Fidelity Healthcare Limited

Marlborough Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Marlborough Lodge is a residential care home providing personal care for up to up to 18 people. The service provides support to people aged 65 and over, including those living with dementia. At the time of our inspection there were 18 people using the service. Accommodation is provided in one adapted building over two floors.

People's experience of using this service and what we found

During this inspection, we found two breaches of regulations in relation to infection control and good governance.

The service was not always clean and the risk of infection was not always managed effectively.
Risks to people were not always recorded consistently. Medicines were administered safely however we saw that missing medicines had not always been investigated appropriately.

The service did not always follow best practice guidance or advice from other agencies. The service's visiting policy was not in line with Government guidance and the service had taken admissions against advice of the local health protection team. There were quality assurance systems in place however these were not always effective.

People were cared for by staff who were recruited safely and were trained appropriately for their role.
People's relatives told us they were happy with the safety of the service.

Relatives and staff told us the service had a registered manager who was open and approachable and communicated clearly with people, staff, relatives and professionals.

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

Rating at last inspection
The last rating for this service was good (published 12 December 2018)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to infection control and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Marlborough Lodge

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
This inspection was completed by two inspectors and an expert by experience.

Service and service type
Marlborough Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Marlborough Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to this inspection, we reviewed the information we already held about this service. This included information shared with us by the provider, feedback we received from the public and feedback from other agencies that work with the provider. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

During the inspection-

During this inspection, we reviewed five care plans, medicine records, daily notes and other records relating to the management of the service. We spoke to five members of staff including care staff, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We spoke to 10 relatives of people using the service about their experience with the provider and received feedback from two professionals who work closely with the service.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement.
This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
• At the time of our inspection, Marlborough Lodge was closed due to an outbreak of COVID- 19. The service had been in outbreak status since November 2021.
• The service was not always clean. On the day of our inspection, we observed that some communal bathrooms were not clean. One communal toilet had bodily fluids left unattended for over one hour. We observed another bathroom had been left with wet used towels on the bath and bath seat and another had a used mug on the toilet cistern. Toilets were stained and did not appear clean.
• PPE was not always stored appropriately; we saw PPE left uncovered in toilets, hung over grab rails and on the floor. This meant there was risk that PPE could become contaminated.
• Some areas of paintwork, fittings and furniture were chipped and required repair. This meant that they could not be cleaned effectively and increased the risk of the spread of infection.
• There were cleaning schedules in place, however there was no record of cleaning for high touch points or soft furnishings.
• The service was not completing regular legionella testing in line with Health and Safety Executive (HSE) guidance. This increased the risk of legionella being present within the water system of the home. Legionella is a type of bacteria that can cause Legionnaires' disease.

Failure to ensure the service was clean and reduce the risk of the spread of infection was a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• We raised these concerns with the registered manager. They told us that they would discuss concerns regarding cleanliness with the staff. Since inspection, the registered manager told us appropriate storage for PPE has now been purchased and legionella testing has been arranged.
• We shared our concerns about cleaning records with the registered manager, they told us regular high touch point cleaning was being completed however was not recorded. They told us this would now be recorded.

Visiting in care homes
• The registered manager had misinterpreted current guidance around visiting and had therefore not supported people to have 'essential care givers'. Current guidance states that everybody living in a care home should be supported to choose an essential care giver to benefit from companionship and additional support provided by someone with whom they have a personal relationship. Essential care givers are supported by care homes to receive the same regular COVID-19 testing as care home staff.

• The service had been mostly closed to visitors since November 2021. This period consisted of two separate Covid outbreaks with a 12-day period open to visitors in December 2021. This meant, at the time of our inspection, people had not had visits from their family for over two months, besides the aforementioned 12-day period.
• Relatives we spoke to told us they were not aware of guidance regarding essential care givers but told us they were happy their relatives were being kept as safe as possible. Comments included "Not been told anything about government's [essential care givers] by the manager. Don't know anything about it" and "manager has not told us about [essential care givers] Haven't seen [Person] since the beginning of December when the home stopped visits but do let us know how [Person] is getting on.

Systems and processes to safeguard people from the risk of abuse
• Systems were in place to safeguarding people from abuse. We saw that safeguarding referrals had been made appropriately when required.
• Staff had received training in safeguarding, they told us they were confident they knew how and where to report concerns if required.

Assessing risk, safety monitoring and management
• People had risk assessments in their care plans, however risks identified were not always consistently recorded throughout people's documents. For example, one person's care plan identified them as having an allergy to medicine, however their hospital transfer form identified them as having no allergies. The 'hospital transfer form' was a document completed by the provider to inform healthcare professionals of a person's healthcare needs in the event of hospital admission.
• Emergency plans and individual fire evacuation plans were in place to ensure staff could support people in the event of a fire or other emergency.

Staffing and recruitment
• Staff were recruited safely and received training that was relevant for their role.
• People's relatives told us they felt their family members were looked after safely by staff; comments included "Not at all worried about [person's] safety. Very active by nature, not told to sit down and wait. They have achieved a balance between independence and supervision" and "Visited regularly before Covid so know [person] is very happy and safe living in Marlborough Lodge."

Using medicines safely
• Medication errors and incidents were recorded. However, it was not always clear when investigations had been completed. For example, we saw one incident that had been reported regarding missing sleeping tablets in January 2022, however staff statements had not yet been received. We raised this with the registered manager who told us they would chase up the statements and review the way medication incidents were managed.
• Staff completed competencies to ensure they were able to dispense medicine safely. We observed staff following best practice guidelines for medicine administration on our inspection.
• People had personalised 'profiles' in place, these were documents that informed staff of how people preferred to take their medicines.
• Topical medicines were managed safely, there were clear instructions in place for staff in relation to topical creams and lotions. Charts in people's rooms showed where and when staff needed to apply them. Records showed staff applied these as prescribed.
• People had protocols in place for PRN (as required) medicines. These informed staff when to administer additional medicines such as pain relief.

Learning lessons when things go wrong

• Staff reported accidents and incidents appropriately. The registered manager reviewed these and took action to reduce future risk. For example, if people had experienced falls, referrals were made to the local falls team for advice.
• Accidents and incidents were analysed for trends and patterns regularly. Lessons learned from incidents were shared with staff.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others
• There were quality assurance systems in place to monitor and improve the quality of care at Marlborough House. However, these systems had not identified the concerns we identified regarding the management of risk, legionella testing and management of medicine errors.
• The registered manager and the provider were not following current guidance on visiting in care homes and essential care givers
• During the current outbreak of COVID- 19, the service had been advised by health protection team not to admit new people whilst the outbreak was still active within the home. When we inspected, we observed that two people had been admitted to the service against this advice. This meant that new admissions to the service were at an increased risk of catching COVID 19.
• We discussed this with the registered manager, they told us they had risk assessed this and had discussed the potential risks with people's relatives.

Failure to assess, monitor and improve the quality and safety of the services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Relatives told us the registered manager was approachable and communicated with them openly. Comments included "Have spoken to the manager, they are very approachable, I feel I can call anytime to discuss anything." "The manager came to the house to do [person's] first assessment, I was so impressed right from the start. I feel I have a good relationship with him." "The Manager keeps in touch by phone and email makes you feel very welcome. [Person] had friends visiting, and they were made so welcome by staff and the manager. Made them feel like one of the family."
• Staff told us they felt supported by the manager in their day to day role, comments included "managers are understanding" and "I Feel supported by my manager"

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 understood their responsibility under the duty of candour and complied with this when

appropriate.

• We received mixed feedback from professionals, one professional raised a concern around communication and investment in the infrastructure. However, all professionals told us they felt that staff cared about the people living in the service and knew people well.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• The service sought feedback from people, their relatives, staff and professionals. We saw the most recent survey had been completed in August 2021 and feedback had been positive.
• Where people had given feedback about Marlborough Lodge, this had been acted on by the registered manager. For example, we saw one person used the survey to express their room was too small, this person was offered a move to a larger room as soon one was available.
• People and their relatives had the opportunity to attend residents' meetings that were in place. These meetings updated people about the home and any upcoming changes that were happening. Meetings also provided an opportunity for feedback and questions from relatives.
• Relatives told us that communication with the service had remained effective throughout periods of lockdown when people had been unable to visit, one person told us; "When we have not been able to visit they have been very good, been in touch regularly and any issues [we] have been contacted straight away. Have spoken to [person] on the phone and they have gone out of their way to enable that to happen."

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always ensure the service was clean, risk of infection was not always managed appropriately

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not always effective.