GCH (Queensway) Limited

Queensway House

Inspection report

Jupiter Drive
Hemel Hempstead
Hertfordshire
HP2 5NP

Tel: 01442266088
Website: www.goldcarehomes.com

Date of inspection visit:
14 September 2016

Date of publication:
24 October 2016

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**

Summary of findings

Overall summary

This inspection took place on 14 September 2016 and was unannounced. Queensway House is an 80 bed care home for older people that does not provide nursing care. There were 73 people living at the home at the time of this inspection. When we last inspected the service on 12 May 2015 the provider was meeting the required standards. At this inspection we found that the provider was not meeting the required standards.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There were not always sufficient numbers of suitable staff available to meet people's needs consistently across all areas of the home. Safe and effective recruitment practices were followed to make sure that staff were of good character and had the experience and qualifications necessary for the roles they performed.

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had internally and externally to local safeguarding authorities. However not all reportable incidents had been reported to the local safeguarding authorities or CQC. Steps were not always taken to mitigate and reduce identified risks relating to behaviour that challenged and to protect people from the risk of harm.

People who lived at the home and their relatives were positive about the skills and abilities of permanent care staff. However a significant number of staff were not up to date with refresher training in key areas such as safeguarding, infection control, dementia, skin integrity, care planning and first aid. There was a high percent of agency staff working at the home of whom more than half had not received basic dementia awareness training although the majority of the people living in Queensway House lived with dementia.

People's records were not always stored securely. Food and fluid records were completed retrospectively, and where people needed their intake monitored, food records did not document the amount people had eaten. People`s care plans were not always reflective of their current needs.

Daily health and safety walk arounds were not regularly completed. We found that a fire escape was blocked by a wheelchair and two mattresses and the general condition of the building was not well maintained. Throughout the home we saw liquid and splashes on the walls, and toilets when used were not flushed. The home had not been decorated to provide a dementia friendly environment, walls were bare, dining rooms had not been given a purpose so people could be prompted to sit and enjoy their meals.

The standard of cleanliness in the home was poor and cleaning schedules in bathrooms and toilets were not completed daily. There were malodours around the home which had not cleared after cleaning. The flooring around toilets was discoloured and stained and bare wooden boards covering the pipe work under sinks presented infection control risks.

Staff told us they had regular supervisions and felt supported by the home management team; however they were disappointed by the provider's lack of response when staff requested meetings with them to discuss on-going issues in the home which were outside the registered manager's remit to address. There was no evidence of regular staff meetings and staff were not able to tell us when the last meeting was for them to share their worries and discuss how the home operated.

Most relatives and carers told us they had been involved, to varying degrees, in the planning and reviews of the care and support their family members received. However, some people could not recall having been involved and their consent was not always accurately reflected in their individual plans of care.

People were cared for in a kind and compassionate way by permanent staff who knew them well and were familiar with their individual needs, preferences and personal circumstances. However, some agency staff members did not know the service well and were unfamiliar with people's needs and preferences.

We saw that most permanent staff members had developed positive and caring relationships with people who lived at the home. They provided care and support in a respectful way, however in many cases people`s dignity was not upheld, their personal hygiene needs were not always met, people had malodours around them and their clothes were not changed after meals if there was a need for it.

People were able to decide how they wanted to spend their days. We saw people on the ground floor engaged in activities around the home, sitting outside and having a tea morning, reading newspapers. People on the first floor whose dementia was more advanced and people who could not leave their bedrooms had little to do to occupy their times.

Weekly audits were submitted by the registered manager to report to the provider key areas of concern and improvement in the home. We found that these had addressed some of the concerns we identified though the inspection, however failed to identify many others and the actions in place had not been carried out effectively to improve the service provided. The provider failed to ensure that the monthly audits required to be carried out by the regional manager were regularly done and effective in identifying all the areas in need of improvement.

People who were nearing the end of their life received kind and compassionate care from staff. There were strong links developed by the management team with local hospices which helped staff get specialist advice when people`s condition declined.

At the time of the inspection the registered manager was supported by the provider`s quality team who begun to review the care in Queensway House and had already undertaken steps to identify areas requiring improvement.

People's medicines were managed safely and given to people as intended by the prescriber. Medicine records were completed accurately and signed by staff when they administered people`s medicines. For those people who required their medicine to be given at a certain time and on a certain day we saw this had been given.

At this inspection we found the service to be in breach of Regulations 12, 11, 15, 10, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient numbers of staff available to meet people's needs safely.

Staff recognised and knew how to respond to the risks of abuse however not all incidents were reported to local safeguarding authorities.

Identified risks to people's health and well-being were not always managed safely and effectively.

Some areas in the home were not sufficiently clean and presented an infection control risk.

People were supported to take their medicines safely.

Safe recruitment practices were followed to ensure staff were of good character and suitable qualified for their role.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not been adequately trained or supported to meet people's needs effectively.

People were supported to eat a healthy balanced diet that met their needs but risks associated with malnutrition and dehydration were not managed effectively in all cases.

The general condition of the building was not well maintained.

People's health needs were met and they were supported to access health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and supported in a way to

promote their dignity.

Some people who lived at the home could not recall having been involved in the planning or reviews of the care they received and consent was not always documented in care records.

People`s personal information was not always held securely.

People nearing the end of their life were cared for in a compassionate way by staff who involved their GP and staff from local hospices to ensure people were pain free and comfortable.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care from staff.

People who were more able were provided with opportunities to pursue social interests and take part in meaningful activities relevant to their needs, however people who were less able had little to do.

Complaints were not always investigated or responded to in a timely way. Lessons to be learned were not always shared with staff to help improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance and governance systems used by the registered manager and the provider were not always effective in identifying areas for improvement.

Records relating to people`s care were not always up to date and did not provide staff with sufficient guidance in how to meet people`s needs safely and effectively.

There was little evidence of support offered to the registered manager and staff by the provider.

The provider has not notified CQC of all the reportable incidents and accidents happening in the home.

Queensway House

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 met 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 under the Care Act 2014.

The inspection was carried out on 14 September 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with eight people who lived at the home, six relatives and nine staff members including two agency staff. We also spoke with the registered manager and a representative of the provider. We received feedback from health care professionals and reviewed the commissioner's report of their most recent inspections.

We viewed care plans relating to seven people who lived at the home and four staff files. We also looked at other documents central to people's health and well-being. These included staff training records, medication records and quality audits. We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that permanent staff were very busy and often stretched because of shortages and the use of agency staff who were not always familiar with the home or people's needs. One person said, "If I could improve one thing, it would be to have more carers because they are all lovely people and it would be nice to sit with them and find out a bit about them, but they just don't have the time to talk." One relative told us, "When the extension was finished they [provider] doubled the number of residents but they didn't double the number of staff." Another relative said, "There are not enough staff particularly at weekends, you have to go looking if you want someone."

We observed staff working under pressure to attend to people in need throughout the day. We observed a member of staff struggling to attend to three people who needed them at the same time. One of the people who needed help told us, "I had my breakfast sitting in the chair and now I've gone back to bed but I don't know what the time is or where anyone is or if I should be in bed." Other members of staff appeared within 10 minutes but there was clearly pressure on them to meet people`s needs in a timely way.

All the staff we spoke with told us that they were often working short and a high number of agency staff were also used which meant they struggled with the workload. They said, "If we have agency staff and they haven't been here before it is much more work for us to do when we are already pushed. Sometimes they haven't done caring before and that's double the work." Another staff member said, "We are not enough staff even with agency staff coming we are still short and people wait long times for us to get them up."

Throughout the day of the inspection we observed people walking around or sitting in chairs for long periods of time and we noted that staff were busy and not visible in communal areas for up to 30 minutes. Staff told us there should be a staff member in the communal areas at all times to offer support to people who were at high risk of falls, however they were not enough of them to do this. They told us, "The manager told us one of the carers should be in the lounge all the time because people are falling. We are just too short to be able to have a staff member all the time there." By midday people had odours around them clearly suggesting they needed personal care however staff had no time to ensure people had the opportunity to use the toilet before lunch time. One staff member said, "We don't have the time to take people to the toilet before lunch. We hardly finish getting everyone up. This is why there is a smell around. There is just not enough of us." We found that one staff member had to leave as they were not feeling well and as they were not replaced this meant that staffing was down in numbers on one unit.

We compared the rotas and actual staff care hours used for the week previous to the inspection and found that the care hours established by the provider as needed to meet people`s needs safely and effectively had not been provided. This meant that there were less staff working in the home than had been assessed as needed to meet people`s needs safely and effectively at all times.

We found that this a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider has not ensured that they had sufficient numbers of qualified competent and skilled staff to meet people`s at all times.

Risks to people's wellbeing was not always safely managed. We heard two staff members talking about the care they were about to provide to a person. One staff member was heard to say, "Shall we use the full hoist or the stand hoist." When we checked the care plan and the moving and handling assessment for this person they were only assessed as being safe when staff were using the full hoist. We asked a staff member about this person`s needs and they told us, "We are using the stand hoist if the person is feeling well and up to it. If not, like today we are using the full hoist." Staff were not aware that this person's care plan recorded they were only to be transferred or hoisted with a full hoist and sling and this was also confirmed by a letter from the person`s GP on 24 August 2016. This meant that the person could have been at risk of harm if staff used the equipment they were not assessed for.

Where people had sustained injuries like skin tears or bruising not all of these could be linked to a fall or an incident. Some of these injuries had no explanations of how they happened and there were no investigations carried out to try and establish the cause and prevent it from happening again. For example we found in a person`s notes that they had sustained a skin tear on their leg. The district nurses team were involved in dressing the wound; however the accident had not been investigated and staff did not know how the injury occurred. There were no plans implemented for staff to follow to prevent further skin tears.

We found that another person sustained 13 unwitnessed falls between 14 July 2016 and 14 September 2016. There was evidence that the person`s GP had been involved in their care to check if an infection had caused them to fall and a referral had been made to a physiotherapist on 12 August 2016. However staff had not followed up on the referral and there was no internal investigation into what the cause of the falls could have been. The person continued to have falls and was at risk of injuries as no measures had been introduced to mitigate the risks.

Where people were under the care of specialist mental health services either for their dementia needs or other complex mental health needs, care plans were not always in place for staff to recognise the signs and symptoms of people's specific needs, and how to manage these. Although staff were seen to be patient, kind and responsive to people when agitated, staff spoken with were not aware of techniques they could use to support people positively and pro-actively. Staff recorded incidents on adverse behaviour charts (ABC) as they happened and not tried to prevent them.

People who were at risk of developing pressure ulcers did not always have detailed plans in place for staff to know how to recognise and report when pressure ulcers started developing and how to mitigate the risks effectively. People at risk of developing pressure ulcers had pressure relieving equipment in place. People had pressure relieving cushions, mattresses and air boots to protect their heels, and where they required regular repositioning this was carried out in accordance with their care plan. However we found that where people were assessed as having dry skin which could have been a risk factor for developing sores had no creams applied to their skin, this was not reported or communicated to the person`s GP. Staff recorded in daily notes for one person that their sacrum was very red, with a strong odour and they applied cream. There were no updates to this person's care plan with regards to their skin integrity, and guidance for regular creaming regimes were not in the care records. We gave feedback to the registered manager and asked them to investigate if the person still had sore skin.

We received a notification from a local hospital that a person had been admitted from Queensway House with a grade three pressure ulcer which had not been discovered by staff at the home. This suggested that staff who offered personal care to this person had not recognised the pressure ulcer and not reported it. Staff had not received tissue viability and skin integrity training. The specialist nurse involved in the reviews of the people who were living in Queensway House told us they offered this training several times; however the management team from the home had failed to book and organise the training session for the staff

team.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe.

We found that the environment people lived in was not sufficiently clean. Carpets were discoloured and heavily stained throughout the home. Equally lino flooring remained stained and sticky even after cleaning. We found food ingrained into the corners of the dining room doors and dust and hair balls in the corners of communal rooms. Throughout the home we saw liquid and splashes on the walls.

In bathrooms and toilets the pipework under the sinks was covered by bare wooden panels and in places the tiles were cracked. In the majority of the toilets the flooring had dark stains and under bath chairs there were dark brown spots. There were unpleasant odours around the home which persisted throughout the day and did not clear after cleaning. This meant that the cleaning regimes used were not effective and there was an increased infection control risk.

Toilets were not always flushed after use and the odours around the toilets were more accentuated then in other parts of the home. However this had not prompt staff to regularly check and flush toilets to help odours clear away. People were not regularly supported to use the toilet or have personal care and their clothing had an unpleasant smell.

We checked the cleaning schedules in bathrooms and toilets. These evidenced that these areas were only cleaned once a day by housekeeping staff and they were not completed for each day. For example one cleaning schedule was only signed four times in a two week period. Another one was signed nine times in a two week period. Staff told us these were cleaned once a day by housekeepers, however the poor cleanliness of the environment demonstrated that the cleaning regimes were not effective in providing a clean and hygienic home for people living there. We found that out of the 61 staff listed on the provider`s training matrix only 26 had received infection control training in the last two years and 10 staff had been enrolled for upcoming training. However the rest of the 25 staff, out of which four were housekeeping staff, had not received any infection control training. The manager confirmed the training matrix was up to date.

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

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had to the relevant local safeguarding authority, which included by way of 'whistleblowing' if necessary. However not all staff had received refresher training in safeguarding adults from abuse and some incidents had not been reported to the local safeguarding authorities as required by the provider`s safeguarding policy. For example we found that a person had physically injured another person causing bruising. This had been documented, however had not been reported to the local safeguarding authority.

There were safe and robust recruitment processes in place to make sure staff employed were able, fit and suitable to work with vulnerable people. Appropriate checks had been undertaken before staff started work including written references, satisfactory Disclosure and Barring Service clearance (DBS), employment history and evidence of the applicants' identity.

People were helped take their medicines by staff who had training in safe administration of medicines. There were suitable arrangements for the safe storage, management and disposal of medicines. Where

people used over the counter tablets such as indigestion relief or pain relief, the advice of the GP had been sought and they had signed their authorisation for this. Controlled medicines which were subject to tighter controls were managed safely, with staff witnessing and signing when these were administered and an accurate stock record maintained. Staff maintained accurate records in relation to medicines brought into the home and those returned to the pharmacy. When we checked the stock levels held in the medicine trolley against the record in their MAR we found the correct amount of tablets were held. This demonstrated that people had received their medicines when they required them and as intended by the prescriber.

Requires Improvement

Is the service effective?

Our findings

We found that the general condition of the building was not well maintained. At the rear of the building, wooden cladding secured to the exterior walls above where people sat was poorly maintained and coming loose, and areas of the garden had become overgrown making access for people difficult. Within the home, we found poorly maintained paintwork, fixtures, fittings and furniture. One person's room had water damage to the ceiling that had gone unrepaired with cracking and yellow staining to the ceiling. Another bedroom had a hole in one of the internal doors; another room had a problem with a lock on the front door and had to be vacated. People's bedding was old, faded, had holes and were stained. In bathrooms and en-suites we found broken taps and sinks that were heavily stained with lime scale. Two people we saw in their rooms told us that their duvets were heavy and hot and one did not have a duvet cover on. One person told us, "I usually get up as quick as I can (from the bed) – it's not very comfy in there."

The dementia unit was not decorated to reflect best practice for people with dementia offering little to provide stimulation or interest. Within the whole home, we found walls that were scuffed, areas requiring redecoration and numerous carpets in people's rooms and communal areas were in poor condition or soiled. One person told us, "I like the social side to the home, but it's all a bit tired and tatty and could really do with a face lift, maybe DIY SOS could come."

The registered manager had taken some steps towards addressing the concerns with the bedding, carpeting and redecoration of the home, and the maintenance manager visited the home on the day of our inspection to review some of these areas. However, the home had suffered from a long period of poor maintenance and investment and did not satisfactorily meet the needs of the people who lived there.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff asked them for their consent to care before they carried out any tasks. One person told us, "The carers never make me uneasy or uncomfortable, they ask before they help me, and check I am okay when they do." However some people were not aware they had a care plan or what this contained. One person told us, "I don't know who has my care plan or what it is, sorry." Consent to care was not always documented in people`s care records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that mental capacity assessments were not always consistently carried out for people who had a diagnosis of dementia and they may have lacked capacity to take decisions regarding their daily care needs. Best interest decisions were not always documented to evidence the process of options considered before a decision was made in people's best interests. For example where people had bed rails in place there was no explanation as to why the bed rails had been considered as the best option for people

and what other options had been considered. However two relatives we talked to confirmed they were involved in best interest meetings where important decisions about Do Not Attempt Cardio Pulmonary (DNACPR) decisions were taken for people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted deprivation of liberty applications to the local authorities for people who had limitations to their freedom in place to keep them safe and was waiting for approval. However staff had not always ensured that these limitations were the least restrictive possible. For example we saw on the first floor people were trying to open the door which had a number lock and tried to get out. Staff made no attempt to help people go downstairs or have a walk in the garden. People were confined in the unit they lived in.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had mixed views about the skills and abilities of the staff working at the home. One person told us, "Staff are good, they couldn't do more." One relative told us, "At weekends they often have agency staff and they are not so good, they don't know the people and some of them don't know what they are doing."

Staff members told us, and records confirmed that they had not been provided with all the training relevant for their job roles and refresher updates were out of date. One member of staff told us, "Training is okay but could be better, I think there are bits we don't do that we could." Another staff member said, "We done training in the past and we still do time to time." Newly employed staff confirmed they had induction training and shadowed a more experienced staff member for a period of time until they were confident working unsupervised.

Some staff had not received annual refresher training updates and their training had elapsed. For example out of the 61 staff listed on the provider`s training matrix 11 staff were overdue safeguarding refresher training, 25 staff were overdue infection control training and 52 staff had not received basic first aid training In addition staff had not received training to support them to effectively meet the specific needs of the people in their care including care planning and record keeping, dignity, pressure care and behaviour management training. There was no planned or scheduled training for mental health awareness even though some people had complex needs. Of the 87 agency staff that worked at the home, 47 had not completed dementia awareness training.

We observed how staff looked after people in their care to assess if they demonstrated skills and knowledge to effectively meet people`s needs. For example we observed a person over lunch time. They were very active and not able to sit for long periods of time at the table. They went in and out several times from the dining room sitting down then standing up and walking around again. Staff were busy serving people their lunches and did not notice that the person was drinking from other people`s glasses as they walked around and taking food from other people`s plates. When they served the person`s meal, they prompted them to sit down, however the person was clearly not interested in their own meal, they were taking food from other people whilst walking around. Staff had not considered offering alternative `finger foods` to this person. They had not tried to serve the person first and have them concentrating on their own meals and not everybody else`s. Staff made no attempt to understand this person`s behaviour to establish what they liked and disliked although the person clearly suggested they liked other people`s meals better than the choice they were served.

We also observed people walking around without shoes or slippers just in socks or bare feet. We noted a person who was wearing socks and had no footwear trying to take off another person`s slippers. Staff just called out their name to make them stop and made no attempt to understand what the person was trying to communicate by their actions.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives spoke positively about the food saying it was good and there was a good choice. One person told us, "The food is fine." Another person said, "The food is ok, I'm a fussy eater but they [staff] let me have what I want. Whatever I ask for they let me have." One relative told us, "The cooked breakfasts are good; [person] has porridge and then a cooked breakfast if they want it." On the day of the inspection there were plenty of drinks available and people in their rooms had a jug of water and a glass if they wanted a drink. There were fruit bowls with bananas, apples and crisps in the public areas and we saw people helping themselves when they wished.

At lunch time the staff were very busy in the main dining room downstairs but they spent time with people offering them a choice of main course and later a desert. If people refused an option they were offered alternatives. There was a written and pictorial menu on each table.

We observed two staff members assisting people to eat their meals. They assisted people at their own pace and were attentive to the needs of the people they supported however; there was minimal conversation with anyone at the table. The staff did not facilitate any conversation other than between themselves.

Meal time experience for people living on the first floor was not as pleasant. Tables were not laid to give a purpose to the room and prompt people to sit and have their meals. One staff member dished up the meals and another served people. People were presented with a verbal and visual choice, however there were no alternatives offered if people were seen not eating their meals. There was a busy environment, staff rushed around and there were disruptions to people, like staff administering medicines.

People had their weight monitored regularly and staff used a tool to identify if people were at risk of malnutrition (MUST) however this was not always used correctly and did not flag up concerns to staff. For example, staff had referred a person to their GP for weight loss. They were instructed to provide the person either with fortified milk or a milkshake twice daily. For the previous week of the inspection staff had only recorded once that this had been provided. They also monitored this person`s weight weekly. Staff had completed the MUST weekly, however they recorded that the person`s weight loss had not been greater than five percent. However, when we calculated the weight loss for the month, this was between 5 and 10 percent of their body weight. This gave an inaccurate overall assessment and did not prompt staff to make further referrals to the person`s GP. One of the health care professionals we spoke with told us they were assessing and reviewing people in the home who were at risk of malnutrition and dehydration and they were giving advice to staff about good practice in effective monitoring and recording food and fluid intake.

People were referred to health care professionals if there was a need for it. We saw on the day of the inspection one person who had very swollen feet. Staff told us the GP had visited the person and prescribed treatment for them. Records evidenced that people had access dieticians, GP`s, speech and language therapists involved in their care. Dentists and opticians visited the home regularly. However some relatives were not happy about the communication between them and the staff team. They told us they were not always notified when people had a health issue and were seen by a health care professional. For example,

one relative told us they had not been told that an optician had been scheduled or visited their loved one and they had new glasses. Another relative was happy how they were notified about events concerning their loved one. They said, "They [staff] always let me know if anything happens, they tell me straight away."

Requires Improvement

Is the service caring?

Our findings

People told us that permanent staff were very good and kind, however they were not always happy with the way they were looked after by the agency staff working at the home. One person told us, "Some of the carers are proper carers, they are good, but some of the agency ones don't care much it's just a job." Another person told us, "They [staff] are very nice and kind and caring." Relatives told us they were happy with the staff. One relative told us, "We are very happy with the carers here."

We saw that most permanent staff members had developed positive and caring relationships with people who lived at the home. They called people by their first name and were respectful when talking to people. However not all the people living in the home experienced the same level of caring showed to them by staff. For example one person hadn't seen their relative for several weeks. They told us how worried they were and how they missed them. We asked staff about it and they said, "Oh [relative] is coming in this afternoon to see you." The person was very happy, however staff hadn't thought to tell them about the phone call which had come in the previous day to announce the relative`s visit.

The care and support people received in Queensway House did not always promote their dignity. We observed people on the dementia unit who often walked without shoes just in socks or bare feet. People who required support from staff to maintain a good personal hygiene and to use the toilet did not always receive support when they needed it. For example, one person had a strong odour around them in the dining area at meal times. The person clearly needed staff to offer them personal care and change their clothing; however staff had not had time to attend to their needs before meal time. Staff had put a tabard on another person when they received their meal but it was discoloured and had holes in it.

We observed another person who picked food off other people`s plates during meal times. We saw they put their hands in a person`s plate and picked up a handful of chips, however staff did not change the person`s meal they just asked them if they want more. People who dropped food on their clothes when they were eating were not changed by staff after the meal to help ensure they looked presentable and dignifying.

People's records were not always stored securely. We found that the incident and accident forms relating to people were stored in a box within reception, which was accessible to people who visited the home and those that lived there. These documented sensitive incidents that people had experienced and could be read by people who had not right to do so.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home did not recall having been involved in planning or reviews and most knew little about what their own care plans contained. Most relatives told us they had been involved, to varying degrees, in the planning and reviews of the care and support of their family members. In some but not all cases, this involvement was reflected in people's individual plans of care. One relative told us, "We've had all the conversations about DNAR. We feel very comfortable that they've [staff] had that conversation with us

and that they would do what we all want if we [family] weren't available." Reviews of the care plans were not always documented; however one relative told us they were waiting for a review.

People who were nearing the end of their life received effective care and support from staff. Staff worked closely with palliative care nurse specialists from local hospices and people`s own GP to keep people comfortable and pain free. For example we found that a person was on a palliative pathway, they had input from the local hospice, and staff encouraged them daily to come to the communal lounge. The care plan noted that, "[Person] is approaching the end of their life, and staff should carry out tender loving care (TLC). However if person also appears alert and awake, then staff should encourage them to the communal lounge, and then taken back to bed when sleepy." We observed staff taking this person to the lounge, settling them in the chair, and assisting them with their breakfast. The person, although unable to verbally communicate looked comfortable, and sat contentedly looking around the room at the other people there. Once they became tired, staff then supported them to return to their room. Even where there were obvious staffing concerns, staff continued to ensure that for this person their end of life needs were met. One relative told us, "They [staff] do end of life care here and the hospice is involved in that, it means that people don't have to move if the family don't want them to."

Friends, relatives and carers of people who lived at the home told us there were no restrictions as to when they visited and that they were always made to feel very welcome. One relative told us, "We chose this home because it is relaxed and homely and there is interaction between the families too."

Requires Improvement

Is the service responsive?

Our findings

People told us staff gave them choices and respected their preferences. One person told us, "There's no pressure to go to bed, if I want to sit in the chair for a while longer than I do." One relative told us, "They [staff] do try to let them [people] do what they want to and give them a choice. Sometimes [person] is in her nightdress all day because she wants to."

For people who were not able to verbalise their preferences due to their level of dementia their care plans did not consistently or accurately reflect their life histories, personal circumstances or preferences. This meant that new and temporary staff members who were less familiar with people did not always have access to the information and guidance necessary to help them provide person centred care and support.

People were provided with a range of activities within the home. There were two activity staff employed who were seen to meet the social needs of people living at Queensway House. We saw that on the day of the inspection people were able to enjoy an impromptu tea party in the garden and communal areas due to the pleasant weather. There were groups of people enjoying a music morning and later in the afternoon the bingo session was well attended. In the evening, the activity staff stayed late to hold an evening playing cards with wine and sherry in the dementia café. This was an area that had been recently developed for people to meet with their friends or families in the home in an environment decorated to resemble a period café, offering refreshments and snacks for people to enjoy.

We saw that for people able to attend the activities, staff held weekly discussion forums for them to debate various topics, such as the appointment of the new prime minister and stereotypes held about people with tattoos. Within these groups, staff were able to explore a range of diverse issues, such as why men did not attend the groups as positively as women, and how all involved could seek to address this.

People's various religious and spiritual beliefs were accommodated and we received positive feedback from one relative about how a person's specific religious needs and preferences were met. They said that staff readily held all the documentation necessary to share their family member`s specific religious needs in case they had to be transferred to hospital or elsewhere. They told us they felt that staff respected their faith and managed events appropriately for their family member.

Staff also organised a ,"Cruise" day, where people chose a faraway place that they all then spent time researching and learning about through group discussions, played music from that country, learnt about the culture and the chef prepared a menu with foods from that country for people to taste. The activity team within Queensway House had won an award in recognition of the manner they supported people's needs socially, and staff were obviously proud of this achievement.

A weekly newspaper was available to all people in the home that reviewed events from history about particular days, gave updates on upcoming activities and services in the home, and also provided some reminiscence around areas such as cars people may have driven, music groups they may have listened to and some quizzes and puzzles for people to complete.

We looked at how the staff supported people who were less able to engage with group activity or who chose not to do so. We were told about one person who held a fascination with cars, constantly referring to these when talking with staff. The activity staff were able to organise time out for this person to experience a luxury car, which was thoroughly enjoyed by them. A second person, who was cared for in their room, had been supported by the activity staff who had spent time with them talking until the person wanted to rest. It was clear that the activity staff were committed and enthusiastic about their role and how they supported people in the home. However, people who were cared for in their rooms, or who chose to not participate did not all have the same positive experiences. Some people and relatives told us that they did not receive time reminiscing about things they enjoyed, or time to sit and talk with staff. One relative told us, "They don't encourage [person] to go, [person] stays in her room all day."

We observed during our inspection that where people were in their rooms, staff had not thought to put on some music, the television, pop in to have a chat about the day, or provide a little contact and warmth outside of providing care. There was clearly pressure upon care staff through the day that we observed meant there was not the time to spend with people on a one to one basis. One staff member told us, "Activity is not just the role of the [Activity] coordinator; it is something we all need to provide to the residents whether we cook, clean, fix the doors or care." Another staff member said, "I don't think I would like my mum in here. Don't get me wrong not because we [staff] don't care it is because we don't have the time to spend with people and chat and laugh and have fun. It is all rush, and care is not just about getting people up."

Most people told us that they never complained and could not give us feedback if their complaints would be listened to. One relative told us they had raised issues with the staff in the home and these were addressed. There was a system and procedure in place to record and investigate complaints. However we found that complaints were not always answered and responded appropriately and we found no evidence that lessons were learned and shared with staff to improve the service. This was an area in need of improvement. For example we saw a complaint recorded by the registered manager; however their response to the complainant was just over the phone and recorded on the complaint form. There was no detail about any investigation or any lessons learnt.

Requires Improvement

Is the service well-led?

Our findings

We found that the service was not consistently well-led. The provider offered little support to the registered manager in improving the quality of the care people received, the environment people lived in and failed to implement the systems and processes needed by the registered manager to improve the areas we identified in this inspection.

Weekly reports were submitted by the registered manager to report to the provider key areas of concern and improvement. These areas included confirmation of completion of weekly audits in areas such as care, medication, infection control, health and safety and pressure ulcer prevention. We found that these had addressed some of the concerns we identified though the inspection and sought to remedy these swiftly. For example, we found that when the auditing was completed around medicines, on-going issues identified were that staff had not signed the MAR charts. These areas had clearly been improved upon and we found no errors or omissions within the recording in people's MARs on the day of the inspection.

However with regards to infection control, we found audits completed by the registered manager and the provider's quality team who had identified further concerns, increasing the risk level and an action plan had been developed to address the concerns. However the poor state of the environment was one of the main risk factors which was out of the registered manager`s control to address and this had not been actioned by the provider. Staff training in infection control was arranged and booked following the inspection.

We found that some key areas were not reported on in the weekly audit the registered manager was required to do by the provider. For example, pressure care should have been reviewed weekly. We found that this had not been reviewed since the 12 August 2016 until the day of our inspection. Despite that it had been reported that a person had been admitted to hospital during this period with a pressure ulcer. Maintenance had not been reviewed for a period of 10 weeks, although it was required weekly by the provider.

We saw that monthly checks on behalf of the provider had not been consistently carried out by the regional manager. We asked the registered manager for a copy of the last provider visit, we were given a copy from June 2016, and it was confirmed that this was the last visit undertaken. Issues identified within this review did not reflect the current issues within the home and actions set resulting from this visit had not been reviewed by the senior management team since June 2016. For example, an area of identified improvement was in relation to improving staff morale and working arrangements. The action plan asked for meeting and listening events to be convened for staff to provide feedback to management, and to attempt to improve the working environment. However, we saw no evidence this had occurred, and were told by one staff member that they had approached senior management and requested a meeting but this had not happened. Although the visit had identified areas within care that required improvement, the overall summary of the visit reflected upon occupancy levels, and profitability from the previous year.

The provider`s visit identified that one person's MUST had not been reviewed since January 2016 and a lack of activity taking place on one unit. The action plan did not seek to address these issues, nor did it seek to

improve the overall environment for people, the poor standard of decoration, furnishing and suitability of the dementia environment as areas requiring both improvement and capital expenditure. The lack of effective monitoring had been identified at other homes operated by the provider local to Queensway House.

The registered manager told us they used 45 percent agency staff cover due to staff vacancies and the difficulty in employing suitable permanent staff. They told us they used an assessment tool to calculate the care hours needed in the home. We found that the week previous to the inspection they had not covered the hours they had calculated as needed to meet peoples` needs safely. Out of the 1707.50 hours they had established as necessary they only had staff cover for 1572.10 with 135.40 hours remaining uncovered. This meant that there were approximately two staff short each day that week.

We asked the registered manager how they monitored call bell response times that could also be used to review staffing levels, identify trends where people's needs were not responded to. They told us the system in place at Queensway House did not allow them to review call bell response times, and had not done so. However, during the inspection they organised for a quotation to be sent to them to have their call bell system updated to incorporate this monitoring facility. The provider also sent us an action plan which detailed how they were planning to recruit more permanent staff.

Food and fluid records were completed retrospectively, and where people needed their intake monitored the records did not document the amount people had eaten. For some people their daily records were not accurately completed as care was provided. For example we observed staff both in the morning and after lunch completing records of the care people had received and food and drink they had consumed two to three hours after this had been given. Staff recorded specifics around people's care, such as the exact amount people had drunk, which could not be relied upon to be accurate as they were recalling information from a number of hours previously.

The provider's quality improvement team had begun to review the care in Queensway House and had taken steps to identify areas requiring improvement. For example, a simplified care planning system was in the process of being implemented, and the registered manager was receiving support in addressing concerns around training and the environment. The week prior to our visit, a CQC style review of the home had been undertaken with an overall rating of requires improvement across the five domains. A service improvement plan was in place that addressed some concerns in the home but did not address or identify many of the issues highlighted through the inspection. The quality team were in the process of reviewing and developing an amalgamated quality improvement plan that would bring together the issues identified previously, and issues raised at both this inspection, and those raised by the local authority following their own review and would provide on-going support to the registered manager to implement these.

Staff told us they felt supported by the management in Queensway House, they had regular supervisions, however they felt let down and not valued by the provider. One staff member said, "If I was Gold Care I would appreciate us all, I don't think they care much for us or how hard it has been. The manager is not supported and I know she is stressed because she can't do the things she wants to for the residents." Another staff member said, "I would leave too if I could, why stay here when the owners don't care about us, the manager or even the residents." Staff told us they had requested a meeting with the provider to discuss issues and concerns they had about staffing and the home, however their request was not listened

Staff meetings within Queensway House were not held regularly. We asked for a copy of the minutes from staff meetings, however were not presented with any to review to confirm these had occurred.

We asked the registered manager how they sought the views and opinions of people living at Queensway House. They showed us a copy of the latest survey sent to people, relatives and professionals. This had been compiled by an independent organisation that also developed an improvement plan based upon the feedback from people. However this had been compiled in March 2015 and an updated survey had not been completed. We asked if the manager had sent out their own satisfaction questionnaires since this time, however they told us they had not. There were opportunities for people to discuss various matters that related to the home through a weekly discussion forum, however this was not structured to address improvements in the home, and was not chaired by the registered manager for people to provide feedback.

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

Notification of injury or risk of harm had not been submitted to CQC as required. For example we identified one incident where a resident had been aggressive towards another, causing them superficial injury, and a second incident for the same person where staff recorded bruising to the person`s rib cage. Neither incident had been reported to the local safeguarding authority or CQC as required under regulation.

The registration for the provider was incorrect, giving a different address from the one given to Companies House. This was pointed out to the registered manager who reported the issue to the provider. This was rectified at the time of inspection however this had to be pointed out to them by the inspectors.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission about all the incidents occurred at the service as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that the care people received promoted their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that the best interest decisions taken on behalf of the people who lacked capacity was in line with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks to people's health and welfare were sufficiently mitigated to keep people safe. The provider failed to ensue people had a clean and hygienic environment to live in. Infection control procedures were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises were properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess and improve the quality and the safety of the service they provided. The provider failed to ensure that record were contemporaneous and accurately reflected the care people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has not ensured that they had sufficient numbers of qualified competent and skilled staff to meet people`s needs at all times. The provider failed to give appropriate support and training to staff to enable them to carry out their roles effectively.