifying issues relating to

Requires Improvement

Is the service well-led?

quality and safety, robust action had not been taken to address and manage these issues and risks. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager at Marlborough House. This is a requirement for registration with the Care Quality Commission (CQC). A new manager had been appointed in January 2015 and they were completing the assessment process for becoming a registered manager with the CQC. The new manager had significant management experience and had a good understanding of the improvements required in the service.

Staff demonstrated a sense of pride in their work. They gave us examples of how they felt the management of the home had improved since January 2015 and why they were confident people received the best care they could give. Comments included ‘‘She is very approachable’’, ‘‘We have had more training and better care plans’’ and ‘’We always try to meet people’s requests’’. Staff told us they felt the new manager valued their experience and nurses told us their clinical judgement was respected and they were encouraged to make clinical decisions. Relatives also spoke positively about the new manager. One told us ‘‘The new manager has made huge improvements, the morale is much better’’.

A director of the provider company told us that they had learnt from past experience that they needed to ne more actively involved in monitoring the work of the manager. They regularly met with the manager and the operational manager to discuss progress made. Monthly meetings had been introduced with all the managers of the provider’s homes to develop a consistent way of working across the provider’s services. The manager told us that she found meeting with the other managers meaningful in ensuring she remained up to date with best care practice. This meeting had so far produced a new induction programme which the manager was piloting with two new care staff. The provider’s policy and procedures were being updated to reflect current best practice and support the management of staff performance. Staff told us they have become more confident about what is expected of them since the new manager has been in post. One told us ‘‘I now know what I need to do every day and who I need to go to if I have a concern’’. They also told us they felt more motivated and supported since the new manager came in post.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 Health and Social care Act 2008 (Regulated Activities) Regulations 2010. The registered provider did not have effective systems in place to monitor the quality of the service delivery. Regulation 10 (1) (a) (b) (2) (b) (iv) (c) (i) This corresponds to Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Regulation 21 Health and Social care Act 2008 (Regulated Activities) Regulations 2010. The registered provider did not operate effective recruitment procedures to ensure that information specified in Schedule 3 was available. Regulation 21 (b) This corresponds to Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records The provider did not keep accurate records of medicines administered to people.

This section is primarily information for the provider

Action we have told the provider to take

This corresponds to Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.