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

# Summary of findings

## Overall summary

This inspection took place on 26 and 27 October 2017 and was unannounced. Queensbridge House provides accommodation for 27 people who require personal care. There were 24 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 second manager had also recently registered with CQC to support the established registered manager in managing the home. 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.

At the last inspection in September 2016 we rated the service as 'Requires improvement'. As a result of this inspection, we found the service had not improved in its rating and continues to be rated as 'Requires improvement'. Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we will be asking the provider to send us a written report of the action they plan to take to achieve a rating higher than 'Requires Improvement' to support us to monitor the provider's planned improvements.

People received care and support from staff who were knowledgeable about their support needs and preferences. However people's care records did not always provide staff with the information they needed to support people. The records of the management and monitoring people's risks and their medicines did not provide staff with sufficient guidance. People's consent to their care or the outcome of mental capacity assessments were not reflected clearly in people's care plans. Records showed that people's health care needs were monitored and any changes in their health or well-being had prompted a referral to their GP or other health care professionals.

Relatives highly praised the caring nature of staff and told us they were always welcomed at the home. There were many warm and genuine interactions between staff and people. Staff treated people with dignity and respect. People and their relatives told us they felt safe living at the home. They told us they enjoyed their meals and were supported to eat a healthy diet and have plenty to drink. People enjoyed activities in the home.

Staff had been trained in their role and felt supported by the managers. The registered managers worked alongside staff providing care which gave them a good insight into people's needs and skills of staff, although their assessment and observations of staff were not effectively recorded or monitored. Staff were

aware of their responsibilities to report any concerns of abuse or harm. There were sufficient numbers of staff who had been suitably recruited to support people.

A new management structure provided people and staff with confidence in the management of the home. People and their relatives were confident that any concerns would be dealt with promptly. Quality assurance systems were being implemented and reviewed to evaluate the quality of care being delivered, although had not identified gaps in the details of people's care records. We have recommended that the service reviews the systems that monitor people's care records.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. 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?

Good

This service was safe

Risks to people's health or well-being were assessed and managed well by staff.

Improvements had been made to the recruitment of new staff. There were sufficient numbers of staff to support people.

People and their relatives told us they felt safe living at the home. Staff were aware of their responsibilities to report any concerns of abuse or harm.

### Is the service effective?

Good

The service was effective.

People were supported to make choices about their day and consent to the care being delivered.

Staff had been trained in their role and were supported in their professional development.

People enjoyed their meals and were supported to eat a healthy diet.

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.

### Is the service caring?

Good

The service was caring

People are treated with kindness and compassion by staff who were aware of their needs and support requirements.

Staff adapted their approach when speaking to people with different communication needs. People's dignity was maintained at all times.

Relatives were positive about the care people received.

## Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff understood people's needs and responded to them in a timely way, however people's care plans did not always provide staff with information they needed to support people and manage their risks.

People enjoyed activities when they occurred. The home had been decorated to provide stimulation and to help orientated them.

People and their relatives were confident that any concerns would be dealt with promptly.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems had not always been effective in identifying the shortfalls in people's care records and in some areas of management of the home.

People and staff felt supported and were confident in the management of the home. Communication between people, staff and the managers had improved.

# 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 checked 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 comprehensive inspection took place on 26 and 27 October 2017 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 personal experience of using or caring for someone who uses this type of care service.

This service was last inspected in September 2016 and was rated as 'Requires Improvement'. 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 other information we held about the service and provider as well as previous inspection reports.

During the inspection we spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two people and six people's relatives and visitors. We looked at the care plans and associated records of eight people. We also spoke with six care staff, two housekeepers, an activity coordinator and the two registered managers. We looked at staff files relating to their training and personal development as well as the home's recruitment procedures. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and records relating to the management of the home including quality assurance reports.

Good

# Is the service safe?

## Our findings

People's risks had been identified and assessed by staff, for example, there were records of people's risk assessments relating to their needs such as falls, mobility, skin integrity and malnutrition. Staff were knowledgeable about the measures that had been put into place in order to reduce the risks to people. They demonstrated a good understanding in relation to the management of each individual's needs. We observed staff supporting people to help minimise their risks such as reminding people to use their walking equipment or prompting them to drink. Staff were responsive to any changes in people's risks and well-being and promptly sought advice from the GP or health care professionals

Following safety incidents staff had taken positive steps to manage people's risks and encouraged them to retain their independence. For example, after a fall on the stairs, one person was supported to use the lift until they became familiar with the lift controls. This allowed them to have the freedom to move around the home as they wished. Records showed that all accident and incidents were logged and analysed for trends and patterns. The incident and actions taken were discussed with staff to ensure the risks of similar incidents were minimalised.

People received their medicines in a timely manner and in line with their prescription. Staff who were responsible for administering and managing people's medicines knew people's support requirements in relation to their medicines. For example, one person initially refused their medicines, but the staff member was patient and took their time with the person until they eventually took their medicines. Medicines administrations charts had been completed accurately with no gaps when people had taken their medicines. All medicines received in the home were checked and accounted for. People's medicines were stored securely and medicines that were no longer required were disposed of safely. A regular system was in place to check the management of the people's medicines. Any errors or shortfalls were investigated and addressed immediately.

Since our last inspection, improvements had been made to the systems relating to the recruitment of new staff. People could now be assured that they being were supported by staff who were deemed to be suitable to carry out their roles and of good character. All applications and associated recruitment documents had been reviewed and checked. Background and criminal checks were completed via the Disclose and Barring Service before new staff worked with people. Any queries regarding their previous employment or irregularities were discussed during their interview and documented.

People received care and support from sufficient numbers of staff to meet their needs. Staff picked up additional shifts when there were unplanned staff shortages due to staff sickness and staff holidays. When necessary the service used familiar agency staff. Relatives and staff confirmed that they were confident that people's needs were being met by adequate numbers of staff. Comments included "Generally, yes we have enough and we can use agency if we need to" and "It always seems fine to me". This was confirmed by the staff rotas. We were told that staff were rostered in a manner which gave people the flexibility to get up and go to bed as they pleased. An additional staff member was made available every morning to provide support and encouragement to eat their breakfast. Adequate time was made available for day and night

staff to have a thorough handover of people's needs.

People were kept safe from risk of abuse or harm. Staff told us they had received safeguarding training and were aware of the different types of abuse. They were clear of the provider's safeguarding procedure and their responsibilities to report any suspicions of abuse. One staff member explained, "I am very clear on what I would do if I thought any of our residents were being harmed in any way. I would have no hesitation in reporting it." Additionally, staff were familiar with the providers whistleblowing policy and knew how to report any concerns about poor care. We followed up on the actions that had been taken when safeguarding concerns had been raised and were reassured that the registered managers had taken appropriate actions to safeguard people from harm or abuse. Relatives felt people were safe living at Queensbridge House. One relative said, "Mum got her life back when she came here, and I got mine back. She relaxed because she felt safe."

People could be assured the home was safe, clean and well maintained by the housekeeping and maintenance team. Regular checks were carried out to ensure the building and equipment associated with people's care were cleaned, maintained and serviced. One relative said, "It's very clean and always smells clean. Any mess is immediately cleaned up by the care staff or cleaners."

Good

# Is the service effective?

## Our findings

We checked whether the service was working within the principles of the Mental Capacity Act and whether any conditions on the authorisation to deprive a person of their liberty were being met. 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 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).

Most people at Queensbridge House lived with a type of dementia and were being supported in their best interests and in the least restrictive way by staff who were knowledgeable about their needs. We observed staff supporting people in a personalised and least restrictive manner. The registered managers had applied to the local authority to deprive two people of their liberty.

People were supported to make decision about their care and support. We observed staff encouraging and supporting people to make choices about their day such as what they wanted to drink or eat. Staff were aware of people's preferences and assisted them to make day to day decisions based from their knowledge about people. Staff had a basic understanding of the principles of the MCA relevant to their role and were able to demonstrate how they embedded their knowledge of the MCA in their care practices. For example, they were able to tell us their actions if people refused to be supported with their personal care. One staff member said, "We never force the residents. If one of them refuses something then I give them some space and go back later and ask them again or try another way of persuading them; but never forced."

Staff had been given the opportunity to gain additional health and social care skills from visiting health care professionals. We were told that health care professionals had trained staff in specific skills such as using a type of hoist or had helped staff to implement their recommendations on how to support people. The registered managers observed the skills of staff whilst they worked alongside staff delivering care. They told us they provided staff with on-going support and immediately addressed any observations of poor practices.

All staff had received a basic level of training within their induction period and then went on to receive regular refresher training in the subjects deemed as mandatory by the provider and registered managers. New staff were required to complete the care certificate and shadow more experienced staff before becoming part of the shift team. Senior staff or managers met with new staff and observed their skills and knowledge during their probation period.

Most staff had attended an in-depth dementia course and were aware of the principles and approach of supporting people living with dementia. Plans were in place for new staff to also attend the dementia course and for other staff to receive refresher training in dementia awareness and other training such as medicines

management and dignity in care. Staff were supported and encouraged to professionally develop and gain nationally recognised qualifications in health and social care. Improvements had been made to the systems to support staff. Staff told us they received regular supervision and had on-going support from the management team and from their colleagues. They were confident that their views and concerns were addressed by the new management structure. One staff member said, "Things have definitely improved. We get lots of support of the managers and communication has definitely improved."

People were supported to have enough to eat and drink. They could choose to eat their meals in one of the four dining areas or in their bedrooms. Whilst staff informed people of the choice of meals available, they were not provided with any other information to help them to decide such as pictorial menus or shown samples of the meals. Staff ensured people were comfortable and used different strategies to encourage them to eat their meals. For example, when one person refused a dessert, a staff member said "Oh please try some. It's a new recipe and we could do with some feedback". The person then accepted the dessert. Staff were aware of people's likes and dislikes of foods and provided people with alternative meals if they didn't like the meal options of the day. The registered manager pre-ordered the nutritionally balanced pre-made meals based on a rolling programme and people's preferences. Staff were responsible preparing the meals and monitoring people's diet and fluid intake. Throughout the day people were offered hot and cold drinks and snacks to ensure they maintained a balanced diet and had sufficient fluid.

People were supported to maintain good health and had access to health care services such as an optician. Their 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. The home had good connections with the local GP practices and specialist professionals who support people with dementia.

Good

# Is the service caring?

## Our findings

People told us they enjoyed living at Queensbridge House and were positive about the care and support they received from staff. We received comments such as: "They (staff) are marvellous. I do most things for myself, but they help me if I need it. You can relax when you've got people like that around you" and "Yes, it's very pleasant here. The staff are very nice."

Relatives also complimented the caring nature of staff. One relative said, "Either me or my sister comes to see mum every day at different times. We've never seen anything other than kindness and good care, not just for mum but for all the people here" One visitor felt strongly that the staff were kind and respectful and said about their friend, "She is happy here and although I know she sometimes complains that the staff 'nag' her about eating, I am glad to know that they encourage her. The staff definitely know her well and know how to make her comfortable." Relatives told us they were always welcomed into the home and communication from staff was good and they were always contacted if there were any problems. We met the family of one person who had recently passed away in the home. The family explained they felt the staff had been very person-centred and sensitive in supporting their relative during the final stages of their life. One of the family members said, "The care here is exemplary. I can't praise them enough." They told us they had been kept informed and told of any changes in their relative's health. The registered managers explained that where possible they supported people to remain living at the home during the final stages of their life. They told us they had a good links with specialist health care services who provided them with the advice and guidance to provide end of life care.

The home had a warm friendly feel about it. Staff knew people well and were chatty and attentive to their needs. We observed positive interactions between staff and people with lots of laughter. Staff spoke kindly and respectfully to people. Staff had a good understanding of supporting and communicating with people with dementia. They adjusted their style of communication according to people's communication needs. We observed staff crouching down to speak to people in order to make and maintain eye contact. Staff responded appropriately and respectfully to one person who frequently called out. They provide the person with constant reassurance, for example some staff stopped and chatted with the person while other staff informed them that they were close by and that they were safe or helped them adjust their position in the chair.

People's dignity and privacy was respected. For example, staff supported one person in a dignified manner when they hoisted them from an armchair in one of the lounges. Staff carried out the transfer with care and frequently reassured the person being hoisted. People were encouraged to be as independent as possible. For example, staff took time to put a cup in a person's hand and prompted her to take a sip. The staff member explained that the person usually finishes the drink once she has been encouraged to start drinking it.

Staff spoke passionately about their roles and supporting people. Comments included "I love working here. Everyone is so nice and lovely, it's a lovely environment to work in. People definitely get good care here"; "The care is good here, really good. People are safe, people are happy and chirpy. You can see people are

smiling" and "Its great here. It just feels like you're here looking after your family".

Where known, people's cultural and religious needs were supported. We were told that staff had spoken to relatives in the past and researched people's religion to gain a better understanding of their beliefs such as dietary needs in accordance with their culture.

Requires Improvement

# Is the service responsive?

## Our findings

In September 2016 we rated this key question as good. At this inspection in October 2017 we found the management and provider had continued to work to improve the home. However, not all previous improvements had been sustained, and we identified some new record concerns. We have rated this key question as requires improvement.

People received personalised care from staff who were aware of their needs. Staff were able to describe the support people required to meet their needs and maximise their levels of independence. We observed staff responding promptly and respectfully to people's requests. They observed and monitored people from a distance to allow them to have the time and space they required to be independent but intervened when they thought people may be at risk such as falling or spilling a drink.

However, the management strategies and care practices used by staff were not consistently recorded in people's care plans for care staff to follow. This meant people may not have their care needs met by staff who were unfamiliar with their needs. For example, staff supported one person to mobilise who had been assessed as being at very high risk of falls but their care plan did not provide any guidance for staff on how to reduce the risk of them falling. Another person was being supported to stabilise and manage their diabetes effectively; however there was no clear direction for staff to follow if there was a change in their well-being. People's preferences on how they liked to take their medicines or their need for medicines that were administered 'as required' (PRN) such as medicines to reduce people's anxieties were not always documented."

People had a personalised emergency evacuation plan in place which reflected their support needs in event of an evacuation. Although a change in one person's mobility had been noted in the evacuation grab list that would have been used in the event of an emergency evacuation, we found their personalised emergency evacuation plan had not been reviewed to reflect any changes in their ability to evacuate.

Staff were supporting one person to take regular fluids through a straw or using an oral syringe, however there was no recorded evidence that this person had been assessed as being at risk of choking or if the technique being used had been recommended by a health care professional. The registered manager explained that the person had been assessed by a speech and language therapist and had made the recommendation but could not provide the supporting documents. Therefore it was not clear if the techniques being used were appropriate or had been reviewed to ensure they remained effective. However, we were reassured that the person would be immediately reassessed and that other people's nutrition and hydration records reflected their needs.

We found the details and information in people's care plans were variable and did not always reflect on people's specific care needs such as care plans and information relating to people's mental health or how people's dementia may affect their everyday living, were limited. For example, guidance on how staff should best support and reassure one person who shouted out was not clearly recorded. Staff were aware of people's preferences, preferred routines and emotional well-being and we observed many warm

interactions from staff who reassured people when they became distressed, although records of people's support requirements were not clear. For example, whilst staff reassured a person who often shouted out, their care plan did not demonstrate an understanding of why the person was behaving in a particular way, or give guidance on how to support them positively to reduce risks and distress. This put the person at risk of not having their care needs met, because their behaviour might not always be understood. However records showed that staff had sought specialist health care advice and their medicines had been regularly reviewed.

The strategies staff used to support people in the least restrictive manner were not clearly recorded to guide staff who were unfamiliar with their needs. It was not recorded how people should be supported in the least restrictive manner if the supervision and restriction of people had been authorised to keep them safe.

Best interest decisions had been made on behalf of people who lacked mental capacity to make decisions about their care. However, the outcome of these assessments and information documented during the decision making process were limited including the involvement of people's lasting power of attorney. For example, there was limited documentation in the decision making process of using a bed rail for one person or whether any less restrictive options had been considered.

The management and monitoring of people's risks, support needs and decisions about their care were not effectively recorded. This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

An activities team supported people to access a range of activities and social events such as music therapy, exercise club and sensory games. People benefited from an environment which had been decorated to meet their needs, provide sensory stimulation and help orientate people around the home. There were items of interest for people to pick up and investigate or use. Secured tactile items were fixed to the walls for people to touch and explore. The ethos of the home was to focus on people's well-being and happiness. One staff member said, "The residents are free to move around the home and can touch what they like. It is their home." People had many opportunities to join in group activities. We observed one of the activity coordinators moving around the home playing the guitar and singing to people. They engaged with people and altered their approach depending on the person's needs. A beauty therapist who had been trained in dementia care visited the home weekly and provided a hair and beauty service.

People and their relative's day to day concerns and complaints were encouraged, explored and responded to in good time. They told us the staff and managers were very responsive to any complaints and were willing to listen and act on their concerns. The provider had a complaints policy in place. Records showed that people's complaints had been acted on in accordance to the provider's complaints policy. Complaints had been logged and there was evidence of meetings with the complainant and response letters. The registered managers used feedback from people to help drive improvement across the home. They had recently sought feedback from relatives, staff and health care professionals via surveys and were working on correcting any negative feedback.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection of Queensbridge House in September 2016 we rated this key question as requires improvement. This was because the home did not have effective quality auditing systems in place. At this inspection in October 2017 we found monitoring systems had improved which had identified some shortfalls. However further improvement was needed in the auditing and monitoring of people's care records. We have again rated this key question as requires improvement.

Progress had been made to implement a new quality auditing system based on CQC's key line of enquires to monitor and improve the quality of the service being delivered and provide staff with effective support and development. However, the system had not identified shortfalls in relation to people's care records and other gaps in the management and governance of the home. For example, the temperature of the medicines room and fridges were not consistently recorded, therefore the registered managers could not be assured that people's medicines were being stored in line with the manufacturers guidance. Fire drills were carried out by staff to confirm their knowledge of the home's fire procedures. However records of the fire drills did not always indicate if the fire drill had been effective as the fire drill times, response times and any learning as a result of the drills were not fully recorded.

The registered managers observed the skills of staff whilst they worked alongside staff delivering care. They told us they provided staff with on-going support and immediately addressed any observations of poor practices. However, staff's competency, knowledge and skills had not always been systematically assessed and recorded so that the registered manager could monitor whether the training and guidance staff had received had been effective in developing staff's skills in meeting people's needs. However records showed when poor practices were observed, the registered managers held meetings with staff to address their concerns.
The home's policies and procedures did not always reflect the practices in the home; however action was being taken to update the policies to reflect the practices in the home.

We recommend that the service seek advice and guidance from a reputable source in implementing effective systems in the monitoring of people's care records.

The registered managers told us they were taking action to improve the quality auditing tool to demonstrate how their assessment of the service was effectively being recorded, evaluated and actioned. One of the registered managers told us, "We are using a new monitoring tool which is central so we (registered managers) and the owners can see it. We are making adjustments as we go along. Definitely a work in progress but it will help us to highlight any concerns and record them." For example, a monitoring tool for the prevention of infection control systems in the home was being developed and implemented."

The registered managers were supported by representatives from the provider who frequently visited the home to monitor the quality of care provided and make recommendations. Records showed that there were regular maintenance and safety checks of people's equipment and the premises. A new call bell system had been installed which allowed the registered managers to monitor the response times of staff when people

used the call bell to alert staff for assistance. We were told the monitoring of the call bells would become part of the manager's auditing system to ensure people's requests for help were responded to in a timely manner.

Since our last inspection, a second manager had been employed and registered with CQC to support the established registered manager in their role. The registered managers had collectively reviewed and divided their management role to ensure the home was provided with suitable amount of management support and also be part of the staff team to deliver care and support to people. The registered managers explained how the dual role had been beneficial to themselves, staff and people. One of the registered managers said, "Splitting and sharing our role gives us both an opportunity to get to know the residents and also monitor the staff." It was evident that both registered managers knew people and their relatives well and were confident in their staff team. The new registered manager told us how they were being trained and mentored by the provider and the other manager to develop their management and leadership skills. Staff were positive about the new management structure and spoke highly of the registered managers. Comments included "Both managers are lovely, really nice. You can go to them with any issues"; "The managers are good. They will both roll their sleeves up and help out if needed" and "I do feel very valued as an employee here." They felt that new registered manager was a positive asset to the management of the home and reported that there had been an increase in staff meetings and an improvement in the communications from the management. The registered managers used staff meetings to evaluate and discuss people's needs and safety within the home. Relatives also complimented the managers of the home. One relative said, "I have every confidence in how this home is run. I have no concerns at all."

The registered managers promoted a positive and supportive environment for people who lived with dementia. The staff and provider had spent a considerable amount of time and resources to improve the lives of people in the home, but they were aware that further development was required. They had plans to develop a key working system to help drive improvements in line with guidance of supporting people with dementia as well as reviewing the role of senior staff. One visiting health care professional said "I love coming here because the managers 'get it'. They feel the same as me; people with dementia need meaningful, 'normal' things happening in their lives.''

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<br><br>People's care records did not consistently reflect their care and support needs and decisions taken in relation to their care.<br><br>The management and monitoring of people's risks and their medicines were not effectively recorded.<br><br>Some people's care records did not reflect the assessment of their mental capacity and their decisions in relation to their care and treatment provided. |