Four Seasons 2000 Limited

Marlborough Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Marlborough Court is a care home providing personal and nursing care to 69 people aged 65 and over at the time of the inspection. The care home can support and accommodate up to 78 people across three separate wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were at risk of avoidable harm. Staffing levels were not sufficient to ensure people received safe care and support. Action was not taken to ensure learning from incidents and accidents and when things go wrong.

Staff were not kind and compassionate towards people and did not treat people with respect and dignity. Staff did not always communicate and involve people and their relatives in their day-to-day care and support.

The service was not well-led. The culture of the service did not promote safe care and positive outcomes for people. The registered manager and provider had not taken adequate steps to address concerns relating to poor care, staff conduct and practice. The registered manager did not check the quality of care and risk management plans to ensure they achieved positive outcomes for people.

People's relatives told us they did not receive updates about the service. They had not been given avenues to feedback about or be involved in the running of the service. Relatives complained the registered manager was not accessible and did not maintain communication with them.

Systems and processes in place did not effectively safeguard people from abuse.

People's medicines were administered and managed safely. There were systems in place to control the risks of infection and staff followed this.

The registered manager notified reportable incidents and events as required by their registration.

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

Rating at last inspection and update
The last rating for this service was Good (published 10 January 2018).

Why we inspected
We received concerns in relation to neglect and poor care and the management of people's risk of falls. As a

result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively. The provider was following infection control procedures to prevent and manage the risk of infection and coronavirus.

We have found evidence that the provider needs to make improvement. Please see the safe, caring and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering
We will continue to monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to risk management, staffing levels, dignity in care and good governance at this inspection.

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

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Marlborough Court

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 Care Act 2014.

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

Inspection team
The inspection team consisted of two inspectors and a specialist professional advisor. The specialist advisor was a qualified nurse.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service which included notifications of events and incidents at the service. We spoke to two relatives of people who had recently used the service and we received feedback from a member of the local authority commissioning team. We used all this information to plan our inspection.

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

During the inspection
We interacted with three people, spoke with three care staff members, two nurses, the registered manager and the regional support manager. We looked at six people's care files, medicines management records, staff supervision records, incidents and accidents, quality assurance reports and other records relating to the management of the service, including safeguarding and complaints records. 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.

After the inspection
We spoke with eight relatives of people using the service. We looked at six people's care plans and risk assessments in relation to managing falls, staff training matrix and other records to validate evidence found.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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.

Assessing risk, safety monitoring and management

- People were not protected from the risk of avoidable harm. People were at risk of and had suffered avoidable harm from falling. Staff did not have the information they needed to reduce the risk of people falls. Risk assessments and care plans were not sufficiently detailed to manage known risks.
- We found one person had suffered multiple falls which had resulted in injury. Their care plan stated they needed regular monitoring to reduce the likelihood of falls. We checked their daily care notes and we found there was no consistency in how regularly the person was monitored by staff.
- In another example, a care plan was in place for managing one person's risk of falls and identified the person as high risk due to a medical condition and stated the person needs to be monitored closely. No further measures were looked at or put in place to manage and prevent the risk of falls. The person had experienced multiple falls in September, but this care plan hadn't been reviewed to reduce their risk of falls further.
- In a third example, it was found that equipment in place to prevent falls was found not to be working even though the person had been identified to be high risk of falls. The person had an unwitnessed fall which resulted in injury. The person's relative commented, "When relative came they told us they would put a sensor mat in their room because of their risk of falls. I later realised that the mat in their room was not even working. The deputy manager told me when I asked questions about it." There was no mention of the use of sensor mat in the person's care plan.

We found evidence people were at risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Lessons were not learnt from incidents and accidents. We found reports were made following incidents and accidents, but reviews were not always undertaken to identify what caused the incident and measures were not put in place to prevent further falls.
- For example, no changes or new measures were put in place to address and prevent people at risk of falling. This meant people had multiple falls and exposed to harm as a result.

Due to poor management of incidents and accidents people were placed at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staffing levels were not sufficient to respond to people when they needed care and support. People's calls

for help were not always answered promptly. One person waited for over two hours before they got the help they needed. The person needed two staff members to assist them. Each time a staff member came to the call, they said they were going to find another staff member to help them but never came back.
● On another occasion, one person needed help with their toileting needs but did not get the help they needed until it was late and became unintentionally incontinent. The staff member who responded to the person's call after this incident could not find another member of staff to join them because the person required two members of staff to support them.
● During lunchtime on the second floor, it took about two hours for staff to get to people to provide the assistance people needed to have their meals as most people needed support to eat and there were not enough staff around to offer this support promptly. We observed one person fell asleep in the dining room with their food in front of them because staff were busy, so did not have the time to prompt the person to eat.
● We noticed on the ground and first floors, that people were wandering around the corridors and there were not always staff within sight to ensure people were safe. One relative told us, "I have seen people wandering and there were no staff to keep an eye one them. It worries me sometimes." Another relative commented, "There is definitely not enough staff. How can there be enough staff available and no one knows when a person has a fall or how long a person was on the floor?"
● Staff also commented on the level of staffing. One care staff member told us, "There is not enough staff on the nursing unit. I worked there and it was hard and difficult for the staff. We were always rushed because the residents are heavy and take time to care for. Its better on this floor but more staff is always better so we can care for the clients properly." Both nurses on duty in the nursing unit told us that more health care assistants were needed to ensure safety of people.
● We asked the registered manager how they determined staffing levels. They told us there was no tool used currently but the organisation was in the process of devising one.

People were at risk of unsafe care due to insufficient staffing levels. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were at risk of abuse as systems and processes in place were not effective and did not safeguard people from abuse.
● There had been allegations of abuse relating to poor care, neglect, staff behaviour and practices. Action had not been taken to address poor practices and staff behaviour towards people. Even though records showed staff had completed training in safeguarding adults from abuse. There had been a number of allegations of abuse relating to poor care, neglect, staff behaviour and practices. We found that the registered manager and provider had not carried out programmes to ensure training received was embedded and reflected in staff day-today practices and behaviours.
● Staff gave different views on how they would respond if they noticed abuse. One staff member told us they would escalate their concerns externally if the registered manager failed to take appropriate action. Another care staff said, "If I told the registered manager and they didn't do anything I would not tell anyone else as it's not necessary to tell anyone that doesn't work at the home."

People were at risk of abuse as systems and processes were not effective to prevent abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager reported allegations of abuse to the local safeguarding team and CQC as required

Using medicines safely

● People's medicines were administered and managed safely. Only trained staff and qualified nurses administered medicines to people.

● Medicine administration record charts were maintained and were legibly signed to show medicines administered.

● Where people had 'as when required' medicines, there was protocol in place to manage this and we noted staff followed the protocol.

● There was a protocol in place for the use of covert medicines, where it was used. Covert medicines are medicines administered in a disguised format without the person's knowledge. Controlled drugs (CD) were locked securely in a cupboard. Two staff members administered and signed the CD records and carried out daily checks to ensure record tallied with stock.

● Medicines were stored within safe temperature ranges, in line with the manufacturer's instructions. Regular checks were made of storage temperature areas to ensure they remained safe.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff did not treat people in a caring and compassionate manner. Six of the eight relatives we contacted expressed their disappointment in the way staff treated people. One relative told us, "The carers have no compassion and I wonder why they are doing the job really. They ignore residents, leave them unattended and even insult them. It is really sad." Another relative commented, "The carers are a disgrace. The fact that they treat for people the way they do is unbelievable and sad. The staff spoke to [relative] with no sympathy, and compassion. My relative was often ignored, left without stimulation." These comments from relatives also matched information we had received in March 2020 from a whistle-blower. They expressed concerns that staff treated people poorly and mocked people.
- On the day of our inspection, we observed staff did not show consideration to people's needs and feelings. We heard one person screaming for help for about five minutes. They sounded very distressed. A staff member close by did not respond because they were doing something else and no other staff responded until they saw us coming.
- On another occasion, one person called for help to be put back to bed after lunch. They called for help seven times between 12:40 – 14:30. Each time it took three minutes for a staff to respond, they turned off the call alarm and told the person they were going to find another staff to help but they never came back. They told us, "All I want is to be go to bed to catch some sleep." When we asked how often this happens, they told us it happens quite often. We had to ask staff before the person was eventually assisted to bed.
- People with nursing and complex care needs were left unstimulated. People were left in their rooms with no interactions or activities to stimulate them.

We were concerned about how people were treated. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care.

- People were not always involved in their day to day care delivery. Relatives told us communication had been poor and they were not always given updates about their relative's wellbeing.
- One relative explained, one time when they visited, the care staff who came to assist their relative in the room started wheeling their relative to the lounge without communicating or explaining to them first. The care staff did not ask the person or their relative where they preferred to spend time and did not consider if the family wanted a private time together. The relative told us they insisted that the care staff bring their relative back to the room as they wanted some privacy.
- Another relative commented, "The staff never call me or inform me of anything going on, especially as I

can't visit because of the lockdown. I have to ring every time to find out how my relative is and to find out what they need. Sometimes I ring several times before I get someone to speak to. No feedback is given."
● These comments matched what a member of staff told us when we asked why they delayed in responding to the person's call for help. They said, it hasn't been long since the person was supported out of bed. They implied the person shouldn't be going back to bed at that time but had not communicated this to the person.

This was a further breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were given a choice of what to eat and drink during lunchtime.

Respecting and promoting people's privacy, dignity and independence
● Staff did not promote people's dignity, privacy and independence. Relatives raised concerns about the way staff supported people. They told us their relative's dignity was not supported and people were not supported to maintain their personal hygiene and appearance.
● One relative told us, "When I visited my relative recently, they looked like they haven't had a shower for a long time. They were smelling and had another person's clothes on. They looked very unkempt. Staff knew I was visiting so would have expected them to make more effort to improve their appearance at least. I was disappointed with that." Another complained, "Staff often leave [my relative] unchanged in their soiled incontinence pad. On some occasions the pad was full and heavy and was coming down their trousers." Another relative narrated that one time when they visited, they saw a resident in the toilet half naked, from waist down. A staff member was outside but hadn't thought of closing the door. They had to ask the staff to please close the door. They said, "It was 'not nice to see that at all."
● These comments matched the concerns we had received from a whistle-blower. The concerns included, staff not attending to people when people when they needed personal care and staff not checking people during the day and people not always getting assistance needed with their personal care.

This was a further breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- The culture of the service did not promote positive outcomes for people. People's relatives complained about the quality of care their relatives received. One relative told us, "If the management knew they won't be able to give [relative] the care they need, I don't understand why they accepted them to come. Relative was only there for a few days and they are now a completely different person." Another relative said, "It is obvious [relative] was not getting the care they needed. The question is, if they can't look after people why accept them in the first place."
- There was no evidence to show that staff were supported to improve their practices following concerns about the service. We saw records of a daily 'walk around' from the registered manager and deputy manager. However, this was not focused on improving staff behaviour and culture on how they treated people. Supervision and team meetings were not regular and when they happened, they were not targeted at addressing and improving concerns/issues being raised at complaints and whistleblowing. This meant people were exposed to poor treatment from staff.
- Relatives made comments about the registered manager's ability to address staffing concerns and performance. One relative commented, "The registered manager is weak and too soft with the carers. She is not strong enough to address the culture of the home." Another relative told us they didn't the carers are well-trained or supervised by management due to the poor care they provide.

The provider did not encourage a culture that ensured people's needs were met. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The quality of the service was not regularly monitored to quality and safety in the service delivered. The registered manager kept records of incidents and accidents; and analysed them. However, there was no learning from them. Record showed there had been 23 falls from 1 July to 23 September; and 17 of those were unwitnessed. We found appropriate actions were not taken to reduce the risk of falls for people and to maintain their health and safety.
- Care plans were not detailed and were not addressing risk of falls for people and this had not been picked up by management. There was a fall risk analysis in place which totalled the number of falls in the service. As a service, an action plan had not been developed on how to improve in this area.

● We found care plans were not person-centred and did not provide guidance to staff to support people safely. Care plans were not reviewed when people's needs changed, and measures included to support people with their changing needs.
● Irrespective of the number of falls which resulted in injuries to people, the provider and registered manager had not reviewed staffing levels or checked how staffing levels contributed to this risk. At the time of our inspection, there was no tool for determining staffing levels to ensure people were supported in a safe way.
● The views people and their relatives had not been sought about the service. There had not been any satisfaction surveys or questionnaires done in the last one year. The registered manager told us they held relative's meetings before the lockdown due to the lockdown they haven't had any.
● Relatives complained that they were not getting updates from the service and did not have opportunity to give their feedbacks. One relative commented, "The level of communication is very poor especially during this time. You never get hold of her to discuss matters or asks for feedback. It's frustrating."

The registered manager failed to ensure the continuous improvement of the service. This was a further breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager / provider completed environmental, medicines and infection controls audits which identified and addressed issues relating to the environment and premises.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 registered manager understood in their roles in terms of reporting incidents to professional bodies including CQC as required in line with their registration.
● However, relatives commented that the management team was not always honest with them when things go wrong. One relative said, "There is lack of transparency. The management have been unable to tell us when and how my relative fell. They didn't provide us with sufficient information about the fall." Another relative commented, "I have tried to address concerns with the manager, but they keep swerving on matters, I think because she doesn't know or because she is overwhelmed."

Working in partnership with others
●The service worked closely with local service commissioners, the NHS Clinical Commissioning Group, and health and social care professionals. The registered manager participated in safeguarding meetings.
● The registered manager told us before the pandemic they had partnered with the local community groups to deliver activities to people.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager had failed to ensure that people were safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to ensure there were enough staff to keep people safe.