Four Seasons Homes No.4 Limited

Marquis Court (Windsor House) Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Marquis Court (Windsor House) Care Home is a nursing home providing personal and nursing care to up to 52 people. The service provides support to older people, some of whom may be living with dementia. At the time of our inspection there were 34 people using the service (although 1 person was in hospital at the time of our visit). People would normally live in bedrooms spread across 3 floors; however, the lower-level floor was closed at the time of our inspection as the home was not full and to concentrate staff on the ground and upper floor.

People's experience of using this service and what we found
Quality assurance systems in place were not always effective at identifying concerns or areas for improvement. The provider had failed to implement and sustain improvements. There had been numerous management changes in the home which may have impacted the provider's ability to make improvements. There was mixed feedback from relatives about communication. Medicines were not always safely managed. This had been an ongoing concern in the home, so lessons had not always been learned when things had gone wrong. The home required redecoration and work was ongoing to achieve this. People had access to other health professionals, but improvements were needed to the systems in place to monitor this.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service had not always supported this practice. Action was taken in response to this following our feedback.

People were protected from harm as there were detailed care plans and risk assessments in place and staff knew people well. People were protected as infection control measures were in place. There were enough staff to respond to people's needs; however, we did receive mixed feedback about the staffing levels. Staff were recruited safely. People were safeguarded from abuse. People were supported to have enough food and drinks of their choice and in line with their needs. People were supported by staff who had training and support to be effective in their role. Relatives and staff felt positive about the registered manager and felt they could report concerns, if needed. The registered manager understood their duty of candour. The home worked in partnership with other organisations.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 April 2022) and there were continued breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement overall for the last 3 consecutive inspections. The well-led key question has been rated less

than good for the last 7 consecutive inspections.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This inspection started with us looking at the Key Questions safe and well-led which contained those requirements.

When we inspected, we found there was also a concern with supporting people in line with the Mental Capacity Act 2005 so we widened the scope of the inspection to also include the effective key question.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see all of the sections of this report for the details of this. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marquis Court (Windsor House) on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to medicines management, checking consent and quality assurance systems in place at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Marquis Court (Windsor House) Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by 2 inspectors and an assistant inspector. An Expert by Experience made telephone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Marquis Court (Windsor House) Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Marquis Court (Windsor House) Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, we were informed following the inspection the registered manager left their role.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We also asked Healthwatch for feedback, although they did not have anything to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service. We also spoke with 14 relatives, some who we met while we were visiting the service and others we spoke with over the phone. We also spoke with 6 staff, including care staff, an activities coordinator, nurses, and the registered manager. We also spoke with 3 regional managers. We made observations in communal areas to observe interactions between people and staff and the care and support offered.

We reviewed a range of records. We looked at 8 people's care records and multiple medicines and daily care records. We looked at 4 staff files and 4 agency staff profiles to check recruitment processes. A variety of records relating to the management of the service, including policies and procedures, building safety records and audits were also reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

The purpose of this inspection was to follow up on a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure improvements had been made to infection control practices, risk management and medicines storage.

At this inspection we found improvements had been made to infection control measures and risks were now assessed and planned for. Medicines storage had somewhat improved, however we found further concerns about the management of medicines so there was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely; Learning lessons when things go wrong

- Medicines were not always safely managed, and lessons had not always been learned when things had gone wrong.
- People did not always have their medicines as prescribed and in line with pharmacist guidance. We found evidence there were missed doses of medicines for 3 people. One person was also being given their medicines in a different way to how a pharmacist advised. This left people at risk.
- Some people were regularly refusing their medicine, which is their choice to do so. However, staff had not sought advice from a relevant professional to check if this was ok, or whether alternative methods or medicines could be considered.
- Medicines for disposal were not always recorded as disposed in a timely manner and sometimes left for days. This left them open to possible abuse.
- Medicines management had been identified as an area for consideration and improvement by the provider at the last 2 inspections and we continued to find issues at this inspection. Therefore, the provider had failed to learn lessons.

People had not always been protected by the safe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At the last inspection there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made about the assessing of risk and there was no longer a breach about this aspect of people's care.

- People were protected from harm, as risks were assessed and planned for, with care plans containing

detailed information about people's needs and staff knew people well. One staff member said, "Care plans are not restricted to the nurses, we all get involved, we all look at them. If I need to find out some information, I can go in into the office and get the information."
● Some relatives fed back they had concerns about how people were supported by staff when they needed help with moving and handling equipment. However, we saw clear plans in place about how people were supported with their mobility, and we did not observe inappropriate moving and handling in communal areas.
● People who had health conditions which staff may need to respond to, should the person display symptoms, had clear plans in place. Plans were regularly reviewed.
● Building safety was checked and monitored to ensure the home remained safe for people to live in and they would be protected in an emergency.

Preventing and controlling infection
At the last inspection there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made to infection control measures and there was no longer a breach about this aspect of people's care.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. This was because we received mixed feedback from multiple relatives about the cleanliness of some people's rooms. Rooms we saw during our inspection were tidy.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions in place for visiting.

Staffing and recruitment
● There were enough staff to keep people safe. However, we received mixed feedback from relatives about staffing levels.
● One relative said, "We find on a weekend, there is not as much staff." Another relative told us, "We always feel they are understaffed." Another relative said, "There is definitely not enough staff, no, never."
● Whereas another relative said, "There always seem to be plenty [of staff]." Another one commented, "There seems to be enough staff. There is always someone available if you need someone."
● There was a dependency tool in place to guide how many staff were needed. The rotas showed the number of staff planned generally matched the dependency tool. However, one staff member involved with the dependency tool said, "It doesn't always take into account the layout of the home."
● There was a reliance on agency staff to staff the home; however, we were told agency staff were generally block booked to ensure consistency.
● Our observations showed people did not have to wait long for support, people were supported for example with their meals and drinks in a timely manner and the correct number of staff supported with moving and handling.

● Staff were recruited safely and checks were made on their suitability to work with people. There were Disclosure and Barring Service (DBS) checks. DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● We found one instance of a safeguarding concern not being reported to the local safeguarding authority which we discuss further in the well-led key question. Despite this, people were protected from the risk of abuse.

● One person said, "Staff never shout, they're not rude at all." Another person said, "I like it here. The staff are great, they are very kind to me and to us all."

● A relative said, "We have been very pleased with the home; we feel our relative is safe."

● Staff received training so understood their safeguarding responsibilities and told us they would report concerns.

● We saw other examples of concerns being reported to the local safeguarding authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were not always protected by having decision specific mental capacity assessments in place, and therefore not having the appropriate authorisations in place when they were being restricted.
● One person was being restricted. Whilst their relative was aware of this, there had been no assessment of the person's ability to make decisions about this. The details of this restriction had not been included in their DoLS application for the appropriate consideration and assessment of these measures.
● Another person was also being restricted. There had been no assessment about the person's ability to consent to this. Appropriate advice had been sought from a health professional; however, details of this restriction had also not been included in their DoLS application for the appropriate consideration and assessment of these measures.

People had not always had the relevant consents in place. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the registered manager took action to rectify these omissions. We saw other examples of appropriate capacity assessments in place.

Adapting service, design, decoration to meet people's needs

● The home was in need of redecoration. We observed, and staff told us, they felt it was an area which needed addressing.
● However, work was already ongoing and more was planned to address this.
● There was appropriate equipment in place for people to use should they have needed it.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People generally had access to other health professionals, but improvements were needed to the systems in place.
● We found 2 people who repeatedly refused their medicines and a referral to an appropriate health professional to review this was not evident.
● However, other referrals had been made such as for those who had lost weight. Some relatives told us people had lost weight. We checked this and people had their weight monitored and action was taken in response to someone losing weight. However, the provider was not always following their own processes to monitor and track weight loss. We discuss this further in the well-led key question.
● We saw evidence of other professionals also being involved in people's care, such as GP, dieticians, neurology, chiropodist and podiatrists.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have food and drinks of their choice and in line with their needs. We received feedback from multiple relatives they were concerned about the amount of fluids some people were having. We observed staff encouraged and prompted people to eat and drink to help them remain well and records showed people were receiving fluids.
● People told us they liked the food. One person said, "It's brilliant. I get a choice. They would find you something [if you didn't want something from the menu]." One relative said, "They ask them what they would like to eat from a certain menu, my relative can choose where they sit; they are very relaxed about things."
● People had their dietary needs assessed, recorded and support from staff matched this.
● The head chef had undertaken additional training to prepare and present food for those with a modified diet in a dignified and appetising way. We observed the pureed food looking appetising.

Staff support: induction, training, skills and experience
● People were supported by staff who had training and support to be effective in their role.
● One staff member said, "The training's been great. I did training before I came [to work in the home], and I've enjoyed what I've done since. I have done lots of refresher training lately [whilst working in the home]."
● Staff were aware of their safeguarding responsibilities and we observed safe moving and handling manoeuvres. One staff member also told us, "I've worked in care a long time, so I have experience. I have completed the learning, moving and handling practical, we do fire drills on a regular basis."
● Staff told us, and records showed, they received training. Staff felt supported in their role. One staff member said, "I couldn't have asked for better support."

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The purpose of this inspection was to follow up on a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection the provider had failed to demonstrate systems were effective at monitoring the quality and safety of the service which put people at risk. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we identified that not enough improvement had been made and the provider was still in breach of this regulation. Systems were still not effective at always identifying areas for improvement and ensuring action was taken in a timely manner and people had been exposed to less than good care for a prolonged time.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to implement and sustain enough improvements to ensure they were no longer in breach of regulations and to achieve an overall good rating. This is the 7th consecutive time the well-led key question has been rated less than good. This is the 3rd consecutive time the overall home rating has been rated less than good.
- Quality assurance systems in place were not always effective at identifying concerns or areas for improvement.
- There were multiple issues with medicines management and the providers systems to monitor medication had failed to identify some of these incidents. There were medicines errors, and these had not been recognised. Some people had continually refused medicines and action had not always been taken in response to this. Medicines for disposal were at risk of possible abuse.
- While people had been kept safe following an incident occurring, we found the providers systems had failed to ensure that safeguarding concern had been reported to the local safeguarding authority in a timely manner.
- The providers systems to monitor peoples care had failed to identify that a complete record for each person was not always available in relation to their DoLS applications and their ReSPECT forms or Do Not Attempt Resuscitation (DNAR) documents. A complete and accurate record should be kept for each person. Systems had failed to support the provider to recognise that some people were being restricted and these did not have an appropriate authorisation in place.
- If a person lost a certain amount of weight this was supposed to be recorded on the provider's electronic monitoring system. However, we found multiple instances where this had not happened. Unexplained or

concerning marks on people's bodies were also supposed to be recorded on this system, but this had not always been done. This meant the provider's processes were not always being followed, so oversight was not always clear.
● One agency staff member had some information of concern recorded on their recruitment information. Further queries had not been raised about this, despite this being needed. Action was taken following our feedback.
● Audits in place were not always clearly completed so there was not always an audit trail of what had been specifically reviewed, so we could not verify if they had been completed correctly.
● Action plans in place to track progress and completion of action to improve the quality and safety of the service had not always been effective. We continued to find concerns and some areas we identified were not always included in the action plan, so the provider had failed to recognise these improvements were needed.

Quality assurance systems continued to not always be effective at identifying and resolving concerns about the quality and safety of care to people. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At the time of the last inspection there had been a number of management changes which had impacted on the provider's ability to make improvements. This had continued and the management of the home had changed again since our last inspection. There was a new registered manager in place at the time of this inspection. However, while we recognise the provider had experienced challenges, people had still been exposed to less than good care for a prolonged period of time, which was not acceptable.
● The management team, at this inspection, were aware there had been a sustained history at the service of less than good care at times. There had been numerous manager changes and the management team realised some people and relatives had lost confidence in the service. They recognised work was needed to re-build trust. There was mixed feedback from relatives about communication.
● One relative said, "Managers come and go; they've had more managers than I could mention." Another relative said, "Management has always been a problem, it's weak. There has been a succession of rapid changes in management." Another relative commented, "They have that many in there it's hard to keep up with the managers."
● Some comments from relatives were negative about communication. One relative said, "I haven't been informed about things for a while, I have to question things. I was supposed to be involved in all of this; I was my relative's voice. I should be involved." Another relative told us, "If I want updates I have to ask."
● However, some relatives were also positive about communication. One relative said, "They communicate well, they update me and let me know how my relative is and if there is anything I need to know." Other comments included, "They do ring me and keep me informed" and, "I also have contact every month to update me about my relative."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People, relatives and staff felt positive about the new registered manager and felt able to feedback, if they needed to.
● One relative said, "I feel I can always go and speak with the registered manager if needed." Another relative said, "I have spoken to the new [registered] manager, they are definitely approachable. I'm hoping this one stays." Another relative told us, "The [registered] manager is lovely and has been great."
● One staff member said, "The [registered] manager is always really approachable they're really very good

and they make sure we keep up to date with things there's always changes all the time, but we always know what's happening."

● There was a mixture of staff having 1-1 supervisions and group supervisions; staff could make suggestions and there was documented evidence of follow up to actions identified. One staff member said, "We are actually asked for opinions on improvement and the management will actually implement some of our ideas. We have supervisions, we have team meetings."

● There had been recent relatives meetings to give relatives the opportunity to feedback about the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was aware of their duty of candour.

● One relative said, "Staff always hand information over in detail, good or bad. They also let us know if there are any issues." Another relative gave us an example of something going wrong in the home and there was an apology and action taken to reduce the risk of a reoccurrence.

● Notifications were submitted, as required. The previous inspection rating was also being displayed on the provider's website and in the home, as necessary. However, the rating on display in the home would have benefitted from being a colour version to make it easier for people, relatives and staff to easily identify the ratings clearly.

Working in partnership with others

● The home worked in partnership with other organisations. External professionals visited the home and the registered manager was receptive to feedback.

● The local authority had visited the services and noted improvements under the new registered manager. The provider and registered manager had worked on the action plan set by the local authority to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not always have their ability to consent to restrictions checked. Restrictions in place were not always referred by the home for review and consideration by the relevant organisation.

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
Treatment of disease, disorder or injury	Medicines were not always safely managed.

The enforcement action we took:

A notice of proposal to impose conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's quality assurance systems and processes were not always effective at identifying and acting upon concerns to ensure people received safe and good quality care.

The enforcement action we took:

A notice of proposal to impose conditions on the providers registration.