Four Seasons Homes No.4 Limited

Marquis Court (Tudor 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 caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on the 22 December 2014 and was unannounced.

At our previous inspection of April 2014 we found that the provider was delivering care that was safe and met people's needs.

Marquis Court (Tudor House) Care Home is registered to provide care and treatment for up to 52 people who may have Dementia, require nursing and residential care and who may have physical disabilities.

The provider did not have a registered manager in post at the time of our inspection. This meant the provider was in breach of the conditions of registration. 'A registered

Summary of findings

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.'

We identified that improvements were required to ensure people received their medicines safely and safe storage arrangements were in place.

Some people were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves. We found that the staff did not have an up to date understanding of the DoLS to manage the restrictions they placed on people.

Risks associated with infection control and cross contamination were not effectively managed.

Staffing numbers were not always sufficient to meet the needs of people who used the service.

People's risks were assessed and managed, but staff did not always understand how to keep people safe and report safety concerns.

The staff had received training that enabled them to meet people's needs safely. Care was usually provided with kindness and compassion and people's independence and dignity were promoted.

People's dietary needs were met. People chose the food they ate and specialist diets, such as; diabetic diets were catered for.

People's health and wellbeing were monitored and staff worked with other professionals to ensure people received medical, health and social care support when required.

People were involved in an assessment of their needs and care was planned and delivered to meet people's individual care preferences. People had access to activities but some felt they did not meet their individual needs.

People knew how to make a complaint and complaints about care were managed in accordance with the provider's complaints policy.

There had been a recent change in the management team and people and staff told us the new manager was approachable.

There was a need for the provider to review the effectiveness of the tools they used to monitor and improve quality as these were not always effective.

We found a number of breaches of regulations you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us that they felt safe however; people were put at risk because procedures around medication and the risk assessment process were not always followed. Staff did not always the knowledge to recognise signs of abuse. Infection control systems were not sufficient to protect people from the risk of cross contamination and there were insufficient numbers of staff.

Requires improvement

Is the service effective?
The service was not consistently effective.

People's rights were not always respected because of a failure to recognise unlawful restrictions. People told us they thought staff knew what they were doing. Most staff had the skills and experience they needed to meet the needs of those in their care. Staff supported people to have sufficient to eat and drink.

Requires improvement

Is the service caring?
The service was not consistently caring.

People told us that the support workers were kind and respectful and we observed them treating people with respect. We also saw examples where people did not receive support. People were involved in making decisions about their care and their privacy and dignity was respected.

Requires improvement

Is the service responsive?
The service was not consistently responsive

Plans of care were in place but not always up to date or accurate. People knew how to make a complaint. People's needs were assessed before they started using the service. They were asked about their personal preferences and the things they liked to do, but some people felt the service didn't meet their needs.

Requires improvement

Is the service well-led?
The service was not consistently well led

The service did not have a registered manager in post and the systems in place to monitor the quality of the service were not effective in identifying shortfalls. Staff felt the new management were approachable and listened to them. Systems for the supervision and support of staff needed to be improved.

Requires improvement

Marquis Court (Tudor House) Care Home

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 22 December 2014 and was unannounced. The inspection team consisted of four inspectors.

We had received information from the local authority. There were a number of safeguarding investigations being carried out and we were informed there were concerns about people's safety. The local authority were monitoring the quality of care and undertaking reviews of people's care to ensure it was appropriate to their needs. We reviewed the information we held about the service this included any notifications of accidents and incidents the provider is required to send to us.

We spoke with eight people who used the service, six staff and two visitors, we also spoke with the manager and regional manager. We looked at records relating to people's care, and medicines management records, staff training and recruitment record and records pertaining to the management of the home. Where some people were not able to tell us of their experiences. We carried out a Short Observation Framework Inspection, (SOFI). A SOFI is undertaken to assess the quality of interaction and engagement people experience when they are not able to tell us.

We spoke with the safeguarding lead and the commissioner of the local authority to gain their views about the service.

Requires improvement

Is the service safe?

Our findings

We observed medication was not always administered safely by staff to people who used the service. Medication procedures were not always followed which meant that staff signed to say that medication had been administered without them checking that the person had taken this.

People who used the service did not always receive their medication at the time it had been prescribed. A medication which was prescribed to take with food had been given an hour late. This could mean that this medication was ineffective or could have an adverse effect.

There was a no clear process in place for the application and recording of creams and lotions. There was some confusion amongst staff about the application and recording of creams and lotions. Staff signed records to say that creams and lotions had been administered without having witnessed this.

There was no clear process in place for people who wanted to self-administer medication. We saw that a person was self-medicating for a drug they took as and when they needed it. There was no risk assessment in place for this person in relation to self-administration of medication.

Medication was not always stored securely nor in accordance with the Medicines Act 1968 and the Misuse of Drugs Act 1971. Some medicines were stored in unlocked and unsecure facilities easily accessible to people who used the service or any person visiting the home.

Records relating to controlled drugs were not always maintained in accordance with the Safer Management of Controlled Drugs Regulations 2006. We found that controlled drugs were not recorded in accordance with the regulation. Records were maintained on loose leaf paper instead of in a controlled drug ledger. Staff told us, "We've run out of the proper books".

We found that the registered person had not protected people against the risk of harm. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns and feedback that staffing levels were not being maintained at sufficient levels to meet people's needs. The manager told us efforts were being made to recruit new care staff and nurses and, "We have only one permanent day and night nursing staff employed all other nursing shifts are covered by agency nurses. We have borrowed a deputy manager from another home until we can recruit a replacement deputy". This meant people were at risk of receiving inconsistent care and support because of the numbers of different staff being used.

We asked people for their views on the staff. One person said, "There is not enough of them, could do with three more in the daytime and two more at bedtime to help people get to bed." When looking at the person's records we saw that the person had on occasions been banging their bed rails as they wanted to get out of bed. On one occasion it was recorded that the person had been told they could not get the person out of bed when they wanted as there was not any staff available but that they would come as soon as a staff member was free.

People we spoke with raised concerns about staffing. One person said they had to wait for a long time for assistance as there were not enough staff. Another said they had been incontinent sometimes because of waiting for staff to assist her to the toilet. Three other people who used the service told us they felt there was not enough staff at times. The manager told us that staffing levels were below the expected levels because a member of staff had called in sick. Staff we spoke with expressed concern about the staffing levels. One staff member said, "You can never have enough staff but we should have four carers and one nurse. Today we have three carers and one nurse and this is common." This was confirmed by the manager. Another staff member said that sometimes there were senior staff members working on the floor but this did not happen at weekends. They went on to say, "There is not always enough staff, the residents are safe and we try our best." During our observations we saw staff were very busy trying to meet people's needs.

We found that the registered person had not protected people against the risk of harm. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that one person had been diagnosed and admitted with an infection that required special infection control procedures to be followed to prevent cross contamination. The provider's policy for infection control

Requires improvement

Is the service safe?

clearly stated barrier nursing should be in place. We did not observe staff following the expected infection control procedures. We also observed the person who had the infection had free access to the communal areas, at one point being present in the dining room. We spoke with the person who told us they were just finishing their treatment and were due to have a test this week. One staff member said, "We wear red aprons and gloves and put bed clothes into red bags if a person has an infection."

The provider's infection control policy stated that people should not be admitted if they had infectious diseases. This person's discharge letter from the hospital clearly stated the presence of an infection. This meant the provider had not followed its' own policy and procedure in reference to infection control and had placed people at risk of cross contamination.

We found that the registered person had not protected people against the risk of harm. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had received training in how to recognise and report suspected abuse; this was confirmed from the training records we looked at. A nurse said, "I would report abuse. If it involved a member of staff I would speak with them. I am confident the manager would take action but if no action was taken I would contact CQC." Another staff member said, "Indicators of abuse may be a change in the person's mood, they tell us or, any marks of injuries." When we spoke with three other staff only one out of the three understood the safeguarding procedure and what to do if the suspected abuse. One staff member mistakenly told us, "Safeguarding is capacity to take risks. Everybody has rights to make their own decisions". However, one person we spoke with told us they were content and felt safe. Another said, "Yes I feel safe staff watch me every minute". One person told us they had reported a theft from their room, but felt nothing had been done about it. We spoke with the manager who was not aware of the allegations. The regional manager looked into the concerns during the inspection and confirmed that the records did not show how the concerns had been responded to. They acted immediately to rectify and report the issue under agreed safeguarding procedures.

Three of the care staff spoken with did not have a good understanding of whistle blowing if they had concerns about the care and treatment of people who used the service. They said that it was about raising concerns with the manager but were not able to elaborate to tell us who they would report to if they had concerns about the manager or the provider.

Staff told us recruitment checks were carried out. We saw that appropriate checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. Regular checks were also made that ensured nurses were correctly registered with the Nursing and Midwifery Council.

Requires improvement

Is the service effective?

Our findings

Staff we spoke with had not received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) whilst working at the home. The MCA sets out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves. DoLS ensures they are not unlawfully deprived of their liberty, restricted or detained. One staff member told us that the Mental Capacity Act related to people who could not make choices, they said, "If they could not make a decision the family or a social worker would make the decision." We were told that an application had been made to deprive a person of their liberty however the person's records identified that the person had capacity. This meant they could not be subject to DoLS because they had capacity, this showed a limited understanding of MCA and DoLS.

We identified people who were not able to leave the home and one member of staff told us, "[Person who used the service] requests to go home all the time. We just try and reassure them, offer them a cup of tea and someone sits with them. We just take it day by day for their own safety. They have fluctuating capacity". Another member of staff said, "[Person who used the service] they can't get out anyway, they don't know how to use the code, so that's alright." The provider had not considered this person may be unlawfully restricted.

We found that the registered person had not protected people against the risk of harm. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us new staff were supervised and received an induction to ensure they were familiar with people's care needs and able to support them safely. We observed a new staff member assisting a person to eat without any supervision. We confirmed from discussion with staff that the new staff had not been provided with an induction. They told us, "It's my first day". The manager told us they had not been aware that this had taken place. This showed the providers induction procedures were not effective in ensuring staff were suitably skilled to undertake their role.

One person told us, "The food is very nice. They'll change it if you ask them to". People we spoke with all knew what they are having for lunch and a picture menu in the dining area provided a visual reminder of the choices available. We saw that a variety of food was offered during breakfast and lunch. We observed staff going round and explaining to people what was available for lunch and supporting them to make a choice. We observed that drinks and snacks were available and offered to people throughout the day and appropriate support and assistance given to people who required support. Staff told us who had special dietary needs. We saw that people at risk of malnutrition and dehydration had their food and drinks intake monitored to ensure they took sufficient to maintain their health.

We spoke with two visiting health professionals. They confirmed pressure ulcer management at the home was satisfactory and people were repositioned regularly to prevent pressure damage. We saw that referrals had been made to health professionals such as dietician's and speech and language therapists. For example one person had been referred to the speech and language service due to them coughing when drinking fluids. They had also been referred to the dietician due to on-going weight loss. This showed the health issues were responded to and referred promptly.

Requires improvement

Is the service caring?

Our findings

All people we spoke with said staff were caring. They told us staff would stop and talk to them when they had time. This was evidenced during a period of observation when a staff member came and sat in the lounge to talk to two people. However, we observed and were told that one person, who had stated they would like to go back to bed, was not able to do so because staff did not respond to their needs promptly or acknowledge their wishes.

One person told us, "You won't get a better home anywhere. I'm well looked after and I mean it". Another said, "Staff on this floor are very nice". One staff member gave us an example of encouraging a person to eat by their self instead of them taking over to help the person to retain their independence.

We spoke with staff about people's religious needs. One staff member said, "Most of our residents are Church of England or Catholic. We ask this information on admission but we have no people at the moment with specific cultural needs. We have a priest who comes in." They went on to say, "Recently some relatives specifically asked that a priest visited due to the person's health and we arranged for this." We later observed a priest visiting people who in the home.

One person said, "I can't fault the staff." Another person said, "Staff calmed me down when I became upset." People we spoke with felt happy to discuss needs with staff and felt they were respected. We observed people being asked whether they would like a drink. We heard staff talk to people with consideration and respect.

Staff told us that they respected people's dignity and privacy by calling people by their preferred names and by closing doors and curtains when attending to personal care. One staff member said, "If people want to talk in private we will take them to their rooms."

Requires improvement

Is the service responsive?

Our findings

People and relatives told us they were involved in the initial assessment of their needs. One person said, “They asked me about myself and what I wanted”. A relative told us, “We were asked about [person who used the service] and how they liked things done”. We saw that needs assessments had been undertaken when people came to the home. These had been reviewed monthly to ensure they were up to date. People’s life histories, likes and dislikes were also recorded in their journals and care records. A member of staff told us, “[Person who used the service] was very ill, and they said they were going to die. They said there was one thing they wanted to do, to go on a horse, so I brought my horse in and they were hoisted on the horse. [Person who used the service] has got pictures of it in their room”.

People gave us mixed views on the arrangements made to support them to be involve d in hobbies and interests. One person told us they had been out for lunch recently and had been taken out for Christmas shopping. One person said, “They try to take us out once a week”. A member of staff told us, “It is their choice at the end of the day. If they want to go, they go.” However, we were also told that some people did not have an opportunity to be engaged in their hobbies or interests. One person said, “What can you do here? I just sit here and do nothing at all.” Another person said, “Bingo and that is the usual. I don’t like that.” A senior: “There’s not enough to do with people who sit in their rooms.” Another member of staff said, “We have a person for activities but I don’t think we have enough activities.”

One person said, “I sometimes go into the lounge but I prefer to stay in my room.” We asked them if they like listening to music they said, “Yes, my type of music.” We asked what type of music that was and asked if it was music from the war time. We observed that the person did not have any means of listening to music in their room other than a small television. This meant the provider hadn’t responded to the person’s individual needs.

One person told us they had attended a residents meeting and they found this to be beneficial. They told us they had raised concerns about food choices and felt these were listened to and acted upon. Every person we spoke with told us they felt happy and confident raising concerns with the staff. They said the care staff and nurses were approachable and friendly.

Staff we spoke with told us that resident’s meetings took place. One staff member said, “Residents meetings take place downstairs. People upstairs are given the option but if they have not got capacity a relative can attend.”

People told us they knew how to make a complaint. One person said, “If there is something I don’t like I tell them and it goes in.” They gave us an example of when they were not happy with how staff had attended to their personal care and hygiene they confirmed that the staff took on board what they had said and they had not experienced any problems since then.

A relative said “I think I have a booklet at home with complaints in it. They gave it to me when [person using the service] came here.” They went on to say, “They [the staff] are normally very good.” Staff told us they would try to help people to make a complaint. One staff member said, “I would try and sort out any complaints or I would ask advice.” Another staff member said, “I would try and sort it myself if I could I would go to the nurse to resolve.”

Requires improvement

Is the service well-led?

Our findings

The provider had systems in place to assess and monitor the quality of the care. Quality audits were regularly completed. These included audits of; the environment, medicines management, infection control and care plans. However these systems were not always effective in identifying problems with the quality of the service. We found breaches of medicines management administration practice and storage.

We found concerns around infection control management and staff understanding and knowledge of MCA and DoLS which meant people may be at risk of harm and unlawful restriction. We noted the staff had not always been available in sufficient numbers to meet people's needs and provided

This meant the checks carried out by the provider had failed to identify, assess and manage risks to people.

We found that [the registered person had not protected people against the risk of harm. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a registered manager in post. A new manager had been appointed, but had yet to register with us. People we spoke with spoke positively of the new manager, saying they were approachable and caring.

People told us, "She's new. I've got no worries with her". A care staff told us, "The new manager is lovely very approachable. I feel like I can approach them if there's anything".

Staff we spoke with also told us, "Managers don't stay here very long. They don't get the help they need" and, "They don't get any support". Another staff member said, "New managers come in with high hopes but so much gets swept under the carpet then they have to deal with previous people's mess before they start to make improvements".

One staff member said, "It's a good little home, we have good staff." When asked if they felt supported they said, "Yes, now I do feel supported. It helps having a manager that is approachable." When we asked if they felt valued, one staff member said, "No I don't feel valued. The new manager is nice and will sort problems. I do feel supported. There are issues but staff are good. I want the manager to stay; if the manager goes everything goes downhill."

We asked staff about supervision and staff meetings, one staff member said, "I am due to have supervision, and my last one was about 12 months ago." We asked a member of nursing staff if they had received clinical supervision they said, "I have not had clinical supervision due to having no manager." Another person said, "We had a staff meeting about two weeks ago, we usually have them every two months." They went on to say, "I have not had supervision since the new manager started. I think the last one was in the middle of the year. They do annual appraisal with the supervision."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the risks associated with medicines. Effective and safe systems were not in place for the storage, administration and recording of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not protected because there was a failure to recognise unlawful restrictions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not protected because of a failure to ensure sufficient numbers of suitably trained staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against identifiable risks of acquiring an infection because effective systems were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The provider had not protected people against the risk because they had failed to identify and manage risks relating to people's health safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers The provider had failed to ensure a registered manager was in post.