GCH (Queensway) Limited

Queensway House

Inspection report

Jupiter Drive
Hemel Hempstead
Hertfordshire
HP2 5NP

Tel: 01442266088
Website: www.goldcarehomes.com

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

Summary of findings

Overall summary

This inspection took place on 01 March 2017 and was unannounced. Queensway House is an 80 bedded care home for older people. It does not provide nursing care. There were 54 people living at the home at the time of this inspection. When we last inspected the service on 14 September 2016 the provider was not meeting the required standards. At this inspection we found that some improvements were made but the provider was still not meeting the required standards.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we found that there were not always sufficient numbers of suitable staff available to meet people's needs consistently across all areas of the home. At this inspection we found that staff were not effectively deployed across the home to meet people`s needs effectively and people`s dependencies were not correctly calculated to ensure these were reflected in staffing numbers. Safe and effective recruitment practices were followed to make sure that staff were of good character and had the experience and qualifications necessary for the roles they performed.

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had internally and externally to local safeguarding authorities. Risk assessments were in place to give staff guidance in how to mitigate risks to people`s well-being, however these were not always followed by staff in relation to pressure management and choking risk.

People who lived at the home and their relatives were positive about the skills and abilities of permanent care staff. However they were not as confident in the abilities and skills of the agency staff working at the home. Staff were trained and they felt supported by the management team at the home.

At the last inspection we found that food and fluid records were completed retrospectively, and where people needed their intake monitored, food records did not document the amount people had eaten. We found that this practice had not improved and staff who completed these records were not always the staff who supported people to eat and drink.

Queensway House has had a consistent registered manager, deputy manager and team leaders in post for a long period of time. In this inspection we found that the management team were not effective in Queensway House to implement and monitor the requirements from the inspection we carried out on 14 September 2016.

The standard of cleanliness in the home had improved. Some areas of the home were freshly decorated and there were no unpleasant odours around the home. However we found that the equipment used by staff to

assist people with their mobility like hoist and rota stand was not as clean as it should have been.

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

People were cared for in a kind and compassionate way by permanent staff who knew them well and were familiar with their individual needs, preferences and personal circumstances. We saw that most permanent staff members had developed positive and caring relationships with people who lived at the home. They provided care and support in a respectful way, however in many cases people`s dignity was not upheld, their clothes were stained, they had no socks on and their footwear had dried food stains. Staff were not always attentive to clean people`s face and mouth after they assisted them to eat.

People were able to decide how they wanted to spend their days. We saw people on the ground floor engaged in activities around the home, reading newspapers, listening to music and chatting with each other. However people living on the first floor whose dementia was more advanced had little access to other parts of the home.

The system of meetings was not effectively led by the registered manager who was not able to maintain an oversight of the issues within their own home

The registered manager was supported by the provider, the regional manager, the hospitality manager and a dementia manager to implement and sustain improvements to the quality of the care people received in Queensway House. In addition there was support from the local authority, home improvement nurse and the district nurse team to ensure the care and support people received met their health and social needs. However the registered manager failed to ensure that the improvements needed were successfully implemented and sustained.

People's medicines were not always managed safely. Medicine records were not completed accurately and not always signed by staff when they administered people`s medicines. When we reconciled medicines for people we found that the amount of tablets had not always corresponded with the amount on the medicine administration record (MAR).

At this inspection we found the service to be in breach of Regulations 8, 12, 10, 11, 18 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

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

Measures to mitigate Identified risks to people's health and well-being were not always followed by staff.

The equipment used to assist people with their mobility was not always clean and presented an infection control risk.

People`s medicines were not always managed safely.

Staff recognised and knew how to respond to the risks of abuse.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

The mental capacity act principles and the deprivation of liberty safeguards were not always followed and promoted by staff to ensure the restrictions on people`s freedom was in their best interest.

Staff had been trained in various subjects relevant to their role, however refresher training was not always considered by the registered manager in areas like pressure care.

Staff felt supported in their role by the management team.

People were supported to eat a healthy balanced diet that met their needs.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and supported in a way to promote their dignity.

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

People developed good relationships with staff who were kind and caring.

People`s confidential information was stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care from staff.

People had mixed views about the opportunities provided to pursue social interests and take part in meaningful activities.

Complaints were investigated and responded to in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager had not ensured that staff adhered to the ethos and values of the provider.

The registered manager has not ensured that people`s dignity was promoted.

The registered manager has not ensured that staff were effectively deployed to meet peoples` needs and that people`s dependency assessments were accurate.

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

The registered manager was supported by various members of the provider`s team to improve the quality of the service provided.

Queensway House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider met the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating under the Care Act 2014.

The inspection was carried out on 01 March 2017 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist adviser. The specialist advisor had the experience in nursing and healthcare, elderly and mental health care. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with eight people who lived at the home, two relatives and nine staff members. We also spoke with the registered manager, the hospitality manager, the dementia manager, the regional manager and the provider. We received feedback from health care professionals and the local authority commissioners.

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

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in Queensway House. One person told us, "I feel safe. I have always been happy and comfortable here." Another person said, "I feel 100% safe and sound here." Relatives told us they felt people were safe and well looked after.

At the previous inspection we found that risks to people's wellbeing was not always safely managed. Where people had sustained injuries like skin tears or bruising not all of these could be linked to a fall or an incident. Some of these injuries had no explanation of how they happened and there were no investigations carried out to try and establish the cause and prevent it from happening again.

At this inspection we found that further improvements were needed to ensure that risks to people`s health and welfare were sufficiently mitigated. For example, we observed a person at high risk of falls. Their care plans detailed actions the staff should take to try and prevent the frequent falls this person experienced. These included observations from staff, the use of an alarm mat and a crash mat when the person was in bed. We found that although all these actions were in place the person continued to fall in the communal area where they should have been observed by staff. The person had three falls in February 2017 two in their bedroom and one in the lounge area. There were no observation records and the falls were not witnessed which suggested that staff were not always present in the communal areas to observe this person. Although the risk assessments were reviewed monthly there was no analysis on how effective these measures were and the person continued to have falls.

During the inspection we observed people whose care plan detailed they were high risk of falls and staff had guidance in what measures they had to follow to ensure the risk was mitigated. Staff were prompted to check if people were wearing appropriate footwear and if they had their glasses on. We observed that this was not consistently followed by staff. For example on the day of the inspection we observed that a person who was at high risk of falls was not wearing their glasses and was wearing ill-fitting slippers instead of shoes as identified in the care plan. When we discussed this with a staff member they told us they noticed this and they had changed the person`s footwear. However this meant that not all the staff were aware and knew what measures to take to mitigate the risks for people.

We observed another person having their breakfast assisted by staff. One person required thickener to be added to their fluids due to swallowing difficulties. They also required a pureed diet. The thickener guidance in the person's care plan was recorded as two scoops for 200 millilitres of liquid. However, one staff member told they had to put one or two scoops in a glass of liquid, and a second staff member told us it was only one scoop. We observed one senior care staff member assisting the person with apple juice from a glass with no thickener added, placing the person at risk of choking. When they later gave the person a glass of water, they put three quarters of a glass full of water and one spoonful of thickener. When we measured the quantity of water a glass held, we found it to be 150 millilitres; so once again, guidance for this person's fluid was not followed. This person`s care plan detailed that they had input from the GP, the dietician, the speech and language therapist (SALT), the family and the chef. Records of swallowing difficulties including choking were kept by staff detailing the number of times when the person showed signs of choking whilst being assisted

to eat. For example there were records about the person coughing, turning red, gurgling and gasping for air. However staff had not reported these incidents to the registered manager or the SALT team to ensure the person`s diet could be reviewed and the risk was mitigated further. We saw they had baked beans in the morning in the bottom of their food protector, suggesting they had been given solid food, placing them at risk of choking, staff did not know if the person had beans for breakfast.

People who were at risk of developing pressure ulcers had detailed plans in place for staff to know how to recognise and report when pressure ulcers started developing and how to mitigate the risks effectively. People had pressure relieving equipment in place like pressure relieving cushions, mattresses and air boots to protect their heels, and where they required regular repositioning this was carried out in accordance with their care plan. We found that staff had not always ensured that people who were assessed by health care professionals as needing pressure cushions where actually sat on one. For example we observed a person whose care plan detailed that they had to sit on a pressure relieving cushion to prevent their skin breaking down, however they had the pressure cushion placed behind their back.

Several staff members and the registered manager walked past the person during the morning and had not noticed that they were not sitting on it. This was only rectified after lunch; however the person spent a considerable amount of time without the right equipment in place to keep them safe.

We found that the lack of effective risk management regarding falls, choking and pressure care was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe.

We looked at how information in medicine administration records and care notes for people living in the service supported the safe handling of their medicines. Medicines were stored safely for the protection of people who used the service and at correct temperatures. Staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks.

Medicine administration records (MAR) did not confirm that people were receiving their medicines as prescribed. When we compared medicine records against quantities of medicines available for administration we found discrepancies. For example for two people the quantities of their medicines we found in the medicine trolley had not corresponded with the amount recorded on their MAR. We found that for one person who was in hospital staff had placed a box of their medicine in the medicine trolley. Although this person was in hospital their medicine box was opened and 12 tablets were missing from the box. We asked the team leader about this; however they had no explanation of what had happened.

We found several gaps in people`s MAR`s where staff either administered people`s medicines and didn't sign the charts or they haven't signed because they didn't give people their medicines. There were no detailed explanations for these gaps on the back of the MAR charts and therefore we could not establish what had happened. When staff started a new medicine cycle for people they had not always carried forward the amount of medicines left from the previous cycle. This meant that we could not check if the amount of medicines were correct.

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

At the last inspection we found that there were not enough skilled and experienced staff to meet people`s needs at all times.

At this inspection we found that there were more permanent staff employed at the service, however there were still staff vacancies which were covered by agency staff. People told us they felt permanent staff were more able to meet their needs safely and effectively. One person told us, "I don't like the agency staff as much as the regular ones things are not done the same with them but they have to be here because they [permanent staff] are so short staffed." Another person said, "I have a buzzer but never pressed it to be honest, I do think they are short staffed but the regular ones seem to know what they are doing some better that other's."

Staff told us that staffing levels improved and they were short staffed only if due to short notice for staff absence the shift could not be covered by agency staff. One staff member said, "Agency use dropped and it is better with more permanent staff working. We are short only if staff rings in sick on short notice." However staff also told us that they were not always able to accommodate people`s preferences and wishes because of the lack of time. One staff member said, "Sometimes we have to get people up at night to help the day staff out, we need to have breakfast done by 10:30 which means everyone needs to be up and ready." Another staff member told us, "The seniors will tell us at night who to get up, that does mean at times people are not happy, but we don't have the time to get everyone up. [When they prefer]" A third staff member said, "Staffing is usually okay, we have 5 at night now and in the morning is six carers. We don't have as many residents so it is better, but we still don't have the time to interact properly with them [people] as the staffing is just enough and there is always too much paperwork to do."

We observed how staff was working throughout the day of the inspection. We observed that they had been busy throughout the day, however they attended to people`s calls in a timely way. This was confirmed by people we spoke with. One person told us, "I haven't rang my buzzer while I have been here but I'm sure they would be quick to come to me". Another person said, "I have rung my buzzer a couple of times and they weren't too long in coming to me." When we checked the rotas provided to us by the registered manager we found that on the day of the inspection there were more staff working in the home than listed on the rota. For example, a team leader was not entered on the rota for the day of our inspection and was working from the morning throughout the evening. This pattern was reflected for a senior care staff who also was not on the rota for the day we inspected. This meant that we could not establish if the staffing was effectively planned because the rotas were not a true reflection of the number of staff working in the home.

We observed that during busy periods like meal times the deployment of staff was not as efficient as it could have been. For example at breakfast we observed the main dining area which was a considerable sized room to accommodate the majority of people who lived in Queensway House had only one staff member allocated to serve people their breakfast and assist people who needed help eating. There were 11 people were in the dining room when we observed in the morning, six people clearly required assistance, either with eating or with prompting. This meant that people who required assistance had to wait their turn when the staff member had the time to sit and assist them.

We also saw several staff members in more senior position who were occupied with tasks which were not time specific, like updating care plans whilst people had to wait for assistance to get their food. For example a person came into the dining room and asked for a cooked breakfast. They were given this as requested, however, were seen to push the food around the plate for twenty five minutes. The team leader was sat at the same table, however they were completing paperwork. The person was later offered a refresh of their meal, but this was egg on toast and not the meal they had initially chosen. We observed a staff member assisting two people in the same time. They were seen to be assisting one person with a drink whilst helping a second to eat their meal. One of these people had significant needs in relation to swallowing and required close monitoring, however they did not receive this as required.

At lunchtime, we observed there were 33 people in the main dining room. Only three members of staff were assisting people along with the hospitality manager who did not assist, but ensured the tables were laid and salt and pepper was on the table. People who required prompting and assistance did not receive this when required. For example one person sat for 15 minutes taking small mouthfuls and pushing food around their plate. Staff then took the meal away with only a quarter being eaten and not checking if they required an alternative. The same occurred for a second person, at the exact same times as the previous, after 15 minutes, food was removed.

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

When we previously inspected the home we found that the environment people lived in was not sufficiently clean. Carpets were discoloured and heavily stained throughout the home. Throughout the home we saw liquid and splashes on the walls. People were not regularly supported to use the toilet or have personal care and their clothing had an unpleasant smell.

At this inspection we found that the environment was clean and there were no unpleasant smells around. Corridors were freshly painted and the general appearance of the environment had improved. However we found that the equipment used by staff to assist people with their mobility like hoist and rota stand were not clean and had ingrained food debris on the foot plates. The carpets were due to be changed on the day of the inspection and this was re-scheduled to a different day to minimise the disruption on the day.

At the last inspection we found that out of the 61 staff listed on the provider`s training matrix only 26 had received infection control training in the last two years and 10 staff had been enrolled for upcoming training. At this inspection we found that 36 staff had received infection control training; however there were still 15 staff members who had not been provided with this. This was still an area in need of improvement.

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had to the relevant local safeguarding authority, which included by way of 'whistleblowing' if necessary. However we found that out of the 61 staff listed on the providers training matrix only 37 were evidenced that they had safeguarding training. This was an area in need of improvement.

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

Requires Improvement

Is the service effective?

Our findings

People told us staff asked them for their consent to care before they carried out any tasks. One person told us, "They [staff] ask me if I want this or that, and they listen." However as we reported in the previous inspection people were not aware they had a care plan or what this contained. One person told us, "I have not been asked to sign anything I don't know about my care, my doctor might." Consent to care was not always documented in people`s care records.

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

At the previous inspection we found that mental capacity assessments were not always consistently carried out for people who had a diagnosis of dementia and they may have lacked capacity to take decisions regarding their daily care needs. Best interest decisions were not always documented to evidence the process of options considered before a decision was made in people's best interests.

At this inspection we found that these issues persisted and mental capacity assessments were not consistently carried out. For example, where people were administered medicines covertly there was no mental capacity assessment done to evidence that people`s capacity to understand and take an informed decision about accepting their medicines or not was assessed. There was no best interest meetings documented to reflect what other options were considered before the best interest decision was made for a person to receive their medicines covertly. For example, for one person there was a covert medication administration record signed by the person`s GP, pharmacist and the person`s family members. This record listed the medicines this person received because of their health covertly. However there was no mental capacity assessment done to assess if this person had capacity or not to understand why they needed their medicines.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted deprivation of liberty applications to the local authorities for people who had limitations to their freedom in place to keep them safe. We found that for some people these applications had already expired and needed re-submitting. We also found that the reason listed for the requested authorisations was only that people needed constant supervision and they could not leave the building without supervision. However we found that some people living in Queensway House had behaviour which could have been challenging and they often refused personal care. There were no plans for staff to follow to use the least restrictive methods to ensure that these people`s personal hygiene needs were. The DoLS authorisations had not included all the actions staff were taking like administering covert medicines to people and offering personal care to people when this was not agreed by them. This meant that people`s human rights were not upheld as this decision

had not been legally authorised under the MCA.

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

People and relatives had mixed views about the skills and abilities of the staff working at the home. One person told us, "I like living here I just wish they were the same girls all the time there are some who just help out [agency] and then the other's [permanent staff] they seem more skilled you know looking after the people in wheelchairs and who need lifting [hoisting]. They seem to know what they are doing I haven't seen anything go wrong." Another person said, "I can wash myself I sometimes need help and they [staff] will do it, they wear gloves when they wash me but encourage me to be independent." One relative told us, "I am Impressed with the changes I am seeing, yes, I think they [staff] are skilled at their jobs I have seen people being hoisted and they seem to be doing it right, if I have asked for anything to be done for [person] they have done it."

Staff members told us they were offered more training and they felt that recently there was more support from the managers. One staff member told us, "The training is easy to understand, supervisions are now starting to happen regularly over the last couple of months, I feel supported by my team, definitely." Another staff member said, "We are offered more training now, which is good." Newly employed staff confirmed they had induction training and shadowed more experienced staff member for a period of time until they were confident working unsupervised.

However we found that not all the staff were trained and skilled to ensure the care and support people received was consistent. Not all the care staff received training in all the areas of care they provided to people such as continence care, behaviours that challenged and pressure care. These areas were not considered by the provider or the manager to be mandatory for staff. For example, 43 staff were listed on the training matrix as relevant to receive pressure care training as a non-mandatory subject, however only 21 staff had completed this. None of the staff received behaviours that challenged or continence management training. We found that some people who lived with dementia in Queensway House had behaviours which challenged and staff had little guidance in how to effectively manage this.

Since the last inspection the majority of staff had received a supervision meeting with their line manager. However appraisals for the 2016/17 year began on 25 February 2017, meaning staff had not had an effective assessment and review of their professional development.

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

People spoke positively about the food saying it was good and there was a good choice. One person told us, "The meals are good there is a choice and normally we get menus on the table now, I never feel the need to ask for something else to eat once I have eaten but I'm sure they [staff] would make me something like a snack if I did." Another person said, "The food is excellent it went down for a while I think the cook was off poorly but it seems nice now." A third person said, "The food is good always plenty to eat you don't go hungry here." On the day of the inspection there were plenty of drinks available and people in their rooms had a jug of water and a glass if they wanted a drink. There were fruit bowls with bananas, apples and crisps in the public areas and we saw people helping themselves when they wished.

Before meal times the tables in the dining rooms were nicely laid with written and pictorial menus on the table as well as condiments. People were offered a choice of drinks to have with their meals. Staff offered

visual choices for people who lived with dementia to help them choose the meal they wanted.

The main dining room had an open plan kitchen; food was distributed to staff who then served people at the tables asking them what they would like from the menu. Three staff members were allocated to assist people who required assistance out of the 33 people sitting in the dining room and other staff were seen taking meals to people who were in their rooms or seated in other parts of the home.

We observed the hospitality manager approached a visitor asking them if they would like to have lunch with their relative whilst they were overseeing the food service.
People had their weight monitored regularly and staff used a tool to identify if people were at risk of malnutrition (MUST). People`s care plans provided detailed instructions to staff regarding the needs of people as far as the provision of food and nourishment was concerned. There was also information about the person's preference. There were different textures of food available for people to meet their dietary needs including soft diet, puréed diet and fortified diet. Some people with risk of malnutrition were provided with food supplements. Care records showed specialists such as dietician, chef and speech and language therapist involvement in the planning and monitoring of the delivery of support needed to ensure that people`s nutritional needs were met.

Staff were knowledgeable about of the health need of the people they supported. One staff member told us, "The people here see their GP regularly. We [staff] make appointments for them when it is requested by them and by the relatives. When we have any concerns about the people we also contact the GP."

The records showed that people were seen regularly by health care professionals about their general health. Records showed referrals to physiotherapists, occupational therapist, tissue viability nurse, speech and language therapist, dietician, mental health team, social workers, district nurse, pharmacist, dentist and chiropodist. There were records of regular follow ups and interventions by relevant professionals. For example a person with problems with their feet was seen regularly by the chiropodist. The dietician was a regular visitor, advising the staff on people's diet. The district nurse and the home improvement nurse from the local clinical commissioning group (CCG) also advised staff on the prevention of pressure ulcers.

At the last inspection we found that the general condition of the building was not well maintained. The dementia unit was not decorated to reflect best practice for people with dementia offering little to provide stimulation or interest. Within the whole home, we found walls that were scuffed, areas requiring redecoration and numerous carpets in people's rooms and communal areas were in poor condition or soiled.

At this inspection we found that several areas of the home including some of the bedrooms were decorated. The corridors were freshly painted and there were some new decorations on the walls. The carpet has been scheduled to be changed on the day of the inspection and this was delayed for a couple of days to lessen the disruption. The provider extended the main dining area on the ground floor to ensure the majority of the people living in Queensway house had a nice restaurant like area where they had their meals. Tables were laid nicely with table cloths and condiments on the tables to create a welcoming atmosphere.

The dementia environment upstairs improved with each bedroom door painted in different colour to make it easier for people to find their room. The unit looked much brighter with freshly painted walls. However further work was needed to ensure people had more objects of interest around the unit which could have triggered memories from the past to give people the opportunity to reminisce about past times.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were very good and kind. One person told us, "I'm very happy here let's put it this way I wouldn't live anywhere else I don't know what I would do if I didn't live here, I think they know me, they call me by my name, have a chat, they know which things I like and they know that because they ask me, they do encourage me to be independent and I like that." Another person told us, "I think they care for me in a genuine way the girls are lovely stop and have a chat to me I like to sit here they all walk past me, I don't think there's anything I would like to change about the place."

We saw that staff members developed positive and caring relationships with people who lived at the home. They called people by their first name and were respectful when talking to people. However the care and support people received in Queensway House did not always promote their dignity.

Upon arrival at Queensway House we saw in the dining area people sat in an undignified manner. One person was sat in their nightdress and overcoat with food staining to the lapels, with no socks or slippers on, their hair had not been brushed. A second person was sat asleep in their chair with a white liquid trickling from their mouth and pooling on their tabard and lap. They were sat like this unaided for ten minutes. We spoke with the hospitality services manager, and pointed this person out to them. However they told us that they did not provide care so did not assist the person. The staff returned in the dining room and continued to give people drinks, however their failed to address the undignified manner they were left in with foodstuff and liquids on their tabards and clothing.

Throughout the morning of the inspection we observed several people whose clothing was not clean, had stains and marks on it. One person was sat in a chair outside the registered manager's office, and they remained in stained clothing throughout the inspection. Staff told us the person was reluctant to let staff take their clothes to be washed, however there was no plan to address this. People were seen without socks and wearing slippers which had dried food stains and looked unclean.

The regional manager proudly showed us how the home had developed their own dignity tree, which was a set of statements that all those at Queensway House were to aspire to. For example, it noted, "Support people with the same respect you would want for yourself or your family." We saw that the rhetoric within the dignity pledges were not carried through by staff in practice.

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

People who lived at the home did not recall having been involved in planning or reviews and most knew little about what their own care plans contained. One person told us, "When I first came they took into account my likes and dislikes but since then no one has ever asked me if I want anything different." Another person said, "When I first entered the home I was involved with my care-plan (if that's the name) you know telling them my likes and dislikes I remember that but not been asked since to be part of any discussions. I have been here about four years." Relatives told us they had been involved in the planning of their relative`s

care when they first entered the home. One relative told us, "Only on [person`s] entry to the home I was involved in all the planning for their care here."

Reviews of the care plans were done monthly by staff and did not evidence people`s involvement.

Friends, relatives and carers of people who lived at the home told us there were no restrictions as to when they visited and that they were always made to feel very welcome."

Requires Improvement

Is the service responsive?

Our findings

People told us staff gave them choices and respected their preferences. One person told us, "I consider myself lucky' I'm not frightened to give my opinion on anything they [staff] give me confidence and that's the way they [staff] make me feel, I can go to bed when I want and I get up when I want to have a wash go for my breakfast, what more do I want." Another person told us, "I only need help with a shower and they [staff] never refuse, I wouldn't say they [staff] encourage me to be independent I just do it, I can go to bed when I want but they do ask me to turn my radio down sometimes."

Care plans were not effectively completed or reviewed. Only two of the staff had received training in relation to writing care plans, and for those people who lived with dementia staff had not had training in managing challenging behaviour. The records we looked at demonstrated this lack of awareness. For example, one person`s care plan completed on 27 December 2016 identified, "[Person] is very physically aggressive, this is unpredictable but very frequent." Within this care plan staff referred to a different person`s name, suggesting that the information had been copied and pasted from another care plan. One of the risk areas identified that the person liked to wander around the unit. However the global chart records detailed that they were unable to walk without two staff`s assistance. When addressing how to mitigate the person`s behaviour, the care plan recorded, "We have found no approach or strategies that diffuse or prevent aggressive behaviour. But all staff on one to one with [Person] must try different distraction techniques in the hope that we find something that is effective." This meant that there was not a consistent approach from staff and management to develop a collective and structured approach and monitor the outcome for people.

People gave us mixed feedback about the opportunities offered to them to join in activities. One person said, "I like knitting there is some wool in one of those drawers over there so I do a bit if I feel like it. There is not much else, not everybody wants to go on trips. I do like bingo when they [staff] do it". Another person said, "I have been on a few trips they [staff] do a bit of entertaining in here but most of the day I'm bored that's why I sit here (long corridor) everybody passes by here."

People's care plans had recorded in them people's preferences, hobbies and past life interests, but there was very little to demonstrate how staff supported these. One person who liked going out was taken out by their relatives and staff occasionally in the garden. Staff providing activities held a leisure and social activities group session where they gathered ideas from people living in Queensway house about what leisure and social activities they wanted. This meeting was held on 06 January 2017 and we found that some of the suggestions people made were being planned by staff.

On the day of the inspection there was a sing a long session in the dementia unit in which many of the people got involved together with the staff. Music and Television featured highly on the activities on the day of the inspection. There were very few individual activities observed. People did not have individual activity programme records to indicate that they had individual sessions according to their preferences. For example, one person was a seamstress, loved to knit and cook and enjoyed being creative. From July 2016 there were no records to demonstrate that staff provided any activity that met this person`s personal

preferences. The person was sat in the lounge to watch television, or had their nails painted, but nothing to encourage them to maintain hobbies and interests that were of interest to them. We saw similar examples in the other care plans we looked at. Recent group activities were things such as Chinese evening, games, movie nights and trips out locally. There was also a day trip planned for a few residents on the day of the inspection, and the dining area downstairs and adjoining living room had a sociable feel, people were talking, laughing and appeared to be at ease. This was an area in need of improvement.

Most people told us that they never complained and could not give us feedback about if their complaints would be listened to. One person said, "I haven't complained about anything I don't like to make a fuss, I would say so if there was anything I didn't like." Another person told us, "I have not been told who to complain to, and have never been to any meetings since I have been here, I am happy here if there was something I didn't like I would say so. The manager is very approachable."

Relatives we spoke with told us they were not attending meetings at the home. One relative said, "I was called to a meeting at the beginning of December [2016] I was introduced to the people who were going to be making some changes and a dementia specialist, but prior to that not been called to any meetings." Another relative said, "We were called here for a meeting end of last year they [provider] showed us a letter from CQC that highlighted problem areas, they showed us on a laptop what improvements they were going to make." We found that the registered manager was advertising the meetings for relatives in advance and the meetings held at the beginning of December 2016 was organised by the local council. At this meeting the provider shared their improvement plans with relatives.

Complaints that we looked at had been investigated and responded to, with the registered manager following up the outcome with either the person or the relative. The majority of complaints referred to missing items or laundry issues. The provider tracked each complaint raised as part of their monthly monitoring, and the regional manager reviewed complaints as part of the regular visits to the home.

Requires Improvement

Is the service well-led?

Our findings

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

At this inspection we found that the provider had made improvements and offered support to the registered manager to make the improvements needed. They employed a hospitality manager to improve the meal time experience for people; and the estates team had improved the environment and the décor throughout the home. The provider also employed a dementia specialist to improve the quality of the care and staff`s understanding about the needs of the people who lived with dementia across all their homes in Hertfordshire.

We found that the ethos of the provider was not followed through by staff. Through discussion with the inspectors, the provider told us they had made significant changes to the dining experience, and that their ethos was that the meal times were protected to ensure people had a good nutritional intake without disruption and they benefitted from staff`s prompt attention and time. They told us that staff were expected to assist people on a one to one basis with their meals, giving them their complete attention. This approach however was not adhered to during the morning, and only became visible when the provider visited the home and was present throughout lunch.

As a new initiative the provider held meetings to raise awareness of dignity in care and they adopted the concept of creating the dignity tree in the home. However these were not areas where we found that the provider's view of how dignity was managed was being adopted by staff across the home. The measures in place to monitor and improve how people's dignity was maintained were clearly not effective in identifying on-going concerns.

The provider had introduced dignity champions into the home, and had organised a local dignity network meeting for staff across the local homes to meet and share practice ideas together. Three staff members attended this meeting from Queensway House. Within this meeting, discussions were held regarding challenging undignified care when observed by the champions, particularly if the staff they had to challenge were seniors to them. The network meeting, although new, had identified some significant challenges within staff teams around issues such as culture, differences within teams and lack of both confidence and awareness of the champions to challenge and reward good practice. A dignity day was held on 01 February 2017 where the champions were able to raise awareness of dignity within their homes and use the day to develop awareness among their teams. The meeting although in early stages demonstrated that the provider was looking at ways to empower staff teams to address issues in their homes and promote good quality care.

A dementia services manager had been recruited by the provider to support dementia care in each of their local homes. They spent time each week visiting and supporting staff, raising awareness of dementia care,

and providing training where needed. The provider was steadily introducing dementia champions into the home to continue to support and improve this development. Advanced national training in dementia was being sourced by the provider and the plans suggested that improvements were beginning to occur. For example, the dementia manager told us, "I am seeing positive changes, small, but positive. We have built a small sensory area upstairs, and for one person in particular, when their memories become upsetting for them, we take them in there and it has visibly made an improvement. Staff are beginning to look outside the box and moving away from task led care to using opportunities to engage with people and get to know them such as personal care or meal times."

However, they also told us in their opinion they would have the dementia floor downstairs, enabling people to have access to outside areas and be able to integrate more in the home. They told us they had raised this with the registered manager but they had declined. This was discussed with the provider as in another of their homes they had told us integrating people living with dementia had been a positive move, reducing the number of incidents in the home and giving people a better quality of life. We asked why this had not been incorporated across the organisation. However a dementia strategy based upon good evidence of improvement elsewhere had not been developed at the time of the inspection to ensure effective dementia care was in place and all the homes operated by the provider followed a single strategy.

We have also inspected other homes operated by the provider, and found that care plans were not accurate and not completed when required in those homes. We have been told by the provider that new care plan systems would have been implemented significantly before this inspection. However we found that new care plan systems continued to be an area that was not acted on. When we last inspected Queensway House, the provider told us the quality team was implementing a global care planning system. They were confident this system would be effective in planning and recording the care people required. However, the quality team then resigned, and a new regional manager was appointed. They told us, "We implemented a care plan system [at the last inspection] that did not work, so we are now implementing a new care plan, going back to what we used before, but taking out the volume." The provider continued to adopt a fragmented approach to managing the home, without having a clear strategy and organisational vision of the systems and tools for staff to use, leading to a lack of sustainability and a need for continued improvement.

Systems established in other homes operated by the provider were not successfully implemented at Queensway House. For example, the staffing dependency tool was being implemented, however at two of the providers other homes we inspected, this same tool was also, 'being implemented.'

Provider audits did not identify a lack of training in key areas for staff. For example training around supporting people's behavioural and personal care needs, or leadership training for those staff who supervised and managed others. The provider showed us a one year development plan for all Gold Care staff that addressed these areas, with training in areas such as leadership commencing in March 2017. However, given the issues identified at the last inspection the response to a lack of key skills for staff was not sufficient to ensure staff were appropriately trained and supported to carry out their roles. Where staff had not previously had an annual appraisal of the role, training in appraisals and competencies was not planned until July 2017, three months after the beginning of the appraisal year. The infection control audit was completed on 26 January 2017. The registered manager completed this audit and overall rated the home as 'Good' with the only areas of improvement around staff leaving the building with their uniform on and ensuring the home is clean and dust free. Our findings on the day of inspection did not support this assessment.

People's records were not accurately completed. We found several examples where information was

entered inaccurately. For example we observed the senior carer completing 17 people's food and fluid records. They were completing these after lunch for the entire day. The registered manager told us that all the people with a food and fluid chart had a recognised need to have this documented. However, the senior carer not only completed these retrospectively, but also completed the records of four people they had not assisted at all during the day, which was confirmed by other staff. When asked about this they said, "I have an excellent memory so can remember everything I give to them, I will then ask the other carers what the other people had so it will be correct." However, we saw that they noted that one person had eaten their meal, however we observed this person during meal times and they had not eaten the amount recorded. Also they recorded more fluid for one person when we observed the actual amount was less.

This meant that when health professionals such as the dietician or GP reviewed the food and fluids people had they would be unable to see an accurate picture of what people had eaten or drunk. When we alerted the registered manager to our concerns regarding recording of food and fluid, they went to investigate. Upon returning to the office they told us they had now reviewed the procedure for completing these records accurately, but had not considered why staff were completing them retrospectively, such as deployment levels or pressures on staff. They also failed to address the issue with the staff member. We later reviewed the medicines with a senior care staff member. We found a gap in the MAR, and when investigated found that the medicine had been given, but the MAR had not been completed. The staff member then signed the MAR in front of the inspector although the gap on the MAR was for the previous week. This demonstrated that staff were not considering that completing retrospectively is an unacceptable practice.

The provider had undertaken a range of audits of the quality of care provided in the home. Copies of these were available for December 2016 and January and February 2017 since the regional manager had been in post. These audits looked at a variety of areas relevant to people's care including care planning, safeguarding, nutrition, infection control, the environment, medicines, MCA and a general walk around the home and feedback from staff and people. The regional manager developed an action plan as a result of their visit for the registered manager to implement against agreed objectives. We saw that for every action set, the registered manager had initialled to indicate they were completed, even when they clearly had not been. For example in the audit completed in January 2017, an action had been to eradicate all agency staffing with a target date for review of 28 February 2017. The manager had signed to say this was completed on 28 February 2017, even though the February audit identified that further improvements were needed. It was clear from the auditing that the systems were not effective in monitoring or reviewing either the governance or day to day needs.

We found that in one audit in January 2017 the regional manager was the one who identified that a person who received end of life care had not had the right equipment for staff to be able to meet the person`s needs effectively. The regional manager had to ask staff to ensure a slide sheet (a sheet used for people who are nursed in bed to change their position) was available and that the persons repositioning was decreased from one hourly to two hourly as documented in the care plan.
These would be areas that effective governance from the home management team would be expected to pick up through daily review. Simple actions such as ensuring staff wear name badges had been a continuing issue raised at each provider audit. The regional manager as part of their visit also reviewed the efficiency of the medicines audit and made changes, along with identifying the times of meals required addressing. We found that the registered manager had not had a clear understanding of the concerns in their home, and we concluded that they relied heavily upon the deputy manager and team leaders, alongside professionals from both within the provider's team and external health professionals to identify and recommend areas for improvement. The registered manager was unable to express to us their visions for the service and how they would sustain the improvements required.

At the last senior staff meeting in Queensway House the registered manager did not attend. The meeting was covered and chaired by the deputy manager, although this was an ad hoc meeting organised to address concerns in areas such as people having sufficient toiletries, encouraging snacks and fluids, and completion of monthly updates in people`s care plans. An action plan was developed from this meeting, and one area noted as, "Staff to continue to show good evidence of choice, dignity and well-being." This was noted as completed on the same day as the meeting; however we found numerous examples where this had not been adhered to.

A general staff meeting was held on 14 February 2017. Once again the registered manger did not attend the meeting with their team and updates from the previous senior staff meeting and feedback from the dignity champions were not shared with care staff, even though the discussion at the dignity meeting was for this to be a standard agenda item in staff meetings. The last residents meeting was held on 03 February 2017.

When we looked at how information was shared in Queensway House, it was clear that there was a lack of organisation and structure, that information was not cascaded through from the provider to staff, or back up again to the provider. Significant developments in the home were not discussed, and those matters that were discussed were day to day issues such as ensuring toilets are flushed and people are monitored regularly. We saw no evidence through minutes, or from staff, that ideas were encouraged to be shared, and information was discussed regarding operational matters. The team leaders meeting however, held on 22 November 2016 did discuss the serious concerns raised by Hertfordshire Local Authority. Once again the registered manager was not present, and the meeting was chaired by the deputy manager. Issues identified in this meeting were, "Activities to be continued by all staff and recorded in residents care plan", "Continence issues, staff have a new regime and this must be adhered to" and "Team leaders to keep a check on how this is going and report to deputy manager." The action regarding activities was marked as completed and with regard the continence management the target date given was 14 February 2016, however this was not discussed at the general team meeting. The agreed action regarding continence management did not prompt the registered manager to consider staff`s training needs in this area.

The provider contracted an independent care provider association to carry out a satisfaction survey recently in Queensway House. Out of the numbers of people, relatives, staff and professionals contacted for their feedback on the service 40 percent responded. The author of the survey concluded in relation to the responsiveness of the survey that, "The survey noted that personalised care was practised but only 'If' people had the capacity to get involved with all aspects of their care, support and wellbeing." The responses of the survey were being evaluated by the management team at the time of inspection.

On the day of the inspection we received feedback from two members of the Local Authority`s Commissioning officers. They raised concerns with infection control in the home and told us they have seen unclean lap tables, toilet raisers with water in them, a service user on the dementia unit with finger nails covered in a brown substance and wheelchairs unclean with staining to the sides. They said they had observed safe practise with hoisting, but that agency staff were not friendly towards people. They were at the opinion that the infection control audit was not reflective of the service they saw, with the registered manager scoring themselves positively in the above areas.

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

The system of meetings was not effectively led by the registered manager who was not able to maintain an oversight of the issues within their own home. Underpinning the meetings held in the home, the provider held a regional meeting for home managers across the area. In this we saw the registered manager

discussed a recent safeguarding that they had found as a positive experience once raised. Although they shared this at provider level this was not shared as a learning opportunity for staff in Queensway House. At this meeting a corporate update was provided in person by the provider and senior management team. Issues discussed were around reporting, staffing and recruitment and an incentive scheme known as `perk box` was offered to staff to help the registered managers to retain their existing staff. The overall picture for the organisation was they had success with recruiting staff, particularly with regard to temporary to permanent agency staff. This was not discussed or shared within meetings with staff in Queensway House. This meant that the framework for meetings was in place, but not implemented effectively in Queensway House.

We found that the registered manager was not proactive in effectively using all the resources made available to them by the provider and implement the changes necessary to improve the quality of the care people received in Queensway House. We found that where the changes and improvements occur these were mainly down to the provider and the other professionals involved in the care and support people received.

This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we sent to the provider a requirement to provide the Care Quality Commission with specified information under Section 64 of the Health and Social Care Act 2008. We requested from the provider to tell us how were going to address the failings of the management team in Queensway House to make the necessary improvement.

The provider has sent us an action plan where they detailed that they recruited another manager to work alongside the registered manager and improve the standards. They also detailed how they were going to monitor and oversee the improvements.

At the previous inspection we found that notification of injury or risk of harm had not been submitted to CQC as required. At this inspection we found that the registered manager submitted the notifications as required in a timely way.

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 8 HSCA RA Regulations 2014 General The registered manager was not proactive in effectively using all the resources made available to them by the provider and implement the changes necessary to improve the quality of the care people received in Queensway House

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that the principles of the Mental Capacity Act 2005 were followed and the care and support people received was in their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risk to people`s well-being were sufficiently mitigated. The provider failed to ensure people received

their medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the systems and processes in place were effective in assessing, monitoring and improving the quality and safety of the care people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of skilled staff deployed at all times in the home to meet people`s needs.