Lancewood Limited

Queens Oak Care Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 30 June 2015 and was unannounced. Our last inspection took place on 5 November 2013. We found at that inspection that the home was meeting the regulations inspected.

Queen`s Oak Care Centre provides nursing and personal care for up to 88 older people, some of whom are living with dementia. At the time of our inspection there were 83 people living at the home.

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

People received safe care as risks were assessed and managed. Staff were knowledgeable about keeping people safe from abuse and how to report concerns.

People received their medicines when they required them.

Summary of findings

Staff were well supported and trained to undertake their roles. They referred people to specialists if they needed additional health support and followed advice provided.

People enjoyed their meals and they were designed to meet their health, nutritional and cultural needs. Staff provided people with enough to eat and drink.

People and their relatives said staff were caring and compassionate. They had the opportunity to give their views about how they liked to be cared for. People's privacy and dignity were protected. Staff provided good quality care at the end of people's lives, taking their wishes into account.

Staff provided care which addressed people's individual needs. People had the opportunity to join in activities which had been designed to reflect their interests.

The home was managed well and checks were made by the manager and the provider to make sure good care was provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Risks were assessed and managed. Staff were knowledgeable about safeguarding people and knew how to report concerns.

People received their medicines as prescribed.

Staff were checked and references obtained to make sure they were suitable for their roles.

Good

Is the service effective?
The service was effective.

Staff were trained and supported to do their jobs. Staff liaised with health professionals and followed advice to look after people well. Staff supported

people to get medical attention when needed.

People enjoyed the meals and menus took into account their preferences and their cultural, dietary and nutritional needs.

The home met their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?
The service was caring.

Staff were kind to people. They supported people to say how they wished to be cared for and followed their preferences. People's privacy and dignity were protected.

The home provided compassionate care for people at the end of their lives.

Good

Is the service responsive?
The service was responsive.

People's individual needs and wishes were considered when staff were caring for them. People knew how to complain and any concerns were investigated thoroughly.

There was a range of activities which people enjoyed, including exercise sessions based on ballet and specialist activities for people living with dementia.

Good

Is the service well-led?
The service was well led.

People, staff and their relatives were asked by the managers at the home to give their views about how the home ran.

Managers and the provider's representatives did checks to make sure people received good quality care.

Good

Queens Oak Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 30 June 2015 and was unannounced.

An inspector, a specialist professional advisor who was a nurse and an expert by experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home and notifications we had received. A notification is information about important events which the home is required to send us by law.

While we were at the home we undertook general observations in communal areas and during a meal time.

We used the Short Observational Framework for Inspection (SOFI) at the mealtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people living in the home and with two visitors. We spoke with nine staff members including, the clinical manager, team leaders, the activity co-ordinator and care staff. The registered manager was on leave when we visited and the clinical care manager assisted us with the inspection. We also met with the regional manager and two development managers.

We contacted eight health and social care professionals involved in the care provided to people at the service and received feedback from four. We met three health professionals while we were at the home. We viewed personal care and support records for eight people, and viewed recruitment records for three staff and training records for the staff team. We looked at other records relating to the management of the service, including accident and incident forms, complaints records and audit reports.

Good

Is the service safe?

Our findings

One person said the staff were “all very good people”, another one said there was no bullying from the staff as “you don’t get bossed around”. A relative told us the person they were visiting was “safe and secure” in the home. A professional involved with the service told us the home was “good at picking up when someone may be at risk of abuse or exploitation” and taking the appropriate action to protect them.

People were kept safe. Staff had received training in safeguarding people from abuse. They were knowledgeable and could describe the different forms of abuse. They were clear about the action to take if they felt anyone was at risk of harm and felt confident that if they told managers about concerns they would report the matter for further investigation by the local authority safeguarding team. Staff knew how to use the organisation’s whistleblowing procedure when necessary. The staff team had been trained in equality, culture and diversity issues. This assisted staff to have an awareness of discrimination and the harm people could experience as a result.

People were protected as risks were assessed and plans put in place to manage them. These included risks presented by falling, developing pressure ulcers and associated with medical conditions such as diabetes. For example if a person was judged to be at high risk of developing pressure ulcers they were supplied with appropriate equipment such as pressure relieving mattresses and cushions.

Staff had received training in fire safety, first aid, health and safety and how to respond in an emergency. This helped to protect people from risks in emergency situations. Checks were made to ensure fire safety systems were working properly and a fire risk assessment was in place. There were arrangements for the safe evacuation of people in the event of an emergency. Details of these were included in individual files and on a planning tool to be used in emergency situations.

People received their medicines safely as prescribed. Medicines were stored securely. The managers and senior staff made regular checks to ensure people had received their medicines correctly and that records were correct. Staff were knowledgeable about people’s medicines. They had completed medicines administration record (MAR) charts appropriately. The MAR charts showed people had received their medicines as they were prescribed.

Staff managed situations when the behaviour of some people could have led to conflict with others living at the home. We observed a situation like this during our visit. Staff were aware of the signs that a person was becoming distressed and responded quickly and gently to distract them and prevent further upset.

People were cared for by staff whose suitability for their roles was checked through safe recruitment processes. We looked at three recruitment records and found appropriate checks and references were taken up before staff began work at the home. The checks included criminal records, a nurse’s registration with the Nursing and Midwifery Council and people’s employment history. Appointments to posts were confirmed when staff had successfully completed a six month probationary period.

Good

Is the service effective?

Our findings

Staff received training which assisted them to look after people well. One member of staff said "there's a lot of training" and said they found it helpful and relevant to their work.

Staff had completed training relevant to the needs of the people living at the home including dementia awareness, palliative care and customer care and communication. They had also completed a range of health and safety courses including safe moving and handling, food safety and hygiene and infection control.

All staff received regular supervision and an annual appraisal. These processes gave staff formal support from a senior colleague who reviewed their performance, identified training needs and areas for development. Other opportunities for support were through staff meetings, handover meetings between staff at shift changes and informal discussions with colleagues. Staff told us they felt well supported. One staff member said "I am happy in my work" and the support they received helped them to feel this way.

Care staff knew people's individual needs and preferences in relation to the meals. Care records included completed assessments to check if people were at risk of malnutrition. Staff had received training in using the 'Malnutrition Universal Screening Tool' (MUST) and used this to assess whether people were at nutritional risk. If they were, their meals were designed to increase their intake of calories, specialist advice was sought and records made of their food and fluid intake. A care plan of a person who had been identified as at high risk in relation to their nutrition stated a number of actions to be taken reduce the risk to their health. These included a GP prescription for them to be given nutritional supplements twice a day and to be given high calorie food items such as full fat milk. The person's weight was checked each week so staff could be alert to changes in the person's condition and take further action without delay.

Staff provided people with enough to eat and drink throughout the day. A choice of cold drinks was available in the communal areas and people were offered tea and coffee. People's drinks were in easy reach and re-filled. The ground floor dining room was decorated in the style of a café, and as a café service was provided people were able to go there at any time for a drink.

People could choose their meals from a menu which included photographs of the meals served so they did not have to rely on written or verbal information to make their choices. People's preferences and needs at meal times were met. People confirmed there were choices available if they did not like the food offered. At a meal we observed a variety of options were provided to take account of these. The choices at a lunch we observed reflected people's health and cultural needs and preferences.

People's opinions about the food were generally favourable, one person said "the food's tasty – I like it." Another person told us "The food's always nicely prepared". One person said they did not like everything on the menu although, "sometimes I'm happy with just jacket potato and salad, but they'll give me what I want." A visitor said their relative "had lost a lot of weight" before coming to live at Queens Oak and was pleased that "she likes the food here and she's gaining weight again." They felt this was a sign of their relative's improved health and well-being since living at the home.

A specialist nurse involved with the home said there was "lots of engagement with lots of professionals" and they felt this showed how the home promoted people's healthcare. They also stated that the "physical care of people is good". Staff were trained in using a pain assessment tool and this helped them to assess whether people were experiencing pain even if they were unable to tell the staff. The GP visited the home twice a week and issues of concerns were brought to their attention so they could review the person's condition.

A visiting health care professional described the home as "proactive" in addressing people's health care needs. They said the staff monitored people's conditions well and ensured they provided care in line with advice they and others gave. A professional who provided specialist support for people with mental health needs said "staff recognise people's trigger points and they try to provide the appropriate response".

The building was designed to assist people to get around. Bedroom doors had a memory box located next to them. The memory boxes contained personal items which can

Good

Is the service effective?

help people to reminisce and recall events and people from their past. We saw that one memory box included items including a model stethoscope which was relevant to the person's former profession as a nurse. There was a lift allowing access to all of the floors in the building for people with mobility problems and the corridors were wide and spacious which made access for wheelchair users easy.

Managers and care staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and had received training in when they were applicable. Applications to restrict a person's liberty under DoLS were made as required and, if granted, managers were aware of the need to review them after the specified time. We had feedback from the local authority that applications for DoLS were made appropriately and the managers were aware of their responsibilities under the legislation. Assessments of people's capacity were made in relation to specific areas of daily living. When people could not make decisions independently then 'best interests' meetings were held so decisions could be made on their behalf in accordance with the MCA.

Good

Is the service caring?

Our findings

People and their relatives told us that staff at Queens Oak were caring. One person said of staff "they are polite and genuine". A relative told us they were happy with the caring approach of staff and another described the staff as "kind and caring". A professional who visited the home told us "staff are compassionate".

Staff spoke with people in a warm and friendly way and people looked at ease with staff as they talked together. Staff used their knowledge of people so their conversations reflected their individual preferences. We observed that one man was addressed by their first name and another was addressed as "Mr..." Staff explained that this was in line with people's preferences. In another situation we heard a member of staff speaking a language other than English with a person living at the home. The staff member explained that the person could speak English fluently but they liked to speak their first language because "it reminds him of home" and as they shared the language they provided the opportunity.

People had developed friendships with other people living at the home. We observed people chatting informally together at lunchtime in one of the dining rooms. Two people began singing and others joined in. People looked cheerful and there was a relaxed atmosphere at the meal. A relative said: "It's very happy here. The staff are fantastic and always friendly…. I can see [my mother] enjoys it."

People's views about their care were taken into account and they were involved in decision making. They or their relatives were consulted about their care and their daily routines. One person said, "You can go to bed when you want and get up when you like." They said they used to do a job that that involved working late at night "so I often don't go to bed until 2am." Another person said she was able to choose how to spend her days, saying she goes "to my room and watch my favourite soaps" whenever she chose.

People's privacy and dignity were respected and all personal care was provided in privacy, with doors and curtains closed. People were assisted to dress well and in a way that reflected their tastes. They had the opportunity to have their hair done by the hairdresser who visited every week. Some staff had been designated as 'dignity champions'. This role ensured that they promoted practice which preserved people's dignity.

Staff provided compassionate care for people nearing the end of their lives. Staff had been trained and developed skills in this area. There were well developed relationships between the home, palliative care teams and the GP. They worked in partnership around people's care needs. People were offered the opportunity to make advanced care plans to detail their wishes and preferences. These were discussed with relevant people, including relatives and the GP and observed in practice.

The home had been awarded 'beacon status', which is the highest award given by the Gold Standards Framework (GSF) for end of life care in care homes. To achieve beacon status, a home must show innovative and established good practice across at least 12 of the 20 standards which are set by the framework. A professional involved with the service told us the home was "very good at [providing] end of life care". They said staff were skilled at recognising when someone was in the final hours of their life and they responded by one member of staff staying with them to provide individual care.

Family members visiting people near the end of their lives were able to use a room allocated to them. The room provided privacy and facilities for refreshments and people were able to stay overnight if they wished.

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the home to check their needs could be met there. The assessments were used to write care plans. A visitor said her relative's needs had been assessed and she was consulted to make sure the plan accurately reflected their needs and she was "happy with everything".

Care plans specified the tasks that people did and did not need help with so they maintained their independence but had the assistance they required. For example a care plan stated the person could wash their face and upper body and could brush their hair but they needed help with other aspects of personal hygiene. The notes showed care was provided taking this information into account. People were assisted to maintain their independence and provided with equipment appropriate for their needs. This included adapted cutlery and crockery, walking aids and equipment to assist with moving and handling and pressure care. Equipment was regularly checked to ensure it remained suitable.

Staff were alert to people's needs and people told us staff responded quickly to their calls for assistance. A healthcare professional involved with the service said the home had "a stable workforce" and said this helped the home to provide consistent care. They knew people well and so were familiar with the way they liked to be cared for.

A visiting professional told us they had "no worries" about the people living at the home as they felt it was "one of the best" they visited. They said nurses monitored people's conditions and specialist advice was sought when necessary. When people's conditions changed care plans were reviewed and changes were communicated to the staff team.

The staff gathered information as part of the assessments about people's culture, religious and social needs and arrangements were made to meet them. Religious services were held in the home and celebrations of special days and birthdays took place.

People had opportunities to take part in activities they enjoyed. There was a domino club which people joined in; some people did gardening and others borrowed books from a mobile library. We also heard that ballet sessions had been provided in the home and people particularly enjoyed them. Staff told us they believed people's balance had improved as a result of the exercise. Each week staff set up a 'fruit market' on the ground floor and people from all over the home visited. It was held on the day we inspected. Various fruits were on display for people to choose and take them away in brown paper bags as they would do at a market in the community. We saw people enjoying choosing the items and chatting with the activity coordinator who was the 'stall holder'.

Each day a session was held for people which used methods called 'Namaste'. This is a technique people with advanced dementia have been found to benefit from. There was a specially equipped room where group sessions could be held. Staff could provide individual sessions in people's bedrooms if they wished.

People had opportunities to let staff know their views about the care provided informally and at meetings for people who lived in Queens Oak. The meetings were held every two months. The agenda gave people the chance to give their views about the care they received, the meals, the activities and other items of general concern.

We asked three people what they would do if they had any complaints and they all said they didn't have any. When we asked another person if they knew who to complain to, he said he could speak to any of the staff who would "sort it".

Complaints records showed the manager made full investigations into the matters raised and apologies were made to complainants. Records showed that lessons were learned from complaints and improvements made to procedures to prevent the issue recurring.

Good

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the CQC. The manager was experienced and had worked at Queens Oak Care Centre for nine years. The registered manager was assisted by a clinical care manager who was a qualified nurse. Each of the four units had a team leader who was in charge of each shift, on the two units providing nursing care these were qualified nurses. People and their relatives understood the management structure and who to talk to about any concerns they had.

Staff told us they found the managers of the home "supportive" and they could "ask or call for help anytime" from the registered manager or the care manager. One of the staff members said "the [manager's] door is always open". Professionals who dealt with the home praised the approach of the managers there. One described the registered manager as "excellent". Another professional told us the home has a positive environment which "is led by the example of the managers".

There were monitoring systems which involved checks and audits of a range of issues in the home. These included medicines management, risk assessments, health and safety and care plans. The regional director visited the home frequently and provided management support. Staff and people living at the home were familiar with her and could raise concerns with her if they wished.

A development manager from the provider made unannounced visits and checked the operation of the home each month; their observations were used to assess people's quality of life. Their audits included surveys asking for the views of people and relatives about the quality of care provided and the quality of people's lives at the home. The quality of life assessments included issues of privacy and dignity. The reports showed that in most areas targets of performance had been reached but if there were areas for improvement suggestions were made for how to achieve it. Survey questions included whether people felt they were involved in decisions about their relative's care, had been informed about any changes in their relative's condition and felt their relatives were given emotional support by staff. In June 2015 all of the people who responded said yes to these questions and they achieved 100% satisfaction in these areas.

Notifications of events had been made to CQC as required by regulation. When necessary the manager took action to ensure that adverse events did not recur. For example in the case of a fall the person's risk assessment was reviewed and changes made as necessary.