# George Ronald Limited

# Marquis Court

## Inspection report

Marquis Court
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Tel: 01915210796

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## Ratings

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

# Summary of findings

## Overall summary

This inspection took place on 4 and 7 April 2016 and was unannounced. This was Marquis Court's first inspection under their new registration

Marquis Court is a purpose built care home without nursing which can accommodate 47 people. The home is a two storey building offering single bedrooms with en suite facilities. There are 23 bedrooms on the ground floor for people with general needs and 24 bedrooms on the first floor for people living with dementia.

At the time of the inspection there were 47 people resident at Marquis Court.

A registered manager was registered with the Care Quality Commission at the time of the inspection. They had been the registered manager prior to the new registration in July 2015 and were well established.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care plans and risk assessments were in place however they lacked detail. Care plans did not always specify how to care and support people with specific needs such as moving and handling. Risk assessments did not clearly identify the risk or how it should be managed, for example there was no information in relation to choking risks for people with specific requirements around their food.

There were no personal emergency evacuation plans to support staff to safely evacuate people in the event of a fire, nor was there any equipment to enable people with mobility needs who resided on the first floor to evacuate.

An electrical installation condition report completed in January 2015 had assessed the premises as unsatisfactory. The owner told us the work was being completed next month.

Quality assurance systems were in place but they were not effective in assessing and improving the quality of the service provided.

Safeguarding, accidents and incidents were all recorded appropriately, with actions taken and lessons learnt. Mental capacity was understood and where relevant, applications for Deprivation of Liberty Safeguards were completed.

Recruitment practices were safe and there were enough staff to meet people's needs with contingencies in place to cover unexpected staff absence. Staff had the necessary training to ensure they could meet

people's needs and they said they were well supported.

Medicines were managed safely, although the dates creams were opened were not always recorded and temperature checks of the medicine room and fridge were not recorded. This was actioned straight away.

People told us the food was lovely and there was plenty of choice. People were supported at meal times and the chef understood people's dietary requirements.

Activities were plentiful and varied, ranging from arts and crafts and singing to discussions about current affairs and asteroid deflection. The activities coordinator was passionate about their role and told us the people living at Marquis Court were their boss and they did whatever they asked them to.

Staff approach was kind, caring and compassionate. Staff knew people well and we observed warm and tender relationships with people.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Risk assessments were completed but they did not always identify the risk or the control measures needed to minimise the risk.

There were no personal emergency evacuation plans, some fire doors did not close fully and there was no specialist equipment to aid an evacuation of people living on the first floor.

Staff understood safeguarding and whistleblowing.

There were enough staff to meet people's needs and safe recruitment practices were followed.

### Is the service effective?

**Good**

The service was effective.

Staff were well trained and had the skills and knowledge to meet people's needs.

Mental capacity was understood and Deprivation of Liberty Safeguards (DoLS) authorisations were in place.

People told us they enjoyed the food, and the staff understood people's specific dietary needs.

People had access to health care professionals, one relative said, "The level of outside care is amazing."

### Is the service caring?

**Good**

The service was caring.

People were treated with dignity and respect, kindness and compassion. We observed warm and tender relationships between people and staff.

Relatives were complimentary about the care that was provided, and one relative said, "We couldn't wish for more."

## Is the service responsive?

**Requires Improvement**

The service wasn't always responsive.

Care plans did not always contain detail of how to provide care in a safe way for people, such as when using a hoist.

The activities coordinator was very focused and passionate. Activities were varied and there was a well-established men's group.

Relatives new how to complain and said they hadn't needed to as "little niggles" were dealt with straight away.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Quality assurance systems were in place but they were not consistent in assessing, monitoring and improving the quality of the service provided.

The culture was warm and friendly, and staff felt the registered manager listened to them and was open to discussion.

# Marquis 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 7 April 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up on one adult social care inspector and a specialist professional advisor with a background in nursing care and dementia support.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team and the safeguarding adult's team and a healthcare professional.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people living at the service and two relatives. We also spoke with the owner, the registered manager, the deputy manager and the assistant deputy manage, two senior care staff and a team leader, six care staff, the activities coordinator, the chef, and three ancillary staff. We also spoke with a care worker who was being mentored by the registered manager due to completing their NVQ5.

We reviewed five people's care records and six staff files including recruitment, supervision and training information. We reviewed medicine records, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. 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.

Requires Improvement

# Is the service safe?

## Our findings

Risk assessments relating to the health, safety and welfare of people were completed. However, they did not clearly identify the risk or the control measures for reducing and managing the risk. One person had been assessed as being at risk of aspiration pneumonia. The risk assessment stated, 'If [person] begins to cough when drinking fluids staff to seek further SALT assessments. (Speech and language therapist).' It went on to record, 'Failure to follow recommendations may place [person] at risk of serious harm from choking or aspiration pneumonia.' There was no risk assessment in place for choking, nor were there any immediate actions recorded that staff may need to take, such as first aid or contacting emergency services. The registered manager said, "I know what you are saying, there's a bit missing."

Another person's care plan in relation to their diet highlighted they were not to eat bread, and had been advised to eat a mashed diet by the SALT team. This information had not been transferred to the risk assessment which potentially left the person at risk of harm due to receiving inappropriate foods. Care staff and the cook were aware of this person's needs in relation to their diet.

Falls and pressure care monitoring was in place. The assistant deputy manager explained that they were changing some of the risk assessment tools used for pressure ulcer and skin integrity assessments as it had been noted that they assessed the risks differently. This meant the outcome for some people was that they were at high risk on one document and medium risk on another which was causing some confusion.

The fire service had recently completed an audit. Personal emergency evacuation plans had not been written so there was no information for staff or the fire service about the particular needs of people living at Marquis Court in relation to a potential evacuation.

Dates of fire drills were recorded but there was no information on who was involved or how they responded and whether further training was required to ensure people could be safely evacuated. A senior carer said, "We meet at the meeting point and leave people." They added, "I would move them away from the fire." We asked about evacuating people from upstairs as 15 of the people living on the first floor needed support with mobility and would be unable to manage the stairs in the event of an evacuation. They said, "We were told to use mattresses to get people down the stairs." There was no equipment available to support a safe evacuation of the people living upstairs. The deputy manager said, "It's always been if we can get people out then get them out or close the doors and tell the fire brigade which room people are in. I'm not sure if it's changed now." We spoke with the registered manager who said, "We used to have a stay put policy until the fire service visited and told us we shouldn't have that." We asked how this information was being shared with the staff team. The registered manager said, "Staff meetings are to be arranged and it'll be included in the training." On the second day of inspection we saw dates had been arranged for fire safety training and staff had been allocated to attend.

The last checks for fire doors and emergency lighting were recorded as having been completed on 22 February 2016. We found some fire doors into people's bedrooms were not closing fully. This was raised with the registered manager who ensured this was addressed on the day.

The electrical installation condition report was completed 27 July 2015 and was rated as unsatisfactory due to a number of C2s. C2's are classed as Potentially dangerous with urgent remedial action required. The registered manager said, "This has been passed on to the owner." We spoke with the owner who said, "It is in the budget to do the work next month."

Health and safety risk assessments had been completed for areas such as oxygen use; falls from windows; moving and handling and the kitchen environment. All risk assessments had been reviewed in July 2015. The registered manager said, "They are due again now, they all need to be redone following the fire safety audit." We asked if there was an action plan in place, they said, "No, not as yet as the audit hasn't been received."

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they felt safe living at Marquis Court. One person said, "Oh yes, I'm very safe here, they look after me well." A relative said, "It's quite wonderful, people are safe. It's the right place, everyone is treated the same, they are kind to everyone." Another said, "I'm absolutely delighted. I have peace of mind that they are safe. If they have a fall they are attended to straight away and I'm told."

Staff and the registered manager understood the principles of safeguarding and whistleblowing, one staff member said, "I would go to the police if I needed to. Nothing would stop me." There had been one safeguarding alert since Marquis Court was newly registered which had been investigated and reported appropriately.

Accidents and incidents were recorded and reviewed by a member of the management team or a senior carer. Information recorded included any triggers for the incident, the outcome or action taken and any lessons learnt.

We spoke with relatives to see if they were happy with staffing levels. One relative said, "Staff work really hard, they are quite wonderful and patient. They employ the right kind of people; they are all caring and patient. Recruitment records showed two references had been sought and a disclosure and barring service [DBS] check completed before staff started their employment. DBS checks are used to help make sure only appropriate people are employed to care for vulnerable adults.

The registered manager explained they did not use a dependency tool as they had not sourced one which they felt was appropriate. They said, "I also have the assistant deputy and deputy who can cover the floor if needed." They went on to explain they always had a stand by shift allocated to a staff member. This meant they were available to cover sickness or to work if an extra staff member was needed. One staff member said, "The standby means we are never short on staff to care for our residents." A senior care staff member said, "Yes, there are enough staff, I would say so, the kitchen staff can help as they are fully trained and there's always the assistant deputy and the deputy who would help."

A contingency plan was in place and included actions to take in the event of staffing crises, evacuation and breakdown of utilities.

We observed a medicine round. The administration procedure was accurate and each person was asked their wellbeing even though the person may not have medicines at that time. One relative said, "There were a few changes with medicines but the staff managed it marvellously."

The senior staff member was knowledgeable about procedures for discarding spoilt medicines; covert medicine administration and self-administration. We found medicine administration records (MARs) were completed accurately.

Monthly ordering of medicines was completed by the registered manager in a thorough and effective manner, ensuring any problems were resolved as early as possible so there was no impact on the person.

Temperature checks of the two rooms where medicines were stored were not recorded, nor were fridge temperatures. Prescribed creams were not always dated when opened and they were not discarded on a monthly basis. This meant creams may have been applied after the point at which they should have been discarded and medicines may have been stored at the incorrect temperature which can have an adverse effect on some medicines. As soon as this was raised the management team changed procedures to ensure correct recording was in place.

Good

# Is the service effective?

## Our findings

We looked at the support available for staff including, induction, training, supervision and appraisal. Staff induction was linked to the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The registered manager said, "All new starters are signed up for the care certificate which is linked to NVQ; they also complete shadowing." This was confirmed by two staff who had recently been appointed.

A staff training file showed the training staff were required to attend depending on their role. There was a training plan in place and all up and coming training was displayed on a notice board. For moving and assisting people and fire safety training, staff names had been allocated to the training course. The owner explained how they invested in training and how they valued the importance of ensuring training was delivered face to face rather than using ELearning. Staff told us they felt they were well trained.

The registered manager said, "I don't have documented supervision and I've not had an annual appraisal. I get enough support." They added, "Quality audits would form part of the conversation." We spoke with the owner and the registered manager about this and they agreed that notes would be kept moving forward. The deputy manager said, "I do staff supervisions, the appraisals are done by the manager." They added, "I get regular supervision, I've got an appraisal coming up. I do feel supported and I can go to [registered manager]."

A supervision and appraisal log was in place. Since the new registration in July 2015 three of the 50 staff had not had a supervision meeting. Supervisions are used as a means to assess staff performance and competence. Eight staff had received an annual appraisal since July 2015. We asked whether the staff needing annual appraisals had been in post prior to the new registration. The registered manager said, "Yes, they would have been, I know they need an appraisal. I haven't been keeping up with supervision's so I've delegated them to the deputy manager to do so I can focus on appraisals." Staff told us they had appraisals coming up and they felt well supported and able to discuss any concerns on a day to day basis.

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 registered manager understood the principles of the MCA and DoLS. Applications had been submitted to the 'supervisory body' for authorisation to restrict a person's liberty where it had been assessed as in their best interest to do so.

People and relatives were very complimentary about the food. People commented that the food was very good and there was always plenty of choice. One person said, "I've been here nine years and yet to get a bad meal." A relative said, "[Family member] can be funny with food, but they are really helpful and cook what she likes."

Food and fluid charts were in place however they did not specify the amount the person needed to eat or drink, nor were records specific in terms of recording the amount the person had eaten and drunk that day. New forms were put in place immediately and we were shown these on the second day of inspection.

The cook was very knowledgeable about people's specific dietary needs, such as diabetes or a soft diet. They also had a list of each person's meal choice, dietary needs and preferences which they referred to when serving each person's meal. Pictorial menus were not used, instead the menu was written on a white board. We asked about pictorial menus and the registered manager said, "We have tried them but they didn't work." Staff said, "People are asked for their menu choices. We tried pictures but found the residents liked to be shown small sample plates of food to make their choice."

People had access to drinks and a choice of snacks when the drinks trolley did a round twice a day, and there was also a 'drinks station' set up in the dining room which people could access as needed.

External healthcare professionals such as speech and language therapy, dietitian services, the tissue viability nurse, the respiratory nurse and the district nurse were involved in people's care as needed. Visits were recorded as were communication with doctors, social workers, opticians, dentist and chiropody. One relative said, "They got the falls team out last week and the new walking aid is in hand. The level of outside care is amazing."

Good

# Is the service caring?

## Our findings

We spoke with people and relatives about the staff approach and whether they felt it was caring and respectful. One relative said, "It is so warm and lovely, they have a bar, it's social to have a drink with people." They added, "It has the right feel." Another said of the staff, "Local people, really kind, it's just lovely." Another relative said, "They settled really well, staff listen to you and whatever you ask for they try to accommodate you."

One person said, "The staff are good, they treat me well." Another said, "I am really happy here and the staff are wonderful."

The activities coordinator said, "They are my boss, I do whatever they want. I tell people they have solar powered smiles as that's where I get my energy from." They added, "They deserve the best and get the best."

During the two days of inspection we observed people's needs were attended to promptly and staff did not rush people. Interactions were caring and meaningful with staff spending time with people responding to people's needs quickly and respectfully. We saw lots of people initiating hugs and touch with staff which was reciprocated in a warm and appropriate manner. Staff were knowledgeable about people's needs but also knew about people's personal history and their likes and dislikes. They were kind and respectful at all times. One staff member said, "I love it here and the residents are lovely."

A white board showed pictures of the staff who were on duty that day, together with the date and the weather. This was completed by the night staff so was kept up to date. The activities that were being held that day were also on display and notices showed up and coming events and entertainment.

The activities coordinator explained they had a fortnightly meeting with residents, and discussed the care, the kitchen, hygiene, the handyman and activities. They said, "There's usually no complaints. The minutes go to [registered manager] and if there's anything to act on it gets done."

The registered manager said, "We are like a family, we don't exclude visitors and family from any celebrations, it's an open door policy. We send birthday cards and Christmas cards, we all know each other." They went on to say, "We have memorials for people who have passed if relatives want us to."

Information was available for people should they need the support of an advocate. The registered manager said there was no current involvement.

Staff sought permission from people before offering any care and support and if people said no this was respected. Staff returned to people a few minutes later to see if they had changed their mind.

We observed the dining experience on both days of the inspection. On day one on the first floor we observed six people had a meal in front of them but staff were not available to support them with eating their meal. We spoke to the registered manager about this. They said, "Three staff were supporting people who needed

transfer's and personal care. This wouldn't normally happen." On the second day we observed there were extra staff supporting at lunch time, and all the people who needed support with their meal were receiving it. Lunch had been served in the lounge as the dining area was being renovated but people were relaxed and enjoying their meal with relatives as well as staff. On the ground floor the dining experience was relaxed and sociable. People were sitting chatting with each other, enjoying a laugh whilst the staff brought the meals through from the kitchen which was next to the dining room. We observed people's choice was respected and alternatives were offered if people had changed their minds. One person commented, "I could really do with a drink of water." Staff responded immediately and asked everyone else if they would like some.

The registered manager explained they had completed a three day course on the essential standards for end of life care and had used this training to ensure they provided appropriate care and support to meet people's final wishes. A palliative care register was maintained and the information was shared with nurses who were writing emergency health care plans (EHCP) with people. People were supported to maintain their independence in this area and to share their wishes so they could be supported to ensure they were met. This was done in a sensitive and caring manner. Where people wanted to, they were supported with funeral planning and arranging their own do not attempt cardio pulmonary resuscitation order (DNACPR) and EHCP. There was information on who the person wanted to be contacted and how this should be done; the person's final wishes were recorded. The registered manager explained the information was held sensitively and securely until such time as the person was nearing the end of life at which point the care plan would be replaced by the end of life plan as it detailed all the required information. If there were any changes to the person's wishes the information was updated.

Requires Improvement

# Is the service responsive?

## Our findings

Care plans included mental health, communication, personal hygiene, skin integrity, medicines, activities, equipment and mobility. Some information was person centred and described people's preferences however they were lacking detail on how to care and support people. For example, one person's personal hygiene care plan stated, 'One staff to prompt and encourage, staff to give assistance where required.' There was no information on how the person liked to be encouraged or how to support the person or identify when support was needed. This meant the person may be receiving care in a variety of ways as there was no consistent information for staff to follow.

Another person's personal hygiene plan stated they needed, 'Full assistance' but there was no information on what this actually meant in terms of how to care for and support the person. The care plan also recorded, 'Two care staff to carry out all transfers using the hoist and sling at all times.' There was no detail in the plan about how staff should transfer the person in a safe way.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Reviews of care plans were completed regularly however they stated either, 'continue objective' or 'new objective.' We discussed this with the assistant deputy manager as the care plans did not identify any specific objectives. They said, "The whole care plan is the objective."

The deputy manager said, "[Assistant deputy] does the initial assessment and the care plans. When people come in I do a rough plan, such as general information and an initial risk assessment such as for falls so one is in place immediately for the night shift. If family are here they are involved and so is the person where we can." We asked if there was a timeframe for completing care plans and risk assessments. They said, "No, because we get on with it and do it."

We spoke with relatives about how responsive to the needs of their family member they thought Marquis Court was. One relative said, "[Family members] mobility is down to the staff support." They added, "There's a salon, hairs done every week, nails are done, it's just part of what they do here." They went on to say, "The social side is wonderful, the singing is uplifting, Monday mornings there's reminiscence of Sunderland where they look at old photos, it's really very good." Another relative said, "They got a sensor cushion for the chair, they are so nice and patient. They also support her to go out." They added, "There's always someone available, drinks, activities, medicines, there are people about all the time to help. Everything is really clean, spills are attended to straight away and the carpets washed. I would definitely recommend it. [Family member] likes a daily bath and they do get one every day." People told us their needs were met, one person said, "They try to do everything I ask of them, it really is very good." Another said, "The girls [care staff] are lovely, I couldn't wish for anything better."

Some people on the ground floor had large numbers on their doors, or their name. The registered manager explained this was at people's request due to being partially sighted, or requesting their name be evident to

help them keep their bearings. On the first floor dementia friendly signage was used to orient people to their whereabouts.

An activities co-ordinator was employed who took great care to ensure they met people's needs well. They had a timetable of activities which was current and dated for the next few months which included walks, outings, baking, flower arranging and manicures. They also had a weekly men's group as they recognised the value of the men spending time together. The activities coordinator said, "We do specific activities for men, it's high on the agenda. We talk about all sorts, the shed, work, the migrant crisis, asteroid deflection, physics, and history. I also have conversations in French with one gentleman. Its important people know what's happening in the outside world."

Entertainers were a regular feature at the home and many social events were attended by relatives and visitors as well as the owner. There were many photo boards around the home which showed people enjoying the variety of activities on display including the animals that visited.

The garden was available for people to enjoy and during the summer months there were outdoor bowls and summer fayres as well as barbeques and the opportunity to be involved in gardening and growing plants.

We asked about concerns and complaints. One relative said, "If there are any niggles [registered manager] acts on it immediately. I really like it." They added, "[Family member] is immaculate, they were always concerned about their appearance and sometimes if they don't want their pinny on they will need to be changed. I sometimes need to remind people but [registered manager] acts on it immediately." Another relative said, "There are odd times staff need reminding." They explained, "Odd times I need to remind the staff they need to put cups in [family members] hand but they are straight on the case." People told us they had no concerns or worries about the care they received.

There was a complaints file in place with a copy of the complaints procedure which detailed timeframes for responding to any concerns or complaints. One complaint had been logged and there was a record of the complaint, and the action taken to resolve it.

Resident and relatives surveys had not yet been completed since July 2015 when the registration at Marquis Court changed.

Requires Improvement

# Is the service well-led?

## Our findings

We looked at quality assurance and governance systems to ensure procedures were in place to assess, monitor and improve the quality of the service provided at Marquis Court.

Infection control audits were completed on a monthly basis by the housekeeper. Since July 2015 the same information had been recorded on each audit, for example, no carpet cleaning schedule, sharps box not labelled, waste disposal bags not labelled. There was no action plan completed, nor was their evidence of oversight by the registered manager.

Health and safety audits were completed monthly but there was no information in relation to who had completed the audit or the date the audit had taken place. This audit was a tick list on specific areas or tasks. We asked the deputy manager about this who said they thought the ticks meant everything was ok. Electrical safety was included on the audit, however the outcome of the electrical installation condition report completed in July 2015, did not appear on the audit; electrical safety was ticked. This meant there was no evidence of action taken to address the concerns for nine months which placed people at potential risk for a prolonged period of time. The concerns related to C2's which are defined as 'potentially dangerous.' The owner told us the work was scheduled to be completed. There was no space on the audit to record actions or for staff to sign as a record that they had completed the audit.

We asked the registered manager about care plan audits, they responded by shaking their head to mean no. We noted a policy document titled, 'Routine monitoring of the quality system.' This stated, 'Every 3 months the manager will check the progress of three resident care plans to ensure procedures are being followed and present any findings to relevant staff and general issues to all staff. Observe one care plan file review to ensure adherence to procedures.' As there were no care plan audits being completed the registered manager was not following their own quality assurance procedures.

The registered manager completed monthly medicines audits when they placed the next medicine order. These had identified gaps in recording however there was no space to record any action taken. The registered manager had identified trends in the errors and said, "One staff member was removed from medicine administration due to the number of errors."

Many documents such as pre-admission assessments, care plans and risk assessments were unsigned so there was no record of who had completed the record and therefore accountability was lacking.

Agenda's for various staff meetings which had been held in January 2016 were in place, however there were no minutes available. The registered manager was aware of the need to ensure regular team meetings were held and that minutes of meetings were available for staff.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was proactive in putting things in place during the course of the inspection and welcomed feedback. They were very positive and focused and wanted everything possible to make sure people and staff were happy and that the home was of a high standard. They said, "I love it here, I want it to be all singing and dancing." They were discussing the purchase of a new nurse call system with the owner, which monitored the time people waited for their nurse call to be answered, whether night checks were completed appropriately and could be used to discretely prompt and log the requirements for specific care, such as positional changes or time specific medicine administration. The registered manager explained this would promote people's dignity and respect as monitoring was discrete, it would ensure needs were met in a timely manner as they could monitor activity and would therefore improve the quality of the care provided.

Staff expressed their happiness about working at Marquis Court and one staff member said, "Communication is good, and the manger is responsive to all suggestions and needs." Another staff member said, "The manager is so keen to help us and the residents." They went on to explain how the registered manager listened their opinions and was open to discussion which led to a good atmosphere.
The atmosphere at Marquis Court was warm, friendly and relaxed. Staff appeared confident in their roles and one relative said, "It's a wonderful place. I put it all down to [registered manager], management make it happen."

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided in a safe way.<br><br>Risks to the health and safety of people were not always assessed.<br><br>The provider had not done all that was reasonably practicable to mitigate some risks.<br><br>The provider had not ensured the electrical safety of the premises was maintained.<br><br>Regulation 12(1); 12(2)(a); 12(2)(b); 12(2)(d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes were not effective in assessing, monitoring and improving the quality and safety of people using the service.<br><br>Regulation 17(2)(a) |