GCH (Hertfordshire) Ltd

Queensway House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Queensway House is a residential care home which provides nursing and personal care for up to 80 people aged 65 and over. At the time of the inspection, there were 42 people living in the home.

People's experience of using this service and what we found

Care records were not always accurately updated as people's needs changed. Management oversight of these risks did not identify themes or trends so that action could be taken if required.

Staff had been recruited with the necessary checks being completed. However, induction of clinical staff required further improvement.

Staff understood safeguarding procedures and how to report concerns. They were able to describe to us what they should be observant for and the types of abuse vulnerable people were prone to. However, incidents that required reporting were not always completed in a timely manner.

Oversight and management of the service had been insufficient, it had not identified the shortfalls we found on inspection. The interim manager and provider had not implemented an existing quality assurance system to ensure good and safe care was provided to people.

Relatives felt that limited information had been shared with them during the pandemic at a time when visiting was difficult.

People were protected against the risks associated with the current COVID - 19 pandemic as infection prevention and control procedures were effectively implemented.

People told us they felt safe and there were sufficient numbers of staff to support them. People received their medicines as prescribed and medicines were safely managed.

During the inspection, the provider started to take positive action to address these concerns.

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

Rating at last inspection
The last rating for this service was good (Published 11 January 2019). This service has now been rated requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about safe care and treatment and

managerial oversight of the quality of care provided. A decision was made for us to inspect and examine those risks. During this targeted inspection, we identified further concerns relating to personal care, wound management, recruitment and induction and leadership within the home, so we widened the scope of the inspection to a focused inspection of the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed to requires improvement. This is based on the findings at this inspection.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and good governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always Safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well Led

Details are in our well-led findings below.

Queensway House

Detailed findings

Background to this inspection

The inspection
We carried out this focussed inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Queensway House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, we sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with five members of care staff, both deputy managers, the regional support manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at five people's care records and documents relating to the management of the service. We also looked at three staff files in relation to recruitment.

After the inspection
We continued to seek further information and clarification, from the provider, to validate evidence found. We reviewed a range of records, this included a further four peoples care records and a variety of records relating to the management of the service, including audits, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Incidents and injuries were recorded, but we found on occasion people experienced a delay in their health needs being reviewed. For example, one person was found to have a significant number of bruises on their arm. They were not seen by the GP for nearly two weeks.

● People at risk of dehydration did not have a target calculated to ensure they drank enough. Staff did record how much people drank but this was not then reviewed against the target. With no target in place for those people who required their fluid intake monitoring, there remained a risk people would not drink sufficiently and become dehydrated.

● People at risk of pressure damage to their skin had the pressure mattress setting recorded and checks of the settings verified they were correctly set. However, repositioning charts were not consistently completed when people required repositioning to alleviate pressure. This left people at risk of developing pressure wounds.

● People had not received regular baths or showers which meant people's skin integrity was at risk. For example, one person developed a skin rash on 15 March 2021 but waited three days for a referral to health professionals. Their skin integrity plan was reviewed on 07 March but not after the rash developed. Between 13 and 23 March 2021 they received only eight washes. A bath or shower was not provided. This did not promote good skin integrity, particularly for people who were prone to rashes and dry skin and required daily application of creams.

● Daily records of continence care provided were not accurate due to the limitations of the electronic system in recording when people needed their continence pads changed. Staff had not been proactive in changing people's pads which left people at risk of being in an undignified state.

● We saw meeting minutes in March 2021 identified that supported this as an ongoing issue, noting, in two days staff had used six boxes of wet wipes which was a month's supply to wash people with.

● Competencies for nursing staff had not been completed in areas around wound care, palliative care or catheterisation. All areas where people required nursing interventions. This placed people at risk of harm through unsafe practise as could not be assured that practise was safe.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took immediate action following this inspection to make improvements. Evidence sent to us after the inspection demonstrated that fluid intake had been calculated and people were receiving adequate hydration and personal care.

● The appointment of an acting manager in the absence of the registered manager had improved wound

care in the service. They reviewed and monitored every wound and dressing and carried out a nursing shift regularly to be able to observe practise in the home. Although concerns were raised two weeks after this inspection by a health professional regarding wound care, we found wound management had improved. For example, one person who moved to Queensway just prior to this inspection had several wounds on admission from hospital, which were subsequently verified by a health professional as healing well.
● The provider took action to ensure nursing staff were provided with formal assessment of their competency after this inspection and implemented a system of clinical governance and peer support.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person told us, "I feel safe here. There were a few incidents a little while ago where another resident was going into people's rooms and opening doors. That got sorted though."
● There were procedures in place to keep people safe. Staff had training around safeguarding and keeping people safe and understood their role in identifying and reporting any concerns.
● However, incidents where people may have been at risk of harm were not always documented correctly or reviewed. For example, one person was found to have bruising. Staff reported this to senior staff who developed a wound care plan but did not review for any potential signs of harm such as poor moving and handling practise. The acting manager when asked if they required further investigation said, "I see that yes. It could have been that the carers didn't follow the moving and handling care plan so yes it should have been investigated by us."
● Lessons learned following incidents were not embedded into practise. Records did not show where staff could openly discuss, review, or share good practise. For example, following a significant incident in the home a lesson learned document completed by management instructed staff to report accurately and in a timely manner. This did not seek to review the circumstances of the incident or the culture that led to its cause and did not involve the views of staff.

Staffing and recruitment
● Queensway House at the time of inspection relied upon using agency nursing staff. Six nurses were used, with only one nurse at that time employed by the provider. When starting work, agency staff were offered a limited induction and did not have their competency assessed effectively. The provider agreed and their regional manager told us, "We need to treat the agency nurses like we do our own staff. We will be mentoring and competency checking them from now on and will give them the same training as our own."
● People and staff told us there were enough staff to support people safely. One person said, "If I call for them, they come, there's not any delays or anything and they don't rush me along when helping me wash or dress." One staff member said, "It's getting there now. Everything gets done. We are not running behind so much."
● Permanent staff were recruited safely with the provider completing pre employment checks. These included previous employment references and Disclosure and Barring Service (DBS) checks. These checks help employers make safer recruitment decisions.

Using medicines safely
● Medicine administration record's (MAR) were signed when medicines were administered. Stocks of medicines tallied with the physical stock held. This indicated medicines had been given to people as prescribed.
● When staff administered an 'as required' medicine, records were clearly kept regarding the reason the medicine had been administered.
● Staff who were responsible for administering people's medicines received appropriate training, which was updated when required.

How well are people protected by the prevention and control of infection?

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others.

- Systems were not robust enough to identify the issues we found during the inspection. For example, we found gaps in the recording of repositioning charts, hourly checks, fluid charts, wound care plans and incident reporting.
- Effective audits around daily charts, care plans, risk assessments, cleaning schedules or health and safety had not been carried out prior to this inspection. Our findings at this inspection showed prior to our visit daily management walk arounds to monitor these areas had not been effective.
- Care plans were not always kept up to date and lacked key information for staff. For example, three people required positioning due to risk of developing pressures sores. The frequency the person required positioning was not clearly recorded in the care plan, and records had not been completed to demonstrate these had been completed.
- Some of the concerns found on this inspection had been identified through management discussions with staff in team meetings, but not acted upon. For example, the deputy manager raised the issue of personal care not being provided consistently in the February 2021 meeting and again in March 2021. We found that although this had improved, records still demonstrated that people were not bathed or showered as frequently as they wished. These actions arising from the team meetings did not appear in the service improvement plan or were not reported to the provider. Personal care was not provided in accordance with people's preferences, or in a manner to promote dignity.
- Monitoring by the provider was not effective as the weekly review of information was not accurate. For example, the incidents, accidents and injuries reported to the provider did not correlate with those recorded in the service.
- The providers action plan to address where improvements were required was also not accurate. For example, in August 2020 the action plan identified that fluids did not have a target set. This had been marked as completed, but our inspection findings found this had not been completed and remained outstanding.
- Further examples of actions not being completed were found from August 2020. Lessons learned were identified as requiring embedding into practise, which we found had not occurred. In March 2021 accident logs were signed as complete and up to date, however we found a number that were missing.
- The local authority reported delays when requesting information relating to people's care needs,

particularly when people required assessment for further care.
● The provider was working with the local authority to ensure actions arising from this inspection were implemented.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● During the inspection the provider took action to improve auditing and monitoring of the quality of care.
● We saw evidence of referrals made to external professionals such as speech and language therapists, dietitians and occupational therapists. However we also found that engagement with external GP practises varied, which the provider was reviewing and working with the local authority to improve these pathways.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We found that the provider understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information. However, we found examples where incidents had occurred that required management to follow the principles of duty of candour, but they had failed to do so.
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Due to limitations imposed on the service by the COVID-19 restrictions people, staff and relatives had not been asked to feedback on the service formally.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) Safe care and treatment Care was not delivered in a manner that was consistently safe. Actions to mitigate the identified risks to people's health and wellbeing were not effectively used. The provider had failed to ensure that temporary clinical staff had the sufficient skills, knowledge or experience prior to providing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 Good Governance (1) (2) (b) (c) The provider did not ensure a system was effectively operated to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided.