C B S Nursing Care Limited

Marlborough House Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced on 13 and 14 November 2014. Marlborough House Nursing Home is a nursing home for 52 older people with complex health needs, some of whom are living with dementia. At the time of the inspection 36 people were living at the home.

We inspected Marlborough House Nursing Home on 1 September 2014. Following this inspection we issued three warning notices for breaches in the regulations.

This was because people's privacy, dignity and independence were not always respected, people's care and welfare needs were not planned for and met and people were not supported to eat or drink sufficient amounts for their needs. We had previously asked the provider to take action to meet these regulations

Summary of findings

following the inspection on 17 June 2014. We told the provider they had to take action to meet these warning notices by 31 October 2014. These warning notices were not met at this inspection.

In addition to this we asked the provider to take action to make improvements to cleanliness and infection control in the home and people's care records which we had found contained inaccuracies, inconsistencies and omissions.

Following the inspections that we carried out in June and September 2014, the provider sent us an action plan to tell us the improvements they were going to make. The action plan stated that all actions would be complete by 1 October 2014. During this inspection we looked to see if these improvements detailed in the action plan had been completed. We found that there were still a number of shortfalls.

We found four repeated breaches and six new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In addition we identified a breach of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found they had failed to make improvements. We have taken enforcement action against Marlborough House Nursing Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. You can see the enforcement action we have taken at the back of the full version of this report.

There was no registered manager in post and the acting manager had not yet applied to be registered. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff did not always treat people with dignity and respect or promote their independence. Staff knew people's basic care needs and some personal information about them. We saw some sensitive and caring interactions between some staff and people.

Not all staff were sure how they should respond to, and report any allegations of abuse or how to raise concerns as a whistle-blower. The provider had not notified us of any allegations of abuse that were being investigated by the local authority.

People's medicines were not safely managed, stored, recorded or administered. This was because some people did not have their medicines as prescribed and staff did not have clear instructions when they needed to give people 'as needed' medicines. This placed some people at risk of harm and not receiving the treatment they needed.

Any risks to people's safety were not consistently assessed and managed to minimise risks. For example, medical emergencies had not been risk assessed and planned for so staff knew what action to take.

People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. People did not always receive the care and treatment they needed and this placed them at risk of harm or neglect. Their health care needs were not always met because the healthcare support they needed was not delivered.

People's need for social stimulation, occupation and activities was not consistently met.

Some people, who needed support to eat and drink, did not get the help they needed so they could do this safely and receive the food and drink they needed to keep them well.

There were not always enough staff to respond quickly to people's requests for care and support and for people to get up when they wanted. There were also delays in answering call bells.

Staff did not have the right skills and knowledge to provide personalised care for people who had specialist

Summary of findings

nursing needs such as epilepsy, diabetes and the use of end of life medicines. This was because they did not have the right training, regular support and development sessions with their manager.

Staff did not understand about making decisions in people's best interests and whether there were any restrictions placed on people who were being deprived of their liberty.

Staff were not always recruited safely to make sure they were suitable to work with adults at risk.

Some areas of the home were not clean, there were unpleasant odours in two of the bedrooms. People were at risk from unlocked rooms with hazards in them and the lack of robust infection control measures.

The systems and culture of the home did not ensure the service was well-led. This was because people, relatives and staff were not routinely involved or consulted about the development of the home. The management of the home was reactive rather than proactive. When we identified shortfalls and risks to people they were addressed. However, the quality monitoring systems in place had not identified the shortfalls we found for people or drive improvement in the quality of care or service provided.

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?

Inadequate

People were not kept safe at the home.

Safeguarding training and policies did not make sure that all staff knew and understood when and who they needed to report allegations of abuse to.

Risks to people were not managed to make sure they received the correct care and treatment they needed.

The management and administration of medicines was unsafe. People did not receive their medicines as prescribed and they were not stored safely.

There were not enough staff to consistently meet people's needs.

Staff were not recruited safely to make sure they were suitable to work with adults at risk.

People were not protected by the prevention and control of infection and areas of the home were not clean.

Is the service effective?

Inadequate

People's needs were not effectively met.

Staff did not have the right skills and knowledge, training and support to meet people's needs.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

Some people did not receive the food and drinks they needed to make sure their nutritional needs were met.

Some people did not receive appropriate support to meet their skin and nail care needs to ensure that they were comfortable and protected from harm. Most people were referred to specialist healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was caring but some improvements were recommended.

People and their relatives told us staff were kind and caring.

Staff did not always respect people's privacy and dignity. People's independence was not always promoted.

Staff had some understanding of people's preferences and how they liked to be cared for. Staff were not aware of everyone's life histories and the importance of using this information when providing care and support.

People and their relatives were not involved in the planning of their care.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive to people and their needs.

People's need to be kept occupied and stimulated was not consistently met. They did not receive support that was personalised to their preferences and personal histories.

People experienced delays in receiving care, their needs were not reassessed when these had changed and their care plans did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Information about complaints was displayed and some people knew how to make a complaint.

Is the service well-led?

Inadequate 

The home was not well-led.

People, relatives and staff told us there had been some improvements but they were not actively involved, consulted and kept up to date about important matters and plans at the home.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

Marlborough House Nursing Home

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 checked 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 13 and 14 November 2014 and was unannounced.

There were two inspectors in the inspection team and they both visited on each date. We met and spoke with all 36 people living at the home. Because a small number of the people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five visiting relatives, and two visiting representatives of the CCG (Clinical Commissioning Group) during the inspection. We also spoke with the acting manager, the deputy manager and six staff.

We looked at seven people's care and support records, all 36 people's medication administration records and other documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one commissioner and eight health care professionals involved with people to obtain their views.

Following the inspection, the acting manager sent us information we asked for about policies and procedures, staff recruitment, and staff training.

Inadequate

Is the service safe?

Our findings

People who were able to said they felt safe at the home. One person said, "The atmosphere is good and I feel safe, the staff are nice and friendly and do anything to help you". Most relatives told us they believed their family member was safe at the home.

Most staff had been trained in safeguarding adults at risk. However, not all of the staff we spoke with were confident of the types of the abuse and how to report any allegations. The safeguarding policy did not include any contact details for reporting any allegations of abuse. This meant that staff may not have taken the right action in response to any allegations of abuse. The acting manager had not made notifications to CQC when allegations of abuse were made and investigated by the local authority. This meant we were reliant of information from the local authorities rather than the home as required by the regulations. Staff were not aware of how any learning from previous safeguarding investigations was shared and what actions had been put in place in response.

In order to protect people from further harm the acting manager had made referrals to relevant professional bodies. For example, nursing staff had been referred to the NMC (Nursing and Midwifery Council) following safeguarding adult investigations, repeated medication errors and where staff had not fulfilled their responsibilities as a registered nurse.

These shortfalls in some staff's knowledge of how to report allegations of abuse was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's medicines were not safely managed, stored, recorded or administered. We looked at the medicines plans, administration and monitoring systems in place for people. There were gaps in people's MAR (medicine administration records). The manager sent us information following the inspection that showed they had identified these omissions for two people and followed this up with staff. However, there were a further three people's records where medicines had not been signed for. In addition one person's records did not show whether one or two tablets had been administered for a medicine with a variable dose.

Some people did not have 'as needed' medicine plans in place. These plans were needed so staff knew when, how often and the maximum dose to be given in 24 hours. This meant some people may not have received their 'as needed' medicines when they needed them.

We looked at the controlled drugs records and storage. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. They have to be stored differently to other medicines and a separate register must be kept. Two controlled medicines had been kept in the controlled drugs storage for nine days without being checked into the controlled drugs register. This was a breach of the Misuse of Drugs Act 1971 and The Misuse of Drugs Regulations 2001.

The medicines fridge on the first floor was iced up and one person's insulin was stored against the ice. This meant that this medicine was not stored at the correct temperature and the guidance provided with the insulin stated that it must not be frozen or stored on or near the ice compartment. This may have affected the effectiveness of the insulin and meant the person may not have received the correct dosage. In addition to this, the daily fridge temperature records book on the first floor had not been completed every day so staff could not be sure the fridge was working correctly.

We found a box of medicine packages on the first floor corridor that were waiting to be returned to the pharmacy. On the top of the box was a medicine blister package with a tablet still in it. This was a risk because the medicines waiting to be returned were not secured and people could have had access to this medicine.

These shortfalls were breaches in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not appropriate arrangements in place for the storage, administration and recording of medicines.

People had risk assessments and management plans in place for falls, moving and handling, pressure areas and nutrition. However, risk assessments and management plans were not in place for some areas of risk. For example, one person had complex epilepsy and was prescribed 'as needed' medicine for when they had an epileptic seizure. There was no plan in place to instruct staff when they should administer this medicine and at what point they

should call paramedics. Staff did not know how the person presented when they had an epileptic seizure and what action they needed to take in response to this person having a seizure. We brought this to the attention of the acting manager because of the risks to this person and the acting manager wrote an epilepsy plan on the second day of the inspection.

These shortfalls in risk assessments and management plans, and emergency plans were a repeated breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had not complied with the warning notice we issued at the last inspection for a breach of this regulation.

Most people and relatives said there were enough staff most of the time. However, this contradicted what we saw and some people told us there were delays in people receiving their care because staff were busy. People were still in bed mid-morning on both days of the inspection and some people told us they were waiting for staff to be available to come and get them up. One relative told us their family member's preference was to get up at 10am and they were routinely left in bed up until 11.30am. However, at other times during the day there were sufficient staff to be able to meet people's needs. Staff told us sometimes there were enough staff and other times there were not. One staff member said, "there's no time to sit and talk with people".

The acting manager showed us a staffing levels calculator tool from June 2014 which they used to calculate how many staff they needed. This was based on people's assessed needs at that time and the acting manager updated this tool during the inspection to show that staffing levels had increased. The acting manager told us more care staff had been recruited but they were still short on nursing staff and were reliant on agency nursing staff.

The shortfalls in delays in people receiving care at the times they wanted it and there not being enough staff to meet people's needs was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at five staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were not consistently safe. This was because not all of the relevant safety checks had been completed before staff worked with adults at risk. For three of the staff recently recruited, there were no references from their last health and care sector employer. They had also not provided a full employment history. One member of staff had started working before a safety check of the adults barred list of workers was completed. This meant the provider could not be sure of the suitability of staff working with older people.

The shortfall in obtaining references from previous health and care sector employers and a full employment history put people at risk from staff who may be unsuitable. This was a breach in Regulation 21 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection in September 2014 we identified shortfalls in cleanliness and infection control at the home. The provider wrote to us and told us they had taken action to address the shortfalls by 1 October 2014.

At this inspection people were still not protected by effective systems for the prevention and control of infection. Areas of the home such as kitchenettes were dirty and there were strong unpleasant odours in two people's bedrooms. Action was taken when we brought the smell of these bedrooms to the attention of the acting manager. Cleaning schedules for the kitchen, toilets and communal areas were not consistently completed to show whether the areas had been cleaned.

Where new cupboards had been fitted in kitchenettes, they had not been painted so that they could easily be cleaned. There were damaged and chipped door frames to bedrooms and sluices. This meant that these damaged and unpainted areas were porous and could not be cleaned properly and was an infection risk to people.

Two of the sluices were left open and they had a number of open sharps bins (these are bins for the safe disposal of used syringes and razors). One of these bins was stained with dried blood. This was a risk because of the spread of infection and the risk of injury to people who could enter the unlocked sluices and have access to the open sharps bins.

There was a strong, unpleasant odour coming from one person's bedroom. There was an incontinence pad and food debris under the bed sheets. Staff confirmed that this incontinence pad had been used and that was the source

Inadequate

Is the service safe?

of the unpleasant smell. In addition bed rail bumpers, these are padded waterproof covers that protect people from injury from bed rails, were damaged, porous and could not be cleaned properly.

Infection control audits had been completed on a monthly basis. The audit in September 2014 did not identify any significant shortfalls. However, the October 2014 audit did identify some shortfalls but still did reflect our findings at this inspection.

These shortfalls in the cleanliness, prevention and control infection placed people at risk. This was a repeated breach of Regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Not all staff received adequate supervision, appraisal and training to enable them to fulfil their roles effectively. Two staff told us they did not have regular one to one support meetings or an appraisal. We looked at staff records and the one to one meeting plan. This supported what the staff told us. However, other staff told us they did have one to one meetings and felt well supported by the manager.

The staff training record showed us staff core training was planned. For example, infection control, moving and handling, safeguarding, fire safety, health and safety and food hygiene. Only seven of the 47 staff employed had completed first aid training. The acting manager told us they were aware of the significant gaps in staff training and they had identified that staff training was an area for improvement. They told us there was a monthly training plan and programme being delivered by the provider's trainers.

Representatives of the CCG (Clinical Commissioning Group) were visiting the home to follow up on an incident relating to the incorrect calculations made when using a syringe driver earlier in the year. A syringe driver is a small, portable pump that can be used to give a continuous dose of painkiller and other medicines through a syringe. They raised concerns with us about the training of nursing staff and how their competency to use a syringe driver was assessed. Although the incident had not resulted in harm to a person, they were concerned that the lack of staff skills had the potential for people receive incorrect dosages of medicines. Not all of the nurses had been trained in the use of syringe drivers or had their competency assessed.

These shortfalls in the staff's skills and knowledge, training, and supervision were a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection in September 2014 we issued a warning notice for the repeated breaches in meeting people's nutritional needs.

People told us they were satisfied with the food at the home. One person said, "The food is quite good, not like home but quite good". Another person said, "I'll eat it (the food) it's adequate and we do get a choice".

People were given a choice of meals the day before. People told us that if they didn't like the two choices the cook would make them something different. However, we saw people were not offered a visual or verbal choice of food and drink at the time of their meal. This meant for some people living with dementia, they may not recall what they had ordered the day before. One person said, "We don't get told what we have for lunch".

The cook was aware of which people needed to have their food enriched and fortified with cream, butter and high fat foods to try an increase their weight. They said they did not receive feedback from nursing and care staff as to whether people were benefitting from their specialist diets. This made it difficult for the cook to assess whether these people with complex nutritional needs were having these needs met.

A relative told us they had provided the staff with their family member's food likes and dislikes when they moved in. This included that the person did not eat fish. The previous week they had arrived at lunchtime and their family member was being fed fish by staff. This meant this person was being fed a food they had previously disliked when they were able to communicate this.

One person had been assessed as at risk of malnutrition, was having difficulty swallowing and had previously lost weight. They had been referred to a dietician and speech and language therapist (SALT). The person had been prescribed a nutritional supplement pudding to be given twice a day. However, records showed this person did not consistently have this supplement twice a day. This placed the person at risk of not having enough to eat to meet their needs. This person also had a low fluid intake for over a week prior to the inspection and no medical advice had been sought. They needed to have their fluids thickened to make them easier to swallow. The guidance from the SALT detailed staff needed to give the person thickened fluids on a spoon. However, on both days of inspection the thickened fluids were left in a beaker with a spout on it and the person was not able to independently swallow the drink. On the first day of the inspection this person's breakfast and drinks were left in their bedroom and were still there uneaten and drunk at lunchtime. It was not until the afternoon that staff took action to ensure the person had something to eat and drink. We discussed this with the

manager who acknowledged the person should be having their fluids from a spoon and on the second day of the inspection we saw staff were sitting with the person assisting them to eat and drink as detailed in their plan.

These shortfalls in meeting people's nutritional needs were a repeated breach of the warning notice issued for breaches in Regulation 14 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had not complied with the warning notice issued at the last inspection relating to a breach of this regulation.

Most staff had been trained in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The acting manager was aware of and understood their responsibility of when a DoLS application should be made. They had made the majority of applications they needed to for people. However, staff were not aware of any of the people living at the home who had DoLS applications made and who were being deprived of their liberty.

Where needed, people had their capacity assessed in relation to specific decisions so plans could be made and care could be provided in people's best interests. However, although the staff had been trained they did not have an awareness of these specific mental capacity assessments and best interest decisions in people's care plans. Staff did not understand the presumption that people have capacity to make decisions for themselves and that their capacity was decision specific.

The shortfalls in the staff's understanding of the MCA, implementation of best interest decisions, and those people who were being deprived of their liberty was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

People's healthcare needs were not consistently met. Although people, relatives and doctors told us medical attention was sought promptly this was not supported by some of the findings of the inspection. For example, staff had not noticed or taken action that one person's toe nails on their left foot were long and extending over the end of their toes. This person was diabetic and needed regular visits from the podiatrist to safely manage their foot care. The person told us it had been a long time since the podiatrist had visited and that their toe nails had got so long on their right foot they "broke off". They said their feet were uncomfortable because their nails were long.

Staff reported to nursing staff on the first day of inspection that another person had a red and sore sacrum. We monitored the care that this person received. They were not repositioned four hourly as detailed in their care plan or taken to their bedroom so the nurse could assess the person's sore area. The following day nursing and care staff responsible for this person told us they were not aware of a sore area on this person, even though this had been recorded. No action had been taken to implement a plan of care to encourage the healing and treatment of this person's sore area.

A third person was in bed late morning on the first day of inspection. Their feet were pushed up against the bed base. This was because the person was tall and the bed was not long enough. We showed the manager who acknowledged that this would cause pressure areas on the person's feet and they required a longer bed and padding to minimise the risks. This meant this person's needs had not been properly assessed and equipment had not been provided to minimise the risk of developing pressure areas.

These shortfalls in people receiving effective care, healthcare support and treatment were a repeated breach Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had not complied with the warning notice we issued at the last inspection for a breach of this regulation.

We saw other people were cared for on the pressure relieving equipment such as cushions and specialist air mattresses and there were systems in place to check that mattresses were on the correct settings.

People were referred to specialist healthcare professionals when needed. For example, one person had been referred to the dietician and speech and language therapist.

Requires Improvement

Is the service caring?

Our findings

People and two relatives were positive about the care provided by the staff. Comments included "Staff are very good, they're very nice" and "Staff are wonderful nothing is too much trouble for them and they respect me that's a big thing". However, their views did not reflect some of our observations and findings.

In September 2014 we issued a warning notice for repeated breaches of the regulation for respecting and involving people.

Some people's personal information was left in the ground floor dining room on both days of the inspection. This information was visible to people and visitors. We saw and heard staff discussing one person's diabetes plan in front of other people living at the home. This did not respect people's rights to have their personal information kept private. We also identified this at the last inspection.

At the last inspection we identified that there was a noisy shower pump in one person's bedroom. At this inspection, we found that the shower pump had been boxed in and covered with carpet but was still noisy. The person's relative told us they and their family member were still dissatisfied with the arrangement and this had an impact on their family member's wellbeing.

One person's name was spelt wrong on their bedroom door and this did not respect the person's right to be called by their correct name.

One person was calling out for staff. We used their call bell to summon staff assistance. When the staff member came they did not know the person's name and called them "Dear". This did not respect this person as an individual.

Another person's care plan identified they needed specialist shaped and moulded cutlery and a plate guard. A plate guard is a raised plastic rim that fits to a plate so people can put food on their cutlery independently and it prevents food sliding off the plate. This equipment was not provided to this person and they struggled to eat their meal independently and in a dignified way.

Two people's relatives told us they were not kept up to date about their family member's health and wellbeing. However, three other relatives told us they were kept up to date.

These shortfalls in maintaining people's privacy, dignity and promoting their independence were a repeated breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider has not complied with the warning notice issued at the last inspection for a breach of this regulation.

We saw most staff supported people in a sensitive and caring way. They did not rush people and chatted with them when they had time. For example, staff supported one person living with dementia to eat their meal in their bedroom, they explained to the person what they were having and smiled at them, the person responded by smiling back, gave the staff eye contact and speaking a few words.

Staff had a basic understanding of people's needs, some of their personal preferences and the way they liked to be cared for. For example, staff knew one person liked a personal photograph, hairbrush and mirror to be with them at all times. Some people's life histories were recorded. However, staff were not aware of this and the importance of using this information to make sure people's preferences were respected and they received personalised care.

People were not routinely consulted or involved in developing their care plans after the initial assessment. Relatives had been involved in some people's assessments and had signed some people's care plans where people were not able to do these themselves. One relative commented they had not been kept informed or been involved in developing ongoing care plans for their family member who was living with dementia. This was an area for improvement to involve people and their relatives where appropriate in the ongoing review of people's care planning.

People told us their relatives were free to visit whenever they wanted. Relatives said they were made to feel welcome and staff made them drinks when they visited.

Inadequate

Is the service responsive?

Our findings

One person asked to use the toilet and was asked by staff to wait for five minutes. Staff did not return within five minutes and 10 minutes later another person used the call bell to summon assistance for the other person. During the inspection three people were calling out for assistance from their bedrooms. In addition to this two people did not have access to their call bells and a further two call bells were not working. We went in to one person who was calling out and rang their call bell. The call bell was showing as ringing in their bedroom but was not showing on the panel that staff used to alert them. After 10 minutes we fetched a member of staff. One person told us, "this morning I felt I needed to call out because nobody came, it was 11:15 I asked for a sandwich but nobody came back". We informed the acting manager about the call bells not working and the maintenance worker replaced and checked the call bells. However, they were not sure how long they had not been working.

One person told us, "Staff aren't rough or unkind it's the waiting time when I ring the bell. A few weeks ago I had a bowel action and I had to wait 2 hours". The person explained they were very embarrassed, upset and uncomfortable whilst they waited for staff to come and assist them.

The acting manager gave us the latest call bell summary and this showed that most call bells in the 24 hour period were responded to within five minutes. However, 14 call bells were not answered for over five minutes, three of these were over ten minutes. This meant that these people were waiting a long time for assistance.

People had an assessment of their needs completed prior to moving into the home or on their arrival if they were there for a short stay. However, care was not always delivered as described in people's care plans and some care plans were not updated as people's needs changed or were not in sufficient detail for staff to be able to follow them. Two staff told us they had not read people's care plans but they had looked at their folders kept in their bedrooms. These folders included monitoring records and a summary of the person's needs. This placed people at risk of not receiving the care and treatment they needed.

One person's plan detailed that their mobility fluctuated and if they were unable to stand independently they were to be hoisted. However, staff were not aware of this and repeatedly attempted to get this person to stand. When the person was unable to stand they left them where they were, even though the person had requested to go to the toilet and returned again later to try and stand them again. This person did not receive the care and support as described in their care plan and their needs were not responded to.

An agency nurse who was working for the first time at the home told us they did not have sufficient information about people's health conditions and they needed to contact another nurse on duty for advice. Although they had been given a summary of people's needs this was not in sufficient detail for them to provide the nursing care people needed. For example, one person had to tell the agency nurse themselves they needed their blood sugars testing before their meal. The agency nurse then needed to seek advice as whether to administer the person's insulin because they found it difficult to follow the care plan in place.

Another person was having oxygen 24 hours a day from an oxygen concentrator machine. This was a machine that generates oxygen. This machine had a filter that needed to be cleaned weekly; the instructions about this were clearly printed on the machine. This was also detailed in the person's risk management and care plan. The filter looked dusty and the person told us they could not recall if it had ever been washed. Staff were not aware if the filter had been cleaned and where this would be recorded if it had been cleaned. We found no records to show this filter had been washed. This placed the person at risk because staff had not followed the care plan and the filters needed to be cleaned to make sure they received the correct level of oxygen that was dust free.

One person said, "We do have an activities coordinator but we don't see her very often". Another person told us, "Activities are now only twice a week, last year we went out much more. Staff don't have time to talk to me." A third person said, "I'm fed up, sitting here like a dummy".

There was an activities worker who organised group activities in the afternoons. We saw people attending the weekly lunch club with relatives which they said they really enjoyed. The acting manager told us the activities worker spent time each morning with people who stayed in their bedrooms. However, people, relatives and the records showed this time was very limited and did not focus on

Inadequate

Is the service responsive?

individual activities for people. For example, a relative of person living with dementia told us their family member had previously been a musician and played the keyboard. They were very concerned about the lack of stimulation at the home for their family member who stayed in their bedroom. They told us there was never any music playing for them to listen to. Staff had not explored this person's interests and life histories to plan how to provide meaningful activity and occupation for the person.

These shortfalls were a breach in Regulation 9 (1)(a) (b) (i) (ii)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not receiving the social stimulation, care, treatment and support they needed to meet their care, support and emotional well-being needs. This was because their needs had not been fully assessed and care plans had not been put in place or they had not been followed.

Information on how to make a complaint was in the entrance of the home. There were mixed views from people about whether they felt they could raise complaints or concerns. One person said, "I can't talk to anybody if I was worried there just isn't anyone I can talk to". Other people and relatives told us the acting manager was approachable and when they had raised any concerns the acting manager had sorted it out.

We saw written complaints were investigated and responded to in line with the complaints procedure. However, there was no evidence of how learning from complaints was regularly shared with staff to improve the quality of the service. This was an area for improvement.

Inadequate

Is the service well-led?

Our findings

There was not a fully inclusive and open culture. We found some improvements since our last inspection in that some people, relatives and staff told us they had confidence in the acting manager. The acting manager had moved their office to an empty bedroom next to the reception area of the home so that they were more visible and available to people, relatives and staff.

People were not routinely consulted or involved in the development of the service. They told us that they were not regularly asked their views on their care and activities or kept informed of any action plans were in place to improve the home. The acting manager had consulted with people about the food at the home. However, the cook was not aware of the results of these surveys so they could not take action and implement any changes needed. The manager told us that they had not yet had time to feed this information back.

Relatives were not regularly consulted about issues at the home and they did not have the opportunity to be involved in the development of the service. The acting manager told us they had tried to organise relatives meetings in the past but no one had attended. Two relatives felt that things had improved since our last inspection. Relatives told us they had been invited to a meeting with the provider following some negative publicity in the local press. However, they commented that they had not been kept informed of the concerns prior to the information being published in the press. We saw the minutes of this meeting and saw additional concerns were raised by relatives about the high turnover of staff, staff shortages at weekends and the need for redecoration of some bedrooms. One relative had also commented the staff were good and their relative was cared for. However, the provider did not share with the relatives any action plan of how they planned to address the shortfalls to improve the service for people.

The majority of staff told us the acting manager was approachable, that they could talk with them and that when they raised any issues these were addressed. Staff told us there were handovers at the start of each shift where they discussed each person they were responsible for and any change in their needs. They also discussed any urgent matters and plans for the day. Although staff told us and records showed us there were staff meetings, staff did not have the opportunity to regularly discuss issues, express their views and influence the development of the home. From discussion with the staff and from meeting records there was no evidence of how learning from incidents, accidents, safeguarding and complaints and compliments, was shared with staff to improve the service provided.

The acting manager and staff told us that some staff were paid different amounts for the same roles and this contributed to the lack of team work and loyalty to the home.

Throughout the inspection we raised any issues of concern with the acting manager who then took action to address these areas. However, the management and governance systems in place had not identified all of these shortfalls prior to our inspection. This had placed people at risk of receiving unsafe care and treatment.

The acting manager identified that one of the problems they had was that they had needed to work as nurse on duty and this had reduced their ability to complete management tasks. The manager had the ability to book agency care staff when they needed to cover the staff rota but the provider made decisions about booking any agency nursing staff that were needed. This then had an impact on the amount of hours both the deputy and acting manager needed to work as a nurse providing care to people rather than overseeing the management of the home.

The quality assurance systems in place were not effective and did not drive improvement in the quality of care and service provided. For example, the acting manager and deputy manager told us they checked the controlled drugs every Sunday with another registered nurse. However, their audits had not identified the two controlled medicines in the controlled drugs cabinet that had not been recorded. Medicine audits had been completed monthly up until September 2014. These audits included checks on a small sample of people's medicines and had identified shortfalls which were followed up with the staff involved. The acting manager acknowledged they had not had time to complete the audit for October 2014 and subsequently some of the shortfalls we identified had not been picked up.

A sample selection of people's care plans and records were audited each month. Actions were identified on the audits

Inadequate

Is the service well-led?

but there was no system in place to ensure that actions had been taken. This meant the acting manager and provider could not be sure whether staff had taken action to make sure care plans reflected people's current needs.

The call bells response times for a 24 hour period were audited two or three times a month. However, there was no follow up with staff or action plans to look at how to improve to the response times for people.

Staff told us they were not aware of the whistle blowing policy and how they could raise concerns by whistleblowing but this did not reflect what the acting manager told us. They said they had also identified this and now included information in staff induction and staff meetings to make sure staff knew how to report any concerns. They gave us an example where a member of staff had raised concerns about another member of staff and the acting manager had taken appropriate action. This however, contradicted our findings because discussions with staff showed us the information given by the acting manager about whistleblowing was not effective.

The acting manager sent us policies and procedures that had been reviewed in July 2014. However, these policies had not all been implemented to benefit people and the safe running of the home. For example, there was a policy for emergency planning but this was generic for all the provider's homes. There was no emergency plan in place that gave staff instructions how to manage any emergencies at Marlborough House Nursing Home.

Whilst accidents, incidents, compliments and complaints were recorded, there was no evidence that learning from these was shared with staff.

The local authority and clinical commissioning group had completed a joint contract monitoring visit in July 2014. They had identified many of the shortfalls we identified at this inspection and our previous inspection and set a timescale for meeting the shortfalls by 1 November 2014. Again this reflected many of the concerns and shortfalls we have identified at this inspection that had not been addressed. For example, call bells not being responded to promptly, signing off actions in audits, staff training, infection control and staff not being recruited safely.

These shortfalls in how the service was led, was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Notifications had been made to us for a number of incidents such as accidents. However, the manager had not notified us of safeguarding allegations and investigations as required by the regulations. This meant the provider had not shared information with us appropriately regarding safeguarding allegations and we were reliant on the local authority to notify us of these incidents.

This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 because the provider had not notified the Commission of incidents affecting people.

There were systems in place for the regular monitoring and checking of equipment. For example, fire systems were tested weekly, electrical appliances were tested annually, hoists and the boilers were serviced.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care because they had not assessed, planned and delivered the care to meet service user's needs and ensure the welfare and safety of each service user.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service user's needs.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made arrangements to ensure the dignity of people and did not treat people with consideration and respect.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People were not protected from the risk of infection because appropriate guidance had not been followed.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe storage, use and management of medicines

The enforcement action we took:
We have cancelled the registration of this service.

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 providers People who use services and others were not protected against the risks associated with unsafe or inappropriate care because the registered person did not have effective systems in place to monitor the quality of the service delivery.

The enforcement action we took:
We have cancelled the registration of this service.