Queensbridge Care Limited

Queensbridge House

Inspection report

63 Queens Road
Cheltenham
Gloucestershire
GL50 2NF

Tel: 01242519690
Website: www.queensbridgecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

.This inspection took place on 19 September 2016 and was unannounced. Queensbridge House provides accommodation for 27 people who require personal care. There were 21 people were living in the home at the time of our inspection. The home provided personal care and support for people who live with dementia.

Queensbridge House is set over two floors. It has four lounge/dining room areas with a variety of seating and objects of interest and a secure back garden. The home also offers a day centre service.

A registered manager was in place as required by their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us they enjoyed living at Queensbridge House. Relatives were complimentary about the caring nature of staff. Staff approached people in a kind and caring manner. They had all been trained in the 'Butterfly Approach' which is a way of supporting people living with dementia by focussing on their emotional needs. Staff ensured people received care and support in accordance to their preferences and needs. People's privacy and dignity was respected.

There were sufficient amount of staff to meet people's needs. Staff told us they felt supported and well trained, although they had not consistently received regular private support meetings or staff meetings. The registered manager was actively recruiting new staff. Safe recruitment practices where followed to ensure suitable staff were employed, although we have made a recommendation about safe recruitment practices.

People's care and support needs were documented. People were supported by staff who respected their human rights and encouraged them to make decisions about their care. They were provided with a variety of activities to meet their social needs. Staff were confident about recognising and reporting suspected allegations of abuse although they were not always clear about who they would report their concerns to outside the organisation.

There were safe systems in place to manage people's medicines. People received their medicines on time by staff who were trained to carry out this role. People's care records showed relevant health and social care professionals were involved with people's care. Peoples nutritional and hydration needs were appropriately assessed and monitored. People's specialist dietary needs were catered for.

Quality monitoring systems were in place to identify any shortfalls in the service although the processes lacked evidence if actions had been taken to address the areas of concern. The registered manager sought feedback from people however there was no evidence that the results of the feedback had been acted on.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

Recruitment processes to ensure people were protected from unsuitable staff need some improvements.

There were sufficient numbers of staff to support people.

Staff knew how to recognise and report abuse.

People's medicines were mostly managed well. People's risks were suitably identified and monitored.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have access to formal support systems such as one to one meetings with their line managers.

Staff had the training they needed to meet people's care needs.

People who were able were involved in making decisions about their care and support.

Records indicated that people had been referred to the appropriate health and social care professional when needed

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People's needs were met by kind and caring staff. Staff knew people well and respected their preferences.

Staff ensured people's dignity, privacy and independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's care records provided detailed information about how people's needs should be met. Staff focused on people's individual physical and emotional needs. A new approach of supporting people living with dementia by focussing on their emotional needs was being implemented.

People and relatives were confident that any concerns they had would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes lacked evidence of effectiveness due to limited or no documentation around completion of actions and reassessment.

Feedback on the service was sought however there was no evidence of this feedback being acted upon.

Staff told us they were supported but felt there was lack of communication from senior managers.

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

This inspection took place on 19 September 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience and knowledge of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the home and observing how staff interacted with people. We spoke with three people and three people's relatives and visitors. We looked at the care plans and associated records of five people. We also spoke with six care staff and the registered manager. After the inspection we spoke to the lead activities coordinator by telephone as they were not available on the day of our inspection. We looked at four staff files including the recruitment procedures and the training and development of all staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

People's risks of being cared for by unsuitable staff were minimal because fairly robust recruitment processes were in place. For example the registered manager checked staff member's criminal histories via the disclosure and barring service (DBS). Full work histories and references had also been obtained. However there were some gaps in some staff's employment history where there was no documented evidence that these had been explored during the recruitment process. Also we saw no evidence of relevant risk assessments for those staff whose checks had brought to light areas which required further exploration. We discussed this with the registered manager who stated that these issues had been explored with the relevant staff at the time however they had not made a record of their discussions.

We recommend that the service considers current legislation on the safe recruitment of staff.

People who regularly visited the home such as family members or health care professionals felt people were safe living at the home. One health care professional complimented the approach of staff and said "I have not seen anything that would set off alarm bells in my head. The staff have consistently been good and very accommodating. I believe the residents are safe living at Queensbridge House." People were protected from the risk of abuse because staff had undergone the relevant training in safeguarding. Staff we spoke with were clear that if they saw any signs of abuse or if they had any concerns they would report it to their line manager immediately. However most staff we spoke with were unclear about who to go to with concerns outside of their organisation. The home's policy on reporting poor practice stated that the contact details for the CQC and local authority should be clearly displayed in the staff room. This was not in place at the time of our inspection. We discussed this with the registered manager who said that she would ensure this was now done.

Staff had identified and understood people's physical needs and how they should be managed to reduce the risk of harm. Nationally recognised assessment tools were used to assess the level of risks associated with people's care needs such as the risk of developing pressure areas or becoming malnourished. The tools were regularly reviewed and updated in accordance with people's needs. Health care professionals were positive about how staff managed the risks associated with people's health care needs. Information about how people's risks were managed was detailed in their care plan and managed well. For example, the care plan of one person stated they were at risk of developing pressure sores. The care plan gave staff guidance on how the risk to the person should be reduced which including the use of pressure relieving equipment and assisting the person to reposition frequently. However the details of the frequency of the turns required was not detailed to guide staff. Although, on inspecting the person's turning charts, they showed the person was being turned every two to three hours which had reduced the risk of pressure sores developing. This person's fluid intake was also being recorded but there was no clear guidance of the expected levels of fluid or actions to be taken if they did not reach the desired levels. This meant staff did not always have succinct guidance to ensure people people's needs were being met.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet people's individual needs. Where there had not been enough staff to meet the desired staffing levels of the home, the

registered manager had requested agency staff to fill in any shortfalls. Some agency staff were used regularly as there had been several staff vacancies in the home. The registered manager was currently recruiting and interviewing for new staff. We were told that they were continually reviewing the staffing levels in conjunction with the implementation of the 'Butterfly Approach' (a new approach to improve the quality of people's lives through person centred care and relationship focused dementia care).

Peoples' medicines were generally managed and administered safely. Some people had been prescribed medicines to be used 'as required' such as medicines which had a calming affect if people became agitated. The home held a small amount of homely remedies which would be used in an emergency such as pain killers or constipation remedies. People's medicine administration records showed when staff had given 'as required or home remedies' medicines to people. However, there were no protocols in place to guide staff when these medicines could be used. Additionally, the reason why people had required these medicines had not been consistently recorded. We were told that anybody who became ill would be referred to their GP for further advice and the home remedies held in the home would only be used with the GPs permission. We addressed this with the senior staff member responsible for the management of people's medicines who immediately implemented protocols for the use of 'as required and homely remedies and updated the service's medicines policy.

We observed people being administered their medicines at lunchtime. They were given their medicines in a respectful manner. Medicine administration records were completed correctly. Codes indicated whether people had taken or refused their prescribed medicines. People were asked if they required additional medicines such as pain killers and their decisions were respected. Medicines were stored appropriately and in accordance with current guidance. The stock balances of medicines which could be misused were regularly checked and recorded. Staff observed the well-being of people when they had a change in their prescribed medicines. For example, staff found that one person had had an adverse effect when they had been prescribed some new medicines for their neurological condition. Staff had immediately contacted the GP and sought advice.

Procedures were in place to protect people in the event of an emergency. Personal evacuation plans were in place for each person. Fire safety equipment and systems were regular checked and maintained. The home was clean and well maintained.

Requires Improvement

Is the service effective?

Our findings

People were not always cared for by staff who had access to the support they needed. Not all staff we spoke with had formal support such as one to one supervision meetings with their line manager. Those that had received one to one support had not received this on a regular basis and in accordance with the provider's policy. Some staff we spoke with felt that they were not always listened to and they would welcome time for one to one discussions. The registered manager acknowledged that they were behind with one to one supervisions and staff appraisals however there was a plan in place to address this with senior staff being trained to assist the registered manager in providing staff support.

Staff told us the registered manager was supportive and approachable but they felt that the opportunities for them to raise concerns or make suggestions were limited as they did not have frequent staff meetings. One staff member said, "We've got lots of ideas but we aren't listened to, so nothing gets done." All staff felt that communication regarding the running and changes in the home needed to improve.

All staff we spoke with said that they had access to the training they needed in order to meet the needs of the people they supported, for example, safeguarding, fire safety, dementia care and moving and handling. One health care professional wrote to us and said, "The staff seem well trained and motivated." All staff had completed a comprehensive course in the Butterfly Approach. The registered manager and senior staff had completed an advance course with an emphasis on the leadership of this approach. However some staff expressed the need for the new approach to be better embedded in the service.

A training matrix was in place to allow the registered manager oversight of what training was needed by who and when. New starters were expected to undertake all the training the provider deemed as mandatory within the first three months. Currently the service was not utilising the Care Certificate training however we were informed that there was a plan in place to bring this in so that all new staff would undertake the skills for care modules. The Care Certificate is awarded to staff that have completed training in a specific set of standards which demonstrates they have the relevant knowledge and skills. New staff were assigned a mentor during their probationary period and the registered manager would sign them off as competent at the end of this period.

The registered manager and staff understood her role and legal responsibilities in assessing people's mental capacity and supporting people in the least restrictive way. The majority of staff had been trained in the understanding of the Mental Capacity Act 2005 (MCA). Where staff had not completed this training there was evidence that training had been planned. 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. The registered manager and senior staff had carried out advance training regarding the MCA. Staff understood the principles of allowing and encouraging people to make their own decisions. This was embedded in their practice such as obtaining consent before they supported people with their personal care or provided support. Throughout our inspection we heard staff

asking people about their opinions and encouraging them to make choices about their day. Where possible, people consented to the care and support being provided. Families and significant people had been involved in making decisions where people had been assessed as lacking mental capacity to make their own decisions. For example, some people had been assessed in line with the principles of the MCA as not having the capacity to understand the importance of taking their prescribed medicines. Therefore a best interest decision had been made to provide full assistance in the management of their medicines. The registered manager recognised that not all people's mental capacity in relation to their care and support had been assessed. They told us they were reviewing people's consent to their care as part of updating the format of people's care plans.

Some people were continually being supervised and deprived of their liberty as they were unaware of potential risks and hazards within the home and in the community. People can only be deprived of their liberty to receive care and treatment when this 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 identified people who were being deprived of their liberty and had applied to the local authority to be authorised to do so. The home was waiting for the local authority to assess the supervision and restriction of people. In the meantime, staff supported people in the least restrictive way and allowed people as much freedom as possible.

People were supported to maintain a healthy and well balanced diet. They were weighed regularly to ensure they maintained a healthy weight. People could choose where they wanted to eat their meals. Some people chose to eat at a dining room table in one of the four lounges whilst others preferred to eat from a tray on their lap or in their bedrooms.

Meals and drinks were prepared by care staff. Ready-made meals were bought in frozen and heated up. The meal containers provided staff with the nutritional values for each meal. Portion sizes were flexible and dependent on people's appetites. One staff member said, "We plan what they like to eat and we try to make sure there is something on the menu that everybody likes. We give them different options if they don't like the meal." The kitchen had been rated five stars from the Environmental Health. The kitchen was cleaned daily and the food cooking temperatures and fridge temperatures were taken regularly and recorded.

Meal times were calm and relaxed. People were given a choice of two options at the beginning of the meal. If someone appeared not to understand the choice, we saw that staff offered to bring the two options for people to see. Staff knew people well and knew the preferences and choices in the meals of people who were unable to communicate. People seemed to enjoy the food very much. All of the plates were empty at the end of the meal. One person told us "The food here is usually very nice." Staff offered people hot drinks and snacks throughout the day. They were knowledgeable about people's dietary needs and offered them an alternative snack.

Staff had a good understanding of people's general well-being. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Health care professionals spoke highly of the care and support people received in the home.

Good

Is the service caring?

Our findings

There was a welcoming and relaxed atmosphere at Queensbridge House. Family members and visitors were made to feel welcome and were able to visit their relative at any time. We spent time with people in the various lounge/dining rooms. We observed staff greeting people in a friendly manner as they entered the lounge/dining rooms to eat their breakfast. They enquired how they were and if they had slept well. People were asked if they preferred to eat their breakfast in a comfy chair with a tray or at a dining table. They were asked if they were happy with their breakfast and if they wanted anything else to eat or drink. Most people were unable to express their views about living in the home to us, although one person said, "I like it very much here. They are all so sweet to me." They told us they now sat with people who had similar abilities and they enjoyed to chat to them and staff.

Staff chatted with people in a friendly and warm way and provided them with the sensory and social stimulation they required. Some people liked to hold hands with staff, which staff respected. All staff were continually polite to people and spoke to them in a respectful and kind manner. We were told it was the responsibility of all staff to speak to people in a caring manner which was focused on their needs. We saw staff respecting people's choices and views. For example, staff asked people who they were supporting to walk, where they would like to sit. They asked people who were watching TV in one of the lounges what they would like to watch. Appropriate music played in the background in the other lounges.

Staff provided us with examples of how they supported people with dignity and how they had made a difference to people's lives. They provided people with visual impairments with extra information about their surroundings such as the position of their drink or who was sat next to them. People appeared relaxed and comfortable around staff. Staff knew people well and they adapted their approach and manner to suit each person. Some people were unable to find words to express their views or wishes; however staff patiently listened to them and tried to understand their expressions and words.

People's dignity and privacy was respected. Staff complemented people on the way they looked and helped them with their clothes if they became dishevelled. One staff member said to a person, "I love your top; it's a lovely sky blue." The person smiled back and raised their hand in appreciation. Staff ensured bedroom doors and curtains were closed before they provided people with support with their personal care.

Relatives were positive about the care people received. They told us the staff were caring and very patient with people. We received comments such as: "Very pleased with the care provided"; "She has become a person in her own right again, and she loves the activities"; "I think it is brilliant here. The staff work hard and I've never seen them be anything but patient" and "The changes at the home have made it more homely, not so stark." Health care professionals told us that relatives had confided in them and told them how pleased they were about the approach of staff and the caring manner especially during the last few days of people's lives. One health care professional said, "I have being visiting the home for a long time and from my perspective it has improved a lot." They continued to tell us, "The staff are outstanding in the care they give; they will always contact me if they have any concerns about the residents." Heath care professionals also complimented the décor of the home and told us they felt the change in home's environment had made a

difference to people's lives. They told us the home had a 'homely feel' about it and staff were genuinely interested in the welfare of the people.

Good

Is the service responsive?

Our findings

Since our last inspection, the home had made significant improvements to enhance the home's environment to support people who live with dementia. Staff had been trained in the 'Butterfly Approach' which bases it approach on 'creating a family like atmosphere and sharing closeness which matters in dementia care'. This approach helps to break down barriers and improve the quality of life for people who live with dementia in care homes. There was a change in the home's atmosphere and surroundings. Staff had reorganised the communal areas and had created four lounges, each with a small dining table, a variety of seating and items of interests for people to touch and hold. Each lounge had a homely feel about it which gave people a sense of well-being. For example, one lounge which had been previously been plainly decorated and rarely used had been decorated and had a 'tea room' theme to it. We saw people relaxing and enjoying the newly decorated lounge. As a result of the success of the 'tea room', we were told that plans were in place to review the décor of the other lounges and create areas which are bright, full of interest and meaningful to the people living in the home. Other changes in the home included staff wearing their own clothes to help promote a friendlier atmosphere, and some people's bedrooms had been personalised with personal items and had been decorated in their favourite colours.

People's social, sensory and recreational needs were being met. The lead activities coordinator explained how people were provided with activities which were meaningful and of interest to them. Staff with the key responsibility to provide activities were also required to support people during breakfast time in the home's breakfast club. The lead activities coordinator said this was an important role as it helped staff to understand people abilities to join in activities. They explained that by observing how people managed their breakfast such as buttering their toast this helped them to understand each person's abilities and therefore plan appropriate activities for them to do.

The activities coordinator explained how the Butterfly Approach had changed their attitude in providing activities. They told us no activities were specifically planned as activities were determined by people's mood, interests and requests or the weather. They told us about some people's interests and how people liked crafts or going in the garden or out for a walk. On the day of our inspection people enjoyed an interactive game using a ball and a parachute. Others were unable to participate in many activities due to their advanced dementia, but staff helped to facilitate and provide one to one opportunities which provided sensory stimulation such as washing up in the kitchen or massaging their hands.

The home had some links with the local community such as the church and we were told that people enjoyed a visiting singer who visited the home regularly to sing with people. The lead activity coordinator told us they wrote directly in to people's daily notes rather than keeping a separate log about the activities people had been involved in. They said, "We work as a team, we need to be writing in the same place about the whole person so all staff know what that person has experienced each day."

Since our last inspection, the registered manager had reviewed and amended the format of people's care records. They had worked with the staff team to ensure that people's care plans were written in a manner which reflected their support needs and wishes. People received care and support which had been

personalised to their individual needs and requirements. Their care plans were personalised and reflected their needs such as their communication, mobility and personal hygiene needs and how they wished to be supported. Other information about their personal and medical history, their preferences and preferred routines was recorded. This gave staff an insight in to people's personal backgrounds and personalities. One staff member said, "The care plans are a lot better. They are joined up and all the information is together." Health care professionals told us they found people's care records well organised and up to date. A relative told us that she felt very involved in any decision making around the care of their family member. She said that they respond quickly if she has any concerns. For example, she had noticed that her relative was leaving the pastry and crusts when eating her meals. She mentioned this to the staff who immediately referred them to the speech therapist for a swallowing assessment.

As a result of a complaint made to CQC, we discussed the process of assessing people who stayed at the home for short breaks. A senior staff member shared with us the actions they had taken since they received the complaint. This included an amended process and assessment of people who chose to stay at the home for a short break such as the implementation of fluid charts to monitor people's fluid intake. We were reassured that the reviewed assessment process captured the needs of people.

The registered manager told us any concerns and complaints about the service were taken seriously. Records showed that concerns and complaints were encouraged, explored and responded to in accordance with the provider's policies. People and their relative's day to day concerns and issues were addressed immediately.

Requires Improvement

Is the service well-led?

Our findings

The quality of the service was monitored by a variety of audits including medicine management and care planning. Some new audits had also been designed around the CQC domains – safe, caring, effective, responsive and well led. The provider had completed these audits and then sent action plans to the registered manager. However there was a lack of evidence to show that these monitoring systems had improved the quality and safety of the care people received. Some of the monitoring forms lacked any detail and there was no record of the actions taken to address these concerns, by when and who was responsible. For example, in an audit of 'safe' there was a section looking at 'pre-employment checks'. An action had been identified that 'DBS records needed updating'. We saw a record in a separate learning and development book assigning the action to a staff member, however there was no evidence of a timeframe for completion as per the home's policy. A medicine management audit contained more detail around what action was needed with clear target dates. However none of these actions had been signed off as completed. The home's quality assurance policy clearly stated that there should be an action plan in place for tracking improvement timescales and that there should be reassessments to gauge improvements.

Feedback from relevant persons such as people's relatives was sought through surveys. The surveys showed that the home was in the main rated by relatives as good or excellent. However there were some areas for improvement noted, for example one relative commented that communication could be improved in relation to changes in their relative's healthcare needs of the person living in the home. Whilst this issue was documented there was no record of any action plan to address this concern and therefore we could not evidence that feedback was used to continuously evaluate and improve the service people received.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of policies looked at had been recently reviewed and updated by the provider however we noted that they referred to the old 2010 Health and Social Care Act regulations rather than the current 2014 regulations . This was flagged up to the registered manager who said that it would rectified.

The registered manager said that she met with the provider on a regular basis to discuss service improvements. They told us they had regular support from the provider and they were contactable and approachable. The registered manager also worked with external health care professionals and attended external conferences and workshops to keep updated and ensure staff were following best practices. One health care professional wrote to us and said, "The home seems well run and well invested in both financially and intellectually."

The registered manager took an active role within the running of the home and had good knowledge of the people living at Queensbridge House. The registered manager and senior staff had received additional training in the 'Butterfly Approach' and had visited flag ship homes which had been accredited in the approach. Staff were mainly positive about the approach however we were told some staff had not fully embedded the approach in their practice. We received mixed messages from staff regarding the

implementation of the butterfly approach. Most staff felt it had improved people's quality of life, whilst others told us the momentum of improving the home had dropped. Some staff had become disheartened about the decrease in progress that the home was making. However one staff member explained that they were implementing the changes slowly so not 'to overwhelm' people with too many changes at once. We were told the development of home was a work in progress. After the inspection the registered manager shared with us their action plan and timeframes of further implementing the approach. We were told that they aimed to be accredited by a national organisation specialising in dementia care.

Accidents and incident which occurred in the home were recorded. The reports were reviewed to identify any patterns or trends. The registered manager explained that any accidents and incidents were reviewed and additional measures were put in place to reduce the risk of further incidents. The registered manager audited the call bell system monthly to ensure staff responded to people's requests for support in an acceptable time in accordance with the provider's policy. Audits showed that the registered manager had investigated the times where people were not assisted with their needs promptly.

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 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of the service.