George Ronald Limited

Marquis Court

Inspection report

Marquis Court
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Sunderland
Tyne And Wear
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Tel: 01915210796

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection carried out on 15 June 2017.

We last inspected Marquis Court in April 2016. At that inspection we found the service was in breach of its legal requirements with regard to regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were at risk of unsafe care and treatment, records did not accurately reflect people's care and support needs and audits were not effective. At this inspection we found that sufficient action had been taken in all the required areas to make sure the relevant legal requirements were met.

Marquis Court is registered to provide accommodation for personal and nursing care to a maximum of 47 older people, including people who live with dementia or a dementia related condition. Nursing care is not provided. There were currently 46 people living at the service.

A registered manager was in post. 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.

People and staff told us they felt safe and there were enough staff on duty to provide safe and individual care to people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with vulnerable people who needed care and support.

The necessary checks were carried out to ensure the building was safe and fit for purpose.

Risk assessments were in place and they identified current risks to the person. Records were in place that reflected people's care and support requirements and they were regularly reviewed to ensure they remained accurate. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices, where they were able about aspects of their daily lives. People received a varied and balanced diet to meet their nutritional needs.

Activities and entertainment were available for people. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service.

The provider undertook a range of audits to check on the quality of care provided. Staff and people who used the service said the registered manager was supportive and approachable.

Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Regular checks were carried out to ensure the building was clean, safe and fit for purpose. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

Is the service effective?

Good

The service was effective.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they needed the support

of an advocate.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. Records were in place that reflected the care provided by staff.

There was a programme of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good. They were complimentary about the running of the home and the staff team.

The registered manager monitored the quality of the service provided and introduced improvements with further plans to ensure that people received safe care that met their needs.

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

This inspection took place on 15 June 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission within required timescales. We contacted commissioners from the local authorities who contracted people's care.

During this inspection we carried out observations using 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 communicate with us. We also undertook general observations during mealtimes.

During the inspection we spoke with 13 people who lived at Marquis Court, five relatives, the registered manager, the deputy manager, one team leader, seven support workers including one senior support worker, the activities co-ordinator, one member of catering staff, the housekeeper and one domestic member of staff and two visiting health care professionals. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager and provider had completed.

Good

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One person told us, "I'm always safe here." Another person commented, "Yes, I'm definitely safe here. I was on my own at home, there is always someone here so it saves you worrying." A third person told us, "During the night they check on me every two hours." One relative commented, "It's a lovely safe environment. Another relative said, "I feel [Name] is safe when I'm going home, it makes it better for me."

At our last inspection in April 2016 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service.

At this inspection we found improvements had been made to ensure people received safe care and treatment. Improvements had been made to ensure risk assessments reflected current risks to people's health and safety. Environmental risk assessments such as for the use of oxygen, fire, falls from windows and the kitchen environment were in place with a regular monthly review to ensure they remained accurate and reflected any current risk around the home. The provider had undertaken work to the premises to ensure the areas of potential risk in the electrical installation report of 2015 were now actioned.

People's individual risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, mobility, choking, nutrition and pressure area care. The monthly evaluations included information about the person's current situation.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed regularly to ensure it was up to date. These plans were in place to support staff and emergency services should there be a need to evacuate the building.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. Fire instructions and staff training was in place to inform staff of action to take in the event of a fire. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with appropriately. We also saw records to show that other equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

There were 46 people living at the home at the time of inspection. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. Staffing rosters and our observations showed seven support staff were on duty from 7:30am until 2:30pm. Six support staff were on

duty from 2:30pm until 9:30pm and four night staff were on duty overnight. These numbers did not include the registered manager and deputy manager who were on duty during the day and available on call overnight. One person told us, "There are always staff buzzing around." Another person said, "The carers come fairly quickly." A third person told us, "I think there are enough staff on duty."

We considered there were enough staff on duty to meet people's needs but we discussed with the registered manager some people's and staff comments about the evening shift when staff were busy and people had to sometimes wait longer for staff assistance. Peoples' comments included, "There aren't enough staff at night, if I ring the buzzer after 6:00pm they can be busy", "They could do with a few more staff as they have a lot to do", "It depends sometimes they come straight away, sometimes it can take up to twenty minutes" and "Sometimes I have to wait it depends on how busy they (staff) are." The registered manager told us that this would be addressed.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received recent relevant training. One staff member told us "I'd speak to my manager about any concerns." Another commented "I'm doing safeguarding training now."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged and raised appropriately by the registered manager. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. We were told learning took place from safeguarding incidents.

Medicines were administered as prescribed. We observed part of a medicines 'round.' We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered a position. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff had opportunities for training to help further understand people's care and support needs and said they were supported in their role. Support staff received regular supervision from one of the home's management team every two to three months. One staff member told us, "We have supervision every three months with one of the management team." Another staff member commented, "We're supported to do the job."

Staff members were able to describe their role and responsibilities. A number of staff members had worked at the home for several years. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. A staff training matrix showed that a range of courses took place to ensure they had the knowledge to meet peoples' care and treatment needs. Staff training courses included, dementia awareness, end of life care, dysphagia (swallowing difficulties), health and social care, continence, food nutrition, mental capacity and deprivation of liberty safeguards.

Staff told us and training records showed they were kept up-to-date with safe working practices. One staff member told us, "There are plenty of opportunities for training I've just done safeguarding and fire training." Another said, "There's loads of training, I'm doing a National Vocational Qualification at level two (NVQ) (now known as the diploma in health and social care) you can go up to level five and management." A third staff member said, "There's always training, I've done mental capacity training." One relative told us, "The staff are trained well."

People were supported to maintain their healthcare needs. One person told us, "I have had the doctor come out for my foot." Another person commented, "If you are ill, if they know you need a doctor they (staff) will see to that." A third person said, "The chiropodist came about six to eight weeks ago." People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), district nurses, psychiatrists, dietician and staff from the speech and language team (SALT). Records were kept of professional visits. Care plans reflected the advice and guidance provided by external professionals. We spoke with a visiting health care professional who was complimentary about the care provided by staff. They told us, "Staff involve us in a timely way and follow any advice and guidance."

Relatives told us they were kept informed by the staff about their family member's health and the care they received. One relative told us, "On one occasion they sent a member of staff to the hospital as I couldn't make it. Another time they called the GP when [Name] fell on the floor. I felt they did everything right and they rang to tell me."

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. There was also a handover record that provided some information about people, as well as the daily care entries in people's individual records. One staff member told us, "Communication is effective. Senior staff pass on information from senior handover to the rest of the staff."

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received information from the registered manager when people required a specialised diet. A board was available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements. The cook explained about people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. People received drinks in between meals and the tea trolley provided a variety of drinks and biscuits.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nutritional needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

People were encouraged to make some choices about their food. However we considered some improvements may be needed. We were told people ordered their meal choices the day before. We discussed with the registered manager and cook that people may not always want the meal choice they had made the previous day. People who lived with dementia or people with memory issues may also not recall their order. The registered manager told us that this would be addressed, so people could order on the same day although they told us sufficient food of each choice was always available so that people could choose at the meal time.

Food was well presented and looked appetising. People and relatives were positive about the food saying there was enough to eat and they received nice food. One person told us, "Food on the whole is very good." Another person said, "The cook comes and tells us about the food for the next day. I get two choices and I'm happy with this." A third person told us, "I get plenty to eat, I had to tell them (staff) to cut down on the amount and they did this." Other people's comments included, "We have lots of vegetables, a variety of meals to choose and they (the cook) will make you something else if you don't like it", "The food's alright most times. There's a choice and more than enough to eat", "We get good food, plenty to eat and I'm well satisfied. The food is nice" and "There's a lovely choice of food." One relative told us, "There's a variety of wholesome food. Staff let me come in and eat with [Name], it encourages [Name]. We have our own table."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 45 DoLS applications had been authorised by the relevant local authority.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained some information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. However, people's care records did not all show when 'best interest' decisions may need to be made when people no longer had mental capacity. Information was also not available to inform staff when a person with fluctuating capacity may be best supported to make a decision such as at certain times of day and when they were not tired. We discussed with the registered manager the need to ensure that if and when people no longer had the capacity to make decisions their views were captured in their records. This would help to ensure staff had the information to support people in the way they wanted in the future if they were no longer able to communicate their views verbally. The registered manager told us that this would be addressed.

People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

Good

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with said staff were kind, caring and compassionate. People's comments included, "Staff are very kind, they do their best", "We are very well looked after", "Staff are very friendly and patient", "I'm quite happy here staff are kind and caring", "Staff will go the extra mile" and "They (staff) are polite and nice, nothing is a bother." One relative told us, "Staff know what they are doing, they are pretty good." Another relative said, "Staff carry things out in a professional manner."

People's privacy and dignity were respected. People told us staff were respectful. One person told us, "Staff never come in without knocking." Another person commented, "Staff give you your privacy." We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Staff received training to remind them about aspects of dignity in care.

People told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "They (staff) leave me until I want to get up and I go to bed when I want." Another person commented, "Yes, I do what I want I was watching the television at 12:45am." Other people's comments included, "That's my breakfast, they [staff] sometimes bring it into my room as a treat", "and I can have a bath every night if I wanted, if staff aren't busy" and "In the morning staff ask are you ready to get up?"

We observed the atmosphere around the home was calm, relaxed and tranquil. Throughout the home staff interacted well with people. They were kind and caring and they spent time engaging with people and not only supervising them. We saw staff engaged with people in a friendly and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention. For example, "Do you want an apron" and "Can I help you with that?"

We observed the lunch time meals in the dining rooms. We saw the meal time was relaxed and unhurried. Written menus were available to help inform people about the food. Staff told us they used pictorial menu cards when required to prompt a person if they were no longer able to recognise writing. People sat at tables that were set with tablecloths, napkins and condiments. Some people remained in their bedrooms to eat or in the lounges or hallways. Staff provided full assistance or prompts to some people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff met people's needs in a sensitive and patient manner. They talked to people as they helped them and as lunch was served. Examples of staff interaction with people included, "Is everything alright", "Are you enjoying that" and "Shall I cut that up for you."

Staff we spoke with understood their role in providing people with caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they

knew them well. Staff described how they supported people who may not express their views verbally. Staff told us they observed facial expressions and looked for signs of discomfort if a person was unable to say for example, if they were in pain. However, a written record was not available to inform staff who did not know people so well, the signs to identify if someone was in pain and how they may communicate their pain and distress. We discussed this with the registered manager who told us it would be addressed. People's care plans had become more person centred but further information was being introduced as the result of the joint work with the district nursing team.

Care plans provided information about how people communicated. Examples in care plans recorded, '[Name] speaks quietly. Staff must take the time to listen as [Name] will become frustrated if they think they are being dismissed.' This information was available for staff to provide guidance about how a person should be supported.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. Care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told this was discussed and the relevant people were involved in the decision making to inform staff of the person's wishes at this important time and to ensure their final wishes could be met.

Despite these end of life care arrangements being in place the registered manager told us that they had to advocate on behalf of people who used the service to ensure that people's final wishes were met. They had raised with the clinical commissioning group and other relevant authorities that peoples' rights to remain at the home to die were not always being respected. They told us of a recent situation where this had occurred and the person was taken to hospital by the ambulance service. They told us the matter was being addressed to ensure, in the future, people's final wishes would be respected.

The service supported people to access advocacy services where needed. Some people were supported by an Independent Mental Health Advocate (IMHA) because they lacked the mental capacity to make decisions with regard to their well-being. Advocates can represent the views for people who are not able to express their wishes. Information was displayed that advertised what advocacy was and how the service could be accessed.

Good

Is the service responsive?

Our findings

At the last inspection we had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed.

At this inspection improvements had been made to ensure that records accurately reflected people's care and support needs so staff had guidance to provide appropriate care and support.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, mobility, falls and personal hygiene.

Records showed that monthly assessments of peoples' needs took place and there was some evidence of evaluation. However, monthly evaluations did not include information about people's progress and well-being and some of the changes that may have taken place. For example, for one person up to date information from their nutritional assessment was not reflected in their nutritional care plan. We discussed this with the registered manager the need to ensure an accurate link between the person's risk assessment and care plan so records reflected the care provided by staff. They said they would address this. Reviews of peoples' care and support needs took place with relevant people. One relative told us, "We attend care review meetings to discuss [Name]'s requirements."

Care plans provided information for staff about how people liked to be supported. For example, some care plans for personal hygiene stated, '[Name] requires assistance from one member of staff with personal hygiene. [Name] is able to wash their hands, face and upper body with prompts and encouragement' and 'Requires prompts and encouragement when washing and dressing to help maintain [Name]'s independence and promote daily living skills.' Care plans were broken down to provide details for staff about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted.

Other information was available in people's care records to help staff provide care and support. Examples, in nutritional care plans included '[Name] requires supervision from staff when eating, they eat slowly and independently, requires a plate guard' and 'If a poor diet offer [Name] desserts.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people. However, the food charts did not accurately record the amount of food a person consumed at each meal. Recordings were subjective and stated 'all' or 'half' so it was difficult to monitor as records did not detail the amount offered for the person's meal. The registered manager told us that this would be addressed. Records also included when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and

preferences.

People's care records and personal profiles were up to date and personal to the individual. Information was available about people's history, likes, dislikes and preferred routines. Examples included, '[Name] uses sensitive toiletries and T-gel shampoo and dislikes bubble bath', 'I like to make models and I enjoy watching sport' and '[Name] likes to get up at 9:00am.' Another activity profile recorded, '[Name] is a quiet person who chooses which activities to participate in.'

People and relatives confirmed there was a choice of activities available. One person told us, "I join in most activities it's very good." Another person said, "I like the sing a long, I was there this morning and I really enjoyed it." Other comments from people included, "I was invited to the men's meeting this morning but I chose not to go. [Name] the activities person says it's my choice." One relative told us, "[Name] enjoys the activities, but they're not forced to take part." One person told us they received a daily newspaper. They said, "The activities person brings the paper in for me." One staff member also commented, "When [name] the activities co-ordinator is off I do some activities like karaoke and all staff have access to the garden shed, where the activities are kept."

An activity co-ordinator was employed and a programme of advertised activities was available and this included, percussion, men's club, a bar, library, pamper sessions, bowling, reminiscence, skittles and films. The activity co-ordinator told us, "When people first come in I give them a manicure as it relaxes them, I play soft music and I get to know them." Information about people's likes and dislikes and previous hobbies was available so that care was individual to the person. The activities co-ordinator told us, "I do one to one's with people." Entertainment, seasonal parties and concerts also took place. One relative commented, "They usually have a barbecue in the summer. For Valentine's Day they had a tea for couples it was beautiful. They did one for Mother's day too."

We were told the hairdresser visited weekly and a local member of the clergy visited regularly. One person said, "I have Holy Communion." People moved around the home as they wanted and there was a garden for people to sit in. However, some people said they did not get out into the community unless they were taken out by a relative. Their comments included, "I never go out unless my family take me, staff don't have time to take me" and "I went to the seaside with a carer once but we don't get to go out with the care home staff." We discussed this with the registered manager who told us transport was a problem as the home did not have access to transport with local community groups. They told us it would be addressed.

Regular meetings were held with people who used the service. One person told us, "I go once a month to the resident's meeting. I'm happy to have my say." Another person commented, "I know they have meetings on Fridays." People told us they were listened to by staff. One person gave an example, "I complained about the bed being lumpy about a month ago and now I have another bed, they (staff) will listen."

People knew how to complain. People we spoke with said they had no complaints. A relative told us, "I raised a complaint about a year and half ago and it was resolved." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

At the last inspection we had concerns audits were not always effective. At this inspection we found improvements had been made to ensure audits were more effective with evidence of follow up action where it was required.

A range of auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly checks. All audits showed the action that had been taken as a result of previous checks. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, infection control and pressure area care was completed by the registered manager for analysis. Monthly audits included checks on medicines management, safeguarding, the environment, care documentation, training, kitchen audits, accidents and incidents and nutrition. Three monthly audits were carried out for infection control, falls and health and safety.

We were told regular visits were carried out by the provider when they monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All the registered manager's audits were available and we saw the information was filtered to ensure any identified deficits were actioned. We saw dates and the sign off of these audits from the provider's visits. However, detailed records from the monthly visits carried out by the provider were not available that showed the provider spoke with people and the staff regarding the standards in the home. We discussed this with the registered manager who told us it would be addressed to provide documentary evidence of the external monitoring that was taking place.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

The home had a registered manager who had become registered as manager for Marquis Court in July 2015. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager was enthusiastic and had introduced many ideas to promote the well-being of people who used the service. The atmosphere in the home was warm, lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One relative told us, "The manager is approachable." Another relative commented, "The manager is long standing, they've been here for years and worked their way up through the ranks." Other comments included, "I can ask [Name] the manager for anything and the staff are lovely", "The manager's door is always open" and "The manager is very nice."

Staff were positive about the management of the home and had respect for them. One staff member commented, "There's a pretty good team here." Another told us, "I love coming to work. I do enjoy the job, I

wouldn't stay if I didn't like it." A third staff member said, "It's a good home, I've worked here for ten years."

The registered manager told us they had introduced changes to the service to help its' smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns. One relative commented, "I think the home is one of the best." Another relative told us, "I would recommend it because they (staff) are good and friendly." A third relative told us, "I chose the home because of the manager."

Staff told us regular staff meetings took place and these included health and safety meetings and senior staff meetings. Staff meetings kept staff updated with any changes in the home and supported them to discuss any issues they may have. Minutes of meetings were available for staff who were unable to attend. Meeting minutes from March 2017 showed topics discussed included 'Medicines management, documentation, staff performance and record keeping.'

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. They were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way. The registered manager said they were well supported in their role by the provider. They told us they kept up to date with best practice and initiatives. These included links with the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw surveys had been completed by people who used the service and their relatives in 2016. We were told the results were analysed by the registered manager so that action could be taken as a result of people's comments, to improve the quality of the service. One relative told us, "I've had questionnaires once a year."