Chaptercare Limited

The Queens Residential Care Home

Inspection report

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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

The inspection took place on 6 December 2018 and was unannounced.□

The Queens Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to accommodate 46 older people, some of whom may be living with dementia. There were 38 people living at the home at the time of the inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People living at the service were protected from avoidable harm as staff received training and understood how to recognise signs of abuse and the who to report this to if abuse was suspected.

Risks to people were identified and plans were put in place to help manage the risk and minimise them occurring.

People received their medicines safely. Staff competencies around administering medicines were regularly checked. Checks on medicines were undertaken, however there wasn't a clear record of the amount of medicine stock held for each person. The registered manager assured us they would implement this.

People told us, and we saw there were enough staff on duty to meet their needs. We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

People were supported by a team of staff who were knowledgeable about people's likes, dislikes and preferences. People received care and support from a staff team that was provided with continual learning that enabled them to carry out their role effectively. Staff told us they felt supported and happy in their work.

The home was clean and tidy. Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety was maintained. We noted that some areas of the environment needed attention such as paintwork on skirting boards and door frames. The registered manager gave us assurances that the redecoration of these areas would take place within six months.

Appropriate personal protective equipment and hand washing facilities were available. Staff had completed infection control training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they enjoyed the food provided. Staff supported people to maintain their health and attend routine healthcare appointments.

People who used the service told us that staff were kind and caring. Care plans we reviewed, detailed people's needs and preferences and were reviewed on a regular basis to ensure they contained up to date information.

People had access to a range of activities, and were provided with opportunities for social stimulation.

The service had a clear procedure for handling complaints.

Quality assurance processes were in place and regularly carried out to monitor and improve the quality of the service. Although accidents and incidents were thoroughly recorded the registered manager did not analyse these regularly or in detail to identify any trends and patterns. The registered manager agreed to implement more frequent evaluation of accidents and incidents at the service.

Feedback was sought from people who used the service through meetings and surveys.

Further information is in the detailed findings below.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

The Queens Residential 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 site visit took place on 6 December 2018 and was unannounced. The inspection was carried out by two inspectors, and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Their area of expertise included older people's care.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who used the service, four visiting relatives and two visiting healthcare professionals. We spoke with the registered manager, deputy manager, and four staff.

We reviewed four people's care files, medicine administration records, policies, risk assessments, consent to care and quality audits. We looked at three staff files, the recruitment process, complaints, supervisions and training records.

We walked around the building and observed interactions between staff and people who lived at the home.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the service Comments included, "I feel safe yes, just the fact that there's other people here and staff." Relatives told us, "It's very good. [Name] is safe here" and "Yes, I feel [Name] is safe. I'm very impressed with the place."

There were sufficient numbers of staff on duty to keep people safe and call bells were responded to by staff during the inspection in a timely manner. Staff, people who used the service and visitors did not raise any concerns about staffing levels overall.

The service followed a safe recruitment procedure. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. The staff files we reviewed contained appropriate checks, such as references, identification, and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

The provider continued to protect people from avoidable harm, discrimination, and abuse. Staff had received training in safeguarding, and understood, how to recognise, respond to and report abuse. The registered manager was clear about their responsibilities in reporting and dealing with any concerns to ensure people remained safe.

Risk assessments were in place for all aspects of peoples care and support. The risk assessments were visible to staff in peoples care records. Staff we spoke with were aware of the content of people's risk assessments. This helped ensure staff provided care and assistance for people in a consistently safe way. Where necessary, people had mobility equipment supplied to help them maintain their independence. We observed staff supporting people to use equipment and saw this was done safely.

Appropriate health and safety checks of the premises and equipment continued to be completed regularly and helped to maintain a safe environment for people.

Fire safety equipment were serviced regularly and there was a programme of fire drills so that people and staff knew what to do in the event of a fire. The fire alarm was activated during this inspection and we saw that staff knew the procedure and carried this out appropriately. An overall personal emergency evacuation plan was in place which contained details of the support each person required if they needed to be evacuated in an emergency.

We undertook a visual inspection of the home. We did this to ensure it was adequately clean and appropriately maintained. We noted that some areas of the home needed attention such as paintwork on skirting boards, doors, and door frames. We discussed these findings with the registered manager who assured us the provider had plans to address these areas within the next six months as part of their refurbishment plan. The home was free from odours and was clean and tidy, and suitable for the people who used the service.

Appropriate personal protective equipment and hand washing facilities were available. Staff had completed infection control training.

We looked at how accidents and incidents were managed by the service. We found when they had occurred any accident or incident had been recorded and the action taken in response to this. Although the registered manager had oversight of accidents and incidents they did not analyse these regularly, or in detail to identify any themes or patterns. We discussed this with them and they agreed to implement more frequent evaluation of accidents and incidents at the service.

People received their medicines safely. The service had safe arrangements for the ordering, administration, storage and disposal of medicines. We were unable to see a clear record of the amount of stock held at the service for the people we checked. The registered manager assured us they would implement records of this going forward. Staff responsible for the administration of medicines were all trained and had had their competency assessed.

Good

Is the service effective?

Our findings

We asked people if the staff knew how to support them properly, one person commented, "If you need help with anything at all it's always there. I always feel relaxed and at ease." A relative told us, "The staff know what they're doing, they're good."

Records confirmed that new staff had completed the providers induction and were supported to complete and refresh their training when required. The induction included completing the national Care Certificate programme. This helped to ensure they had the knowledge and skills needed to care for people. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff felt confident and competent whilst carrying out their role. One member of staff told us, "I have done a diabetes course, and mental health course. Yes [I am confident]. I get enough [training], if you want any training they will get it for you." Staff training was up to date and where gaps were identified, training was planned.

Staff were supported in their role and received regular supervisions, observations, and competency checks of their work practices. Supervision sessions gave staff the opportunity to discuss any training requirements or to request additional training.

People's needs were assessed and relevant care plans were put in place. Assessments contained information about people's life history, sexual identity, religion, and medical history. People's care records confirmed a full pre-assessment of their needs had been completed before they moved into the home. Following this pre-assessment, the service, in consultation with the person, their family or representatives, had produced a plan of care for staff to follow. These were regularly reviewed to ensure the information was up to date and appropriate to meet the person's needs.

People's healthcare needs continued to be carefully monitored as part of the care planning process. We saw people had access to healthcare professionals and their healthcare needs had been met. A visiting healthcare professional told us, "Nine times out of ten they [staff] are responsive. I have just seen someone on pressure care and requested they be on a repositionable monitoring chart. I am confident they will do this. They [staff] have the best will in the world."

The provider continued to ensure people's nutritional needs were being met. People we spoke with told us they enjoyed the food. We saw people had care plans relating to food and fluid, and were weighed frequently, if required, as part of their physical health monitoring. Where people needed specialist support, the views of dieticians and speech and language therapists had been requested by the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards. 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 had the appropriate legal authority and were being met.

DoLS applications had been submitted appropriately and CQC had been notified of any authorisations. Staff had been trained in the MCA and DoLS. Mental capacity assessments and best interest decisions had been made and appropriately recorded.

There were clear signs around the service making it easier for people living with dementia to find their way around independently and identify areas such as toilets and bathrooms. In addition, there was a picture menu of the meals provided, and the weather for the day.

We looked around the home and found it was appropriate for the care and support provided. Mobility aids and hoists were in place, which were capable of meeting the assessed needs of people with mobility problems. Doorways into communal areas, bedrooms, toilet and bathing facilities were sufficiently wide to allow wheelchair users access.

Good

Is the service caring?

Our findings

People and their relatives consistently spoke of a kind and caring staff team. One person said, "The girls are good and they take care of me. I can always talk to them if I'm worried about anything. They're good listeners." A relative told us, "They [staff] are definitely caring, kind and compassionate. [Name] is always well turned out. They love doing their hair."

When we spoke with staff it was evident they knew people well. They were able to tell us about people and what kind of support they required. This information was accurately recorded in people's care plans.

Care plans stated what people were able to manage independently and what support staff would be required to give when people were unable to manage tasks independently. We saw that some people were able to move freely around their home alone, whereas some people required staff to support them. All of the people who used the service were encouraged to be as independent as they were able to be; we saw examples of this during the inspection.

People were involved in making decisions about their life and care. People's needs were regularly reviewed. One person told us, "I have a care plan, and they talk me through everything." Other people we spoke with were unsure if they had a plan of care but told us they were able to make their own choices about their care, and were involved in reviews of this. One person said, I went to the first few reviews then my daughter goes now. The reviews are every twelve months. If I'm worried I talk to the girls first. I'm happy with everything."

The registered manager provided details about advocacy services to people who lived at the home. During our inspection, two people were being supported by an advocate. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Staff treated people in a respectful manner and upheld people's privacy and dignity. Staff were trained during induction to treat people equally and take into account people's diversity. Care records documented people's preferences and information about their backgrounds. This included information on protected characteristics as defined under the Equality Act 2010, such as their religion, sexual identity and disabilities.

The registered manager was aware of their responsibilities with regards to confidentiality and protecting people's data. Records were stored securely.

Good

Is the service responsive?

Our findings

People told us they were satisfied with the quality of care and support they received. Comments included, "I just tell them what I need or if there's something I'm not happy about. I can talk to the staff and the manager no problem." A relative told us, "Yes, they [staff] do respond to [Name's] needs well." The people we observed appeared comfortable and happy in their home, and when interacting with staff and the registered manager.

We found each person's documentation was personalised to their individual needs. For example, people's preferences had been recorded in relation to their chosen name, and food and drink. We saw that care plans contained information about daily routines. For example, what time they liked to get up, and retire to bed. Care plans also recorded information detailing people's life history, previous occupations, hobbies, holidays and childhood.

People's communication needs had been assessed and where support was required this had been met. The provider had appropriate arrangements in place to identify, record, and meet communication and support needs of people with a disability, impairment or sensory loss. People's care plans contained guidance for staff if people required glasses or hearing aids to maintain effective communication. One person had been provided with a memory book by a healthcare professional to aid recognition. The persons relative and a member of staff regularly went through the book with the person to help improve their communication and memory. Other people were supported with the use of written sentence cards containing questions such as 'Shall I help you?', 'Would you like a drink', 'Have you got any pain' and 'Are you feeling okay.'

People had a choice regarding how they spent their day. Activities were provided by dedicated staff. Activities on offer included quizzes, exercises, singing, cinema nights and reminiscence. One person told us, "We made Halloween decorations, a remembrance poppy display, and we are having Christmas carols one day next week. We go bowling and have tried flying kites. We do arts and crafts, and we are decorating five Christmas trees."

People were supported with their end of life care needs. People's end of life preferences were sought. For example, one person's records stated how important their faith was to them and that they would like a religious funeral service. The person had chosen the dress they wished to wear, and the song they wanted playing. Some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place which meant if their heart or breathing stopped as expected due to their medical condition, no attempt should be made to resuscitate them. Peoples DNACPR were kept in their patient passport, and on the back of people's bedroom doors, there was a love heart to alert staff the person had a DNACPR in place. This helped to ensure people's end of life wishes were respected.

People were provided with opportunity to feedback their views on the service. People's views were sought through regular meetings, and the completion of questionnaires. One person said, "We have residents meetings once a month. I'm quite happy. I've been here three years now."

The service had a complaints procedure. The procedure was clear in explaining how a complaint could be made and reassured people these would be dealt with. The people we spoke with told us they were happy and had no complaints.

Good

Is the service well-led?

Our findings

We found people were happy with the way the home was managed. One person visiting the home said, "I really do think it's well led. The manager is really good and fights for everything for them [people living at the home]." A person living at the home told us, "I'd recommend them [the home] to anyone."

There was a registered manager in place. 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.

We found the service had clear lines of responsibility and accountability. The registered manager, deputy manager, and staff were knowledgeable and familiar with the needs of the people they supported. Discussions with the staff on duty confirmed they were clear about their role, and between them and the management provided a well-run and consistent service. Comments from staff included, "[Name of registered manager] is approachable and will always help you out. They have a lot of pride in the home" and "[Registered manager is] very understanding, even if its personal. They always have an open-door policy and are very approachable. We are like one big family."

Staff meetings were held. One member of staff told us, "We have had one [meeting] recently. Senior staff have their own, care staff have one, and housekeepers do as well. We normally discuss things before anyway."

Surveys completed by people using the service in 2018 confirmed they were happy with the standard of care they received. We saw 23 out of 23 people said they would recommend the home to others.

Systems and procedures were in place to monitor and assess the quality of the service. A range of quality checks were carried out to monitor the service delivery. Records showed that these checks were carried out on a regular basis and where they had highlighted areas for improvement, actions were implemented.

The service worked in partnership with other organisations to make sure they were providing a quality service and people in their care were safe. These included healthcare professionals such as district nurses, occupational therapists, and GP's. This ensured a multidisciplinary (MDT) approach had been taken to support healthcare provision for people in their care.

The provider had a contract with the local City Health Care Partnership to provide four 'active recovery' beds at the home. These beds were used for people who were not safe to go home but medically fit for discharge from hospital. People were supported to build their confidence whilst waiting for packages of care to be provided in their own homes. A visiting healthcare professional providing support to people using the active recovery beds told us, "We have good communication [with the home]. We ring them and they ring us. Someone always attends the MDT meeting every Monday."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. The registered manager had made timely notifications to the CQC when required in relation to significant events that had occurred in the service.