Four Seasons 2000 Limited

Marlborough Court

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 26, 27 and 28 April 2016. The inspection was undertaken to check on serious safety concerns we had received about the service. We identified breaches in legal requirements in relation to safe care and treatment and monitoring the quality and safety of the service. We took action to impose a condition to restrict new admissions to Marlborough Court without the prior written agreement of the CQC. We also imposed conditions that the provider undertakes audits of the training and supervision of all staff at Marlborough Court and send the CQC written reports of the results of these audits and any action taken or to be taken as a result of the audits. The provider must continue to provide us with such reports following each and every audit undertaken in respect of these matters. You can see what action we told the provider to take at the back of the full version of the report.

Marlborough Court provides care for up to 78 older people requiring residential or nursing care, some of whom may be living with dementia. The service is provided over three floors. Thames unit on the ground floor provides nursing care for 21 people, the Union Jack unit on the first floor provides residential care for 28 people who live with dementia and King George unit on the top floor provides residential care for 29 people. We last inspected Marlborough Court in June 2015. At that inspection we judged that the home was outstanding in the key questions effective and well led. The overall rating for the home was "Outstanding".

At the time of this inspection, a number of changes had taken place in the home, which negatively impacted on the quality of care provided to people. The overall rating of the home dropped from outstanding to inadequate. The primary reason for the decline in quality and rating is the changes in management and staffing.

The home did not have a registered manager in place. The previous registered manager left the home in December 2015 and the previous deputy manager left the home in February 2016. Twenty one other staff had left employment at the home from 28 December 2015 to 24 April 2016 including two senior health care assistants and seven health care assistants. Some regular bank staff had also stopped working at the home. The current manager started working at the home on 1 February and a deputy manager had been appointed on the 1 April 2016.

At this inspection we found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014 in relation to safe care and treatment and staffing. Action had not always been taken to support people where risks to them had been identified. Staff did not assess risks to people using the service in a timely way following a fall and Staff did not respond appropriately and in good time when a service user had a fall. Staff were not always following the guidance as recorded in some people's care files and staff were not updating some people's care plans to reflect their current or changing needs. Staff had not received the appropriate support, training and supervision to enable them to carry out their duties. We found that untrained staff were administering medicines to people using the service.

Some staff were not aware of their responsibility to report abuse. Staff were not always aware of people's

care needs. Some staff had not had the time or the opportunity to read care files and risk assessments or get to know the people using the service. People using the service were not always treated in a dignified manner. The provider's systems for monitoring the quality of the service provided to people were not operating effectively as we found some issues with care plans and risk assessments that the provider had not identified.

We found that appropriate recruitment checks took place before staff started work. People received their medicines as prescribed by health care professionals. There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely.

The manager understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans. People had access to a GP and other health care professionals when they needed them.

People using the service and their relatives, where appropriate, had been consulted about their care and support needs. There was a range of appropriate activities available for people to enjoy. People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Staff said they enjoyed working at the home and they received good support from the manager. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.
The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Action had not always been taken to support people where risks to them had been identified. Risk assessments were not always updated following changes.

There were safeguarding adults and whistle blowing procedures in place however not all staff had a clear understanding of these procedures.

People were not always receiving their medicines as prescribed by health care professionals.

There were arrangements in place to deal with foreseeable emergencies although staff were unsure of the protocol to follow after a person fell.

Appropriate recruitment checks took place before staff started work.

Is the service effective?

Inadequate

The service was not effective

Staff had not completed mandatory training that enabled them to meet peoples care and support needs.

Staff were not receiving on-going supervision in their roles to make sure their competence was maintained.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans.

People had access to a GP and other health care professionals when they needed them.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff practices and behaviours that did not promote people's privacy and dignity. People using the service were not always treated in a dignified manner.

People using the service and their relatives, where appropriate, had been consulted about their care and support needs.

People using the service and their relatives were provided with appropriate information about the home before they moved in.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans had not always been updated to reflect their changing needs.

Staff were not always aware of peoples care needs.

People were provided with a range of appropriate social activities.

People using the service and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Inadequate

The service was not well-led.

The home did not have a registered manager in post.

The provider's quality monitoring systems were not operating effectively.

The management team had not developed the staff team at this point to make sure they always displayed the right values and behaviours.

Staff said they enjoyed working at the home and they received good support from the manager.

There was an out of hours on call system in operation that ensured that management support and advice was available to

staff when they needed it.

Marlborough Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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. The inspection was also undertaken to check on concerns we had received in relation to safety.

This unannounced inspection was carried out on 26, 27 and 28 April 2016. The inspection team on the first day consisted of three inspectors one of whom was a CQC pharmacist inspector and another was an enforcement inspector. The inspection team on the first day also included two specialist nurse advisors. One inspector visited the home on the second day and two inspectors returned to the home on the third day.

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required by law to send us. We spent time observing the care and support being delivered. We spoke with eight people using the service, four visiting relatives, two health and social care professionals, 16 members of staff including the chef, deputy manager, home manager, regional and three members of the provider's residents' experience team. We looked at records relating to the management of the service including the care records of fifteen people using the service, medicine's records, staff training and supervision records and six staff members' recruitment records and quality monitoring records.

Not everyone at the service was able to communicate their views to us so we also 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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service and their relatives told us they felt staff supported them safely. One person told us, "The staff make sure I get my medicines when I am supposed to. They are not rough with me when they help me in and out of my wheelchair. I feel quite safe. The staff seem to know what they are doing." A relative said, "I think my relative is safe here. They seem to be happy, well looked after and cared for." Despite these positive comments we found that the service was not safe.

At our inspection in June 2015 we rated this key question – Is the service safe? "Good". We have rated this question as "Inadequate" after this inspection. This is because there has been a significant number of staffing changes at the service, which contributed to the decline in the quality of care being provided. We have recorded the details of the staffing changes in the Well Led section of this report.

Action had not always been taken to support people where risks to them had been identified. People's care files included assessments of risk in areas such as falls, moving and handling and medicines. We saw that guidance was in place for staff detailing what support people required when mobilising and the prevention of falls by ensuring the correct foot wear was worn when out of bed. On the morning of the first day of our inspection we found a person using the service lying on the floor outside their bedroom. They told us they had fallen over. We called two health care assistants who responded quickly. They asked the person if they were okay and checked the person's limbs. However we had to point out a further minor injury to the person. A senior carer told us they had only just started work on the unit and did not know the person's health needs or if they were at risk of falls. Staff were not clear about the protocol for care following a fall. We received conflicting responses when we enquired what staff needed to do when a person using the service had a fall. A senior health care assistant said they usually called the home manager as the manager was a nurse and they assessed people when they fell. As the manager was not on duty, they would go to the nurse on the nursing unit for support. They could not find any written guidance on falls when we requested it. Later on a senior manager told us as the fall occurred on a residential unit and therefore staff were required to call a GP or a district nurse.

We found that a person who had a specific medical condition required weekly blood monitoring tests to be carried out on Tuesday mornings. At 11am on the first day of the inspection, a Tuesday morning, we saw that the test had not been carried out. A senior health care assistant told us they had not been trained to carry out this blood monitoring and they would ask the nurse to do this. At 2.30pm a nurse undertook the blood monitoring test and reported the result to a GP. However on the third day of the inspection we checked the blood monitoring record sheet for this person and found their blood monitoring test results had not been recorded. The service had not acted to monitor the risk to this person's health.

On the third day of our inspection we saw a person using the service walking unsteadily down a corridor with their shoe laces flapping around their feet. When we pointed this out to staff they took action immediately to support the person. This person's care plan review for February 2016 stated they could walk short distances independently. They were to be monitored by staff because they were prone to falls. Their care plan review for March 2016 stated the person's mobility was still unsteady and they were being

supervised. We also saw that where people using the service had had a fall, their care plans and risk assessments had not always been reviewed or updated. For example one person using the service had a fall on the 31 March 2016, their care plan and falls risk assessment had not been updated since 15 March 2016. Therefore the most recent fall had not been taken in to account when reviewing their risk. During our inspection in June 2015, staff were aware of people's risk of falls and managed this in a person centred way. At this inspection, we observed that there had been a significant number of staff changes. Some of the new staff did not know people well enough to meet their needs and were not always familiar with guidance in place for managing falls.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.
A senior manager later showed us a new policy for falls management which included a post falls protocol flow chart. They told us these protocols would be laminated and displayed throughout the home. This was to inform staff of what to do following a fall. However we were unable to assess the effectiveness of this measure at the time of our inspection.

Medicines were not always managed safely. We looked at the medicines administration records, MAR's, of sixteen people using the service. These included the person's photograph, details of their GP and any allergies they had. Staff had signed the MAR's confirming that they administered medicines to people using the service. The MAR's recorded when staff had applied prescribed creams however staff had not always recorded the dose of creams given. Staff had also recorded where they had applied patches to people. Although this enabled staff to rotate the sites of application of the patches, they did not always do this. This meant that medicines were not always administered in the most effective way.

Staff administered medicines to some people using the service by hiding it in food or drink. However there were no instructions from health care professionals for staff on how to give medicines covertly and staff disguised medicines themselves, which was unsafe. One person's medicine's risk assessment had been reviewed on 18 April 2016. The assessment recorded that the person had refused to take their medicines for 6 days in one month. A nurse had recorded that a GP had recommended hiding the person's medicines in porridge. However there was no covert medicines agreement in place or best interest decision making record and the care plan and risk assessment had not been updated. Pharmacy advice had not been sought. The nurse on duty told us they were not aware that this person needed to take their medicine covertly and would not give it to them without an appropriate agreement in place. This person was at risk of harm because they were not receiving a regular dose of their prescribed medicine and appropriate action had not been taken to ensure this was managed safely.

Staff recorded the temperature of the rooms where medicines were stored daily however we saw a seven-day gap in one set of these records. One of the rooms was too hot at 25.4°c. Whilst staff also documented fridge temperatures each day, they did not reset the fridge thermometers correctly. Therefore some of the recorded temperatures were incorrect. This meant people could be at risk of receiving medicines that were not effective because they were not being stored at the correct temperatures.

One person in the home was receiving prescribed oxygen. No checks had been carried out to ensure the machine delivering the oxygen was working as it should. The nurse in charge of the unit was able to tell us the sort of checks that should be made but was new to the service and had not started carrying out the checks at the time of our inspection. There was a spare oxygen cylinder available in case of equipment breakdown, but this was stored in a room without the appropriate signage in place to alert people to oxygen

storage.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Following our inspection the provider produced some printed signs to indicate where the oxygen was stored these signs were on paper and would not be able to withstand fire. The room where medicines were stored was clean and spacious with hand washing facilities. Staff ensured that all prescribed medicines including controlled drugs were available and stored securely. Staff checked controlled drugs twice daily. We checked some controlled drugs and found the stock reflected the quantity written in the controlled drugs registers. A local pharmacy supplied medicines to the home each month. Most tablets and capsules came in blister packs. Staff kept records of the stock levels of medicines supplied in their original packaging. Staff kept records of medicines for disposal and returned unwanted medicines to the pharmacy. Staff gave medicines to people using this policy and kept appropriate records. Staff completed daily checks of the MAR charts to ensure that there were no gaps. A manager conducted additional monthly checks of a sample of MAR charts, and sent action plans to staff.

The home had a policy for safeguarding adults from abuse and a copy of the "London Multi Agencies Procedures on Safeguarding Adults from Abuse". The manager was the safeguarding lead for the home. Most of the staff we spoke with demonstrated a clear understanding of the types of abuse that could occur. They told us about the signs they would look for, what they would do if they thought someone was at risk of abuse and whom they would report any safeguarding concerns to. One member of staff told us, "I would report any concerns I had to the manager. I would go further than the manager if they didn't take any action. I would let the local authority and the CQC know." However some staff were not sure of the correct reporting procedures. One member of staff who told us they had received safeguarding training, when asked what they would do if they witnessed abuse occurring, said they would not report the incident straight away to the manager. They would address their concerns with the abuser first then tell the team leader and then the manager. They said they would not know how to escalate any safeguarding concerns they had outside of the home. Another member of staff told us they would report any safeguarding concerns to the team leader after talking to the carer involved, then to the manager or 'someone higher'. Neither of these staff were aware of the homes whistleblowing procedure. People using the service were at risk of abuse because some staff were not aware of their individual responsibilities to prevent, identify and report abuse.

These issues are a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of this inspection there were two safeguarding concerns being investigated by the local authority. We cannot report on these at the time of this inspection. The CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

There were arrangements in place to deal with some foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. Staff said they knew what to do in the event of a fire and we saw records confirming that regular fire drills were carried out at the home. We saw that where required call bells had been placed within peoples reach. We observed that staff responded quickly when call bells were activated. One person using the service told us, "If I call the staff they come, they are usually pretty quick to respond." Another person told us their call bell had stopped working the previous evening but been replaced by that morning. The homes maintenance man showed us records confirming that equipment such as hoists, pressure mattresses, wheelchairs, call bells, the lift and fire equipment were routinely serviced and maintained to

reduce possible risks to people. Checks were also made on the safety of the premises in areas including legionella, and electrical and gas installation safety.

Appropriate recruitment checks took place before staff started work. We looked at the recruitment records of six members of staff and found completed application forms that included their full employment history and explanations for any breaks in employment, two employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out. We saw that checks were carried out to make sure nurses were registered with the Nursing and Midwifery Council (NMC). The manager told us that the organisation monitored each nurse's NMC registration to make sure they were able to practice as nurses. The manager monitored the on-going suitability of staff and took action in line with their policy in relation to concerns about staff suitability.

We found the staffing of the home required improvement and the provider was taking steps to address this. The deputy manager told us that 23 staff had stopped working at the home since December 2015. Consequently, staff working with people were not always familiar with their needs. A recruitment drive was carried out at the beginning of April. Eleven health care assistants had been recruited. Four of these staff had started working at the home in April and other staff were due to start in May. The deputy manager said the recruitment of these staff would significantly reduce the homes usage of agency staff and staff covering shifts as overtime.

Inadequate

Is the service effective?

Our findings

One person using the service told us, "It's absolutely nice here, the staff work very hard 24/7 and they are always helpful. The food is great, whatever is on the menu is always lovely." Another person said, "I have not been here long as I am on respite. The staff seem to know what I need." A relative said, "The staff seem to know what they are doing. My relative is well looked after." Despite these positive comments our findings did not indicate that the service was effective.

At our inspection in June 2015 we rated this key question – Is the service effective? "Outstanding". We have rated this question as "Inadequate" after this inspection. This is because staff had not completed mandatory training and they were not being supervised appropriately. This contributed to the decline in the quality of care being provided and exposed people to risk of unsafe and inadequate care.

Staff were not all trained and assessed as competent in the administration of medicines. On the first day of our inspection we observed two health care assistants administering medicines to people using the service on two units at the home. One told us they had received training from another senior health care assistant on administering medicines. However neither care worker had received any formal training on administering medicines nor had they been assessed by the provider to be competent to administer medicines. The regional manager confirmed this. We looked in the medicines administration folders for these two units and found lists of specimen signatures of 21 staff that had been administering medicines to people. The lists contained the names of five staff that no longer worked at the home. A senior manager checked the remaining staff on the lists against staff training records and confirmed with us that ten staff had received training on the administration of medicines, six of these staff required refresher training and six staff had not received any training on administering medicines. None of the staff on the lists had been assessed as being competent by the provider to administer medicines to people using the service.

We asked to see the training for all staff with regards to medicines. Only clinical staff and senior health care assistants (15 in total) were required to complete medicines managements, medication foundation and medication advanced training. Eleven staff had completed medicines management training but five of these staff required refresher training. Six staff had not completed medicines management training. Eleven staff had not completed medication foundation training. Eleven staff had not completed medication advanced training.

We brought these issues to the attention of the regional manager who made prompt arrangements to make sure that people using the service were administered medicines from fully trained and competent staff. During the inspection we also observed staff being trained by senior managers qualified to train staff on the administration of medicines. They told us that staff would not be permitted to administer medicines to people using the service until they had been assessed as fully competent to do so and we will continue to monitor this.

We observed an incident where five members of staff were trying to support a person out of their seat into a wheelchair using a hoist. The person was distressed and said they did not want to move from their seat. The

staff did not appear to know how to support the person appropriately and eventually removed the hoist from the person when they protested. We checked with a senior manager to see if these staff had completed training on moving and handling and using a hoist. They informed us that one of the staff had completed moving and handling theory training in June 2014, one staff was an agency staff, another was a new staff on induction and the two remaining staff had not received any training on moving and handling. When a senior manager checked the training of all staff at the home they found that nineteen staff had not completed moving and handling training.

A senior manager provided us with a document indicating that mandatory training for clinical and health care staff included basic life support, care of medicines advanced, care of medicines foundation, child protection, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), equality and diversity, fire safety, first aid awareness, food safety, health and safety, infection control and safeguarding adults. On the 28 April they showed us a training matrix. This indicated that although some staff had previously received mandatory training they were not completing training in line with the frequency required by the provider. There were gaps in training. For example twenty seven staff had not completed child protection training. Fourteen staff had not completed COSHH training. Eleven staff had not completed fire safety training. Twelve staff had not completed first aid training. Twenty one staff had not completed food safety training. Fourteen staff had not completed safeguarding training. Eleven staff had not completed infection control training. People were being placed at risk of receiving poor care and treatment because staff had not received the appropriate training to meet people's care and support needs.

Some staff told us they received formal supervision with senior staff and managers. One member of staff told us they received supervision each month from a senior health care assistant. Another member of staff said they usually received supervision every three months but had not had any supervision since the previous manager left in December 2015. We looked at the provider's matrix for recording staff supervisions. This showed that since April 2015 that most staff had not received any supervision. The matrix indicated that no staff received any supervision in July, September, October and November 2015. Fourteen staff received supervision in January and two staff received supervision in February 2016. People were being placed at risk of receiving poor care and treatment because staff were not receiving on-going supervision in their roles to make sure their competence was maintained.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

Staff said they completed induction when they started working at the home. One member of staff told us they were shadowed by experienced staff as part of their induction before they were permitted to work alone. A senior manager told us all new staff completed a two day induction at the home before completing a 12 week on line training programme in line with the care certificate. They showed us a "Care Assistant, Care Certificate Guide" and told us they would be training staff as care coaches in May 2016 to support new staff during their inductions. Once the care coaches had been trained the new Care Certificate induction program will be used for all new staff.

The Union Jack unit was accredited as a Positively Enriching And Enhancing Residents Lives (PEARL) dementia service. Staff had received additional specialised training in dementia as part of this organisational accreditation process and staff talked about the significant improvements made in practice on the unit in the past three years. An activities coordinator told us they had attended a four day course on dementia care mapping. Dementia care mapping is an established approach to achieving and embedding

person-centred care for people living with dementia. They said this helped them to assess people's needs and plan individualised for them. They said, "The principles of the PEARL have been instilled in staff throughout the home and everyone works to the programme." Another member of staff told us they had recently completed training on dementia, they said, "We support people with dementia every day so the training really helped me understand their needs and how I need to support them."

The home had attained the Care Quality Mark for older deaf people. This quality mark recognised the home's accessibility and commitment to older deaf people and staff received training as part of the accreditation process. An activities coordinator told us they had completed lots of training that would enable them to work with people who were born deaf. They learned about specialised equipment and how to adapt the environment to meet people's needs. There was no-one requiring this specialist support at the time of our inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager demonstrated a good understanding of the MCA and DoLS. They said that most people using the service had capacity to make some decisions about their own care and treatment. We saw that capacity assessments were completed for specific decisions and retained in people's care files. Where the manager had concerns regarding a person's ability to make specific decisions they had worked with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA. We saw that a number of applications had been made to the local authority to deprive people of their liberty. Where these had been authorised we saw that the appropriate documents were in place and kept under review and the conditions of the authorisations were being followed by staff.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements, food likes and dislikes, food allergies and their care and support needs. Care plans included information relating to people's dietary needs for staff to refer to. For example, one person's care plan stated, "Does not eat fish." Another person's care plan described they were a vegetarian and required a vegetarian diet. A third person's care plan recorded the need to avoid certain foods due to the medication prescribed. We spoke with the chef. They showed us documents that alerted kitchen staff to people's dietary risks, personal preferences and cultural and medical needs. The chef said they accommodated people's personal preferences by offering range of choices each meal time.

We observed how people were being supported and cared for at lunchtime. A daily pictorial menu was displayed on a notice board in the dining room in each unit for people to make their choices from. Some people required support with eating and some ate independently. The atmosphere in the dining room was relaxed and not rushed and there were plenty of staff to assist people when required. Some people ate their meals in their rooms. We saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day and these were available in the lounges on each unit. One person using the service told us, "I complimented the chef about his cod and

parsley sauce. He came to see me and thank me. We get meals three or four times a day, lots of drinks and tea and biscuits at night. I can't complain at all."

People were supported to access care from a range of professionals for example, physiotherapists, chiropodists, dentists, opticians and specialist nurses when required. A GP visited the home twice a week or when required to attend to people's needs. We saw reports from health care professionals were held in peoples care files. A visiting health care professional told us they had been visiting the home for over a year. They advised the home on how some people needed to be supported and staff had followed through on any recommendations they had made.

Requires Improvement

Is the service caring?

Our findings

One person using the service told us, "The staff are definitely caring. To me anyway. I can't say anything bad about them." Another person said, "I cannot knock the staff but they are always very busy." A relative told us, "This is a lovely place. I am always made to feel welcome. The staff are caring and seem to know what they are doing. My relative is really well looked after." Another relative said, "It is good here. The staff are always friendly. We like the staff and how they treat the residents." A third relative told us, "We have been to other homes and they are not as good as this one." However other people told us that staff were not always kind to them and we reported this to the senior management team during the inspection. The manager said they would investigate this.

At our inspection in June 2015 we rated this key question – Is the service caring? "Good". We have rated this question as "Requires Improvement" after this inspection. Although most people were positive about the care they received, we observed some practices and behaviours that did not promote people's privacy and dignity.

We saw some instances of undignified care from staff that did not appear to know how to support people appropriately. For example we saw one person using the service being hoisted by staff in lounge area. The person was left hanging in the hoist sling in full view of other people using the service calling out and anxious. We observed another person who was half undressed, distressed and agitated, calling out at staff, they said they wanted to talk. A senior member of staff told the health care assistants to take the person to their bedroom. Four staff attending to the person with a hoist and a wheelchair and were unable to keep them calm. One member of staff laughed at them and told them they were going to her room. When we reported this to the manager, the manager agreed they had also observed staff to laugh inappropriately at people using the service.

These issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also witnessed many examples of good care giving and saw that in many cases people were treated with understanding, compassion and dignity. For example we heard member of staff on Thames unit supporting a person using the service who was crying. They stayed with the person, showed a very caring comforting attitude and asked them if they wanted a drink. We saw staff interactions with a new person attending the home on respite were responsive and purposeful in terms of settling them into the home. They were approached soon after arrival and offered a tea or any other drinks they preferred. The staff interaction gave the person's relative the opportunity to detach themselves and prepare to leave. By the time they did leave the resident was settled and calm. We also observed other staff actively listening to people and encouraging them to communicate their needs.

We saw that staff ensured people's privacy by drawing curtains and shutting doors when providing people with personal care. A member of staff told us they tried to maintain people's privacy, dignity and independence as much as possible by supporting them to manage as many aspects of their care that they

could. They said, "When I help people with personal care I always explain to them what I am doing. I always ask if there is anything else I can do for them before leaving." One person using the service said, "The staff treat me with dignity and respect at all times. They tell me what they are doing because I cannot do some things for myself."

Information contained in the care files indicated that people using the service, their relatives and appropriate healthcare professionals had been involved in the care planning process. A relative told us, "This is a very good care home. We looked at lots of places before we decided on Marlborough Court. When my relative came here the staff asked me a lot of questions about the things my relative needed and what the staff needed to do to care for them the right way. I think I have good communication with the home." A visiting health care professional told us they had no concerns about how staff were supporting people using the service and said, "The staff are caring, this is one of the better care homes I have been to."

People using the service and their relatives were provided with appropriate information about the home in the form of a service user guide. This included the complaints procedure and the services they provided and ensured people were aware of the standard of care they should expect. The deputy manager told us this was given to people and their relatives when they started using the service.

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us the service met their care and support needs. One person who used the service told us, "I receive good care from staff. If I need anything I just ask. There is always something going on here so you can get busy if you want to." A relative told us, "My relative is very happy here. They are happy with the staff. My relative has been to many homes around this area for respite, this is the best home compared to others." Despite these positive comments we found that some aspects of the service were not always responsive.

At our inspection in June 2015 we rated this key question – Is the service responsive? "Good". We have rated this question as "Requires Improvement" after this inspection. This is because staff were not always fully aware of peoples care and support needs, and therefore could not adequately care for them.

People's needs were assessed and care and treatment was planned. However care was not always delivered in line with their individual care plans. We saw that care and health assessments were undertaken to identify people's support needs before they moved into the home. Staff told us that care plans and risk assessments were developed using the assessment information. Care plans included detailed information and guidance to staff about how people's needs should be met. They described people's daily living activities, their communication methods, mobility needs and the support they required with personal and nursing care. The care files included a personal profile "My Choices" giving details of person's life history and personal preferences, capacity assessments and, where appropriate, Deprivation of Liberty Safeguards authorisations and associated records. We saw that peoples care plans and risk assessments were reviewed and signed each month by staff. However we found that these reviews did not always reflect changes to some people's care and support needs. For example where people using the service had falls their care plans and risk assessments had not always been reviewed or updated. This issue was referred to in the safe section of our report.

Each person had a care plan that described the support they required to manage their specific behaviours. We saw, for example, that one person liked to go to their room if they became agitated. On the first day of our inspection we saw that this person had locked themselves in their bedroom. The staff were aware from the care plan this was a usual pattern of behaviour when the person became agitated and it described how to talk calmly to them and to diffuse the situation by getting a member of staff they knew to talk to them. We saw this action was applied as the activities coordinator came to talk to the resident and gained entry to her room to check she was safe. However we observed when another person became distressed and agitated that staff were unable to keep them calm. We checked this person's behaviour care plan and found reference to the person's behaviours however the care plan did not describe how staff should support this person to manage their behaviour. This person was at risk of not having their needs met as staff were not aware of how they needed to support them.

Staff on each floor and the deputy manager told us about 'flash meetings' that took place at 11am daily. These were attended by staff from different departments across the home with the focus to communicate information about any new admissions and the needs of people using the service for example, individual

health issues of people such as pressure sores or weight loss. A health care assistant told us that senior health care assistants passed on information relating to the needs of people using the service from these meeting to staff on each floor. However we found that some staff had not had the time or the opportunity to read people's care files and risk assessments or get to know the people they were working with. One member of staff told us it was the first time they had worked on a unit. They hadn't had time to read people's care plans and personal histories and knew little about them. They said they would have liked to have had a few hours to read care files so they could get to know what people wanted and needed. Another member of staff told us they were working at the home on a bank shift. They said this was their third shift but they had not had any time to read people's care plans. They had worked their first shift with an experience member of staff but otherwise they were not familiar with people's needs.

These issues were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us the home had had a series of parties to commemorate the Queen's 90th birthday. We saw records that included photographs of people from all of the units at the home partaking enthusiastically in the activities. There were balloons, sandwiches and cakes on tables and items from the 1940's and 1950's were used to assist in storytelling and reminiscing. One person said, "We have parties and had one last week. We all enjoy getting together and talking about the past." The deputy manager said, "We get good support from the manager and head office to plan activities. The variety and frequency of the activities we hold is one of the things that I am particularly proud of."

The home employed two full time activity co-ordinators. We saw an activities program for people using the service included bingo, pampering sessions, ipad games, arts and crafts, sing-song and yoga sessions. Journals were used to record the activities undertaken by each person and those seen included people attending mobile karaoke, yoga and exercise sessions. We observed people using the service and local school children partaking in a yoga session on one unit. An activities coordinator told us the children visited the home every Wednesday and got involved with various planned activities. They said that the following week the children would be baking cakes with people using the service. One person using the service told us, "I like the activities, they do some interesting things, the yoga is good and I like seeing the school children." Another person said, "There is lots of things going on and I can do them if I want to. Sometimes I do, sometimes I don't." A third person told us, "I have a telly in my room and a friend down the hall who I like to spend time with. The activities are good too but I don't tend to bother."

One activity co-ordinator told us they provided one to one activities for people nursed in bed or who liked to stay in their rooms. They gave people sensory hand massages and had sing a longs. We saw them reading a book to one person and engage them in a conversation about their life history. We also saw them visit people in their rooms, with the mobile karaoke machine. They told us one person liked origami and made birds with paper another person liked to watch old comedy programs with them on the ipad. They said that people nursed in bed were supported out to attend events and shows if they wanted to.

People using the service and relatives said they knew about the service's complaints procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to and their complaints would be fully investigated and action taken if necessary. We saw copies of the complaints procedure displayed throughout the home. One people using the service said, "I would raise my concerns with the manager if I had any. I am confident they would deal with them appropriately." We saw a complaints file that included a copy of the provider's complaints procedure and forms for recording and responding to complaints. Complaints records showed that when concerns had been raised these were investigated and responded to appropriately and where necessary

discussions were held with the complainant to resolve their concerns.

Inadequate

Is the service well-led?

Our findings

People using the service did not comment directly about the leadership at the service but their relatives told us they felt the service was well run. One relative told us, "The home is clean and looks comfortable and seems to be well run." Another relative told us, "I think this is a good home. It appears to me to be well organised." Despite these comments we found that we found that the service was not well led.

At our inspection in June 2015 we rated this key question – Is the service well-led? "Outstanding". We have rated this question as "Inadequate" after this inspection. Although the systems and processes established when we inspected in June 2015 were still in place, they were not always followed. The significant changes in management and staff meant that the consistent leadership, individualised care and the positive environment we found in June 2015 was lacking.

The regional manager sent us a number of completed audits carried out at the home including bedrail, resident care and health and safety audits. They also sent us copies of their monthly audits at the home from January to April 2016. The April audit recorded that the home had not completed any residents' care audits in previous weeks. An action was set that the home manager reinstate the audits with immediate effect. The report recorded that checks on housekeeping, information governance, human resources, health and safety and home governance been not completed as required. Daily medicines audits and daily walks around the home by managers to monitor how the home was operating had not been completed between 15th and 18th April 2016. The regional manager told us they had requested the manager and the deputy manager complete all of these quality and safety checks. The audit also recorded the number of reported incidents that month, if the incidents had been investigated, if there were any trends and if so had the home responded to mitigate these. There were ten incidents on the system which were overdue a review, all of which related to falls. The regional manager recorded in the audit that the home manager needed to ensure that they were reviewing incidents in a timely manner. The provider was not operating an effective system as audits had not been completed when due and incidents had not been reviewed to ensure learning and to mitigate risks to people's safety.

Following the inspection the regional manager sent us another action plan that was being implemented to address the areas of concern identified by the provider and the CQC. The action plan covered the management of medicines, reviewing peoples care plans and risk assessments, ensuring staff were aware of the falls protocol and safeguarding and whistleblowing procedures, ensuring staff received training, supervision and appraisal and implementing robust quality monitoring system. They also sent us a training plan which indicated that 72 staff would receive moving and handling training between 4 and 12 May 2016. However the issues of concern had only been identified in April 2016, and therefore an effective system was not in place to monitor and improve the quality and safety of the services provided to people.

On the first day of our inspection the regional manager showed us an April 2016 action plan following audits carried out at the home. The action plan indicated that a residents' experience manager and a manager from another of the providers care homes had started to carry out supervision observations and competencies assessments of staff. The action plan recorded that care files were being reviewed as there

was insufficient information in risk assessments and some sections of people's care plans were lacking information for example, on end of life care. The action plan had also identified the lack of staff training. Letters were sent to staff on the 12 April 2016 advising them of their contractual obligation to complete eLearning training and they were required to complete this training by the 30 April 2016. However despite these audits we found some issues with care plans and risk assessments that the provider had not identified and significant numbers of staff had still not completed training by the 28th April.

These issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did not have a registered manager in place. The current manager started working at the home on 1 February and the deputy manager had been appointed on the 1 April 2016. The manager had applied to the CQC to become the registered manager for the home. The previous registered manager had left their post in December 2015 and had not worked at the home since November 2015. The previous deputy manager also left their post in February 2016. We found that staff had not been adequately trained or supervised, some staff were not aware of their responsibilities to report safeguarding concerns and some staff were not aware of peoples care and support needs. The management team had not developed the staff team at this point to make sure they always displayed the right values and behaviours as we had observed a member of staff laughing at a person when they were being taken to their room. The manager had also observed staff to laugh inappropriately at people using the service. There was also a high turnover of staff. A residents' experience manager showed us a staff leavers report from 28 December 2015 to 24 April 2016. This indicated that, apart from the previous manager and deputy manager, 21 other staff had left during that period including two senior health care assistants and seven health care assistants. Eleven of the remaining leavers were bank staff. The current deputy manager told us that some of the bank staff worked at the home on a regular weekly basis and had formed good working relationships with the staff team and people using the service. For example one of the staff was really good at planning activities and was a valued member of staff.

The manager was not present on the first two days of our inspection however the deputy manager was available. The regional manager was also present throughout the inspection as were members of the residents' experience team. The regional manager and members of the residents' experience team told us they had been attending the home on a weekly basis to assess and improve systems at the home. One residents' experience manager told us they were looking at staff training, induction, supervision and they were supporting the deputy manager on clinical issues such as medicines management and audits. Another residents' experience manager showed us a "Manager's Bible". This was a file they had recently developed for recording, auditing and reviewing accidents and accidents, people using the services weights and medical conditions, medicines audits and errors, staff training and supervision, safeguarding, complaints and environmental and fire risk assessments. The deputy manager told us they found this file had already been really helpful. However we identified concerns about the auditing systems in place.

Staff we spoke with told us the manager and the deputy manager were approachable and supportive. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it. One member of staff said, "The new manager is very approachable and easy to speak with." Another staff said, "The manager is good, he has an open door policy. You can talk to him about anything and he listens to what you say about most things." Staff said they liked working at the home however some expressed concerns about recent changes to the staffing roster. Some staff were working on units where they had not worked before and told us they were not fully aware of people's care and support needs. One member of staff said some staff had left or were considering leaving because the new roster made it difficult for them to continue working at the home. For example staff were required to

work night shifts and some staff were not able to make arrangements for child care. On the second day of our inspection the regional manager told us they had made a "business" decision to revert back to the old roster system. A residents' experience manager told us they had relayed this information to staff. A member of staff told us this was good news as staff morale had been a little low.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People using the services care plans had not always been updated to reflect their changing needs. Staff were not always aware of peoples care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People using the service were not always treated in a dignified manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service were not always protected against the risks associated with unsafe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People using the service were at risk of abuse because some staff were not aware of their individual responsibilities to prevent, identify and report abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

People using the service were being place at risk because the providers quality monitoring systems were not operating effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Action had not always been taken to support people where risks to them had been identified.

The enforcement action we took:

1. The registered provider must not admit any new service user to Marlborough Court, 7 Copperfield Road, Thamesmead, London, SE28 8RB without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the appropriate support, training and supervision to enable them to carry out the duties.

The enforcement action we took:

1. The registered provider must not admit any new service user to Marlborough Court, 7 Copperfield Road, Thamesmead, London, SE28 8RB without the prior written agreement of the Care Quality Commission.