Chestnuts (Arnesby) Limited

Queens Park Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Queens Park Care Home provides care and support for up to 16 adults with a learning disability, some of whom have additional needs relating to mental health and/or physical disability. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people living with autism and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance the Care Quality Commission (CQC) follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People did not always receive person-centred care and treatment that was appropriate to meet their needs and reflected their personal preferences. The systems in place to learn from incidents was not always used effectively to drive improvements.

Care plans and risk assessments contained contradictive information and had not always been updated to reflect people's changing needs, which meant staff did not have access to up to information about people.

Risk assessments and care plans did not contain enough guidance for staff to know how to respond to people's behaviour appropriately to keep themselves and people safe.

The provider did not use a systematic approach to determine staffing numbers to ensure they were safe and appropriate to meet people's needs. There was a high use of agency staff during the day and night shifts. The manager told us they were recruiting for more permanent staff to reduce the number of agency staff used.

Some areas of infection control and prevention practices did not follow best practice. Some staff were not wearing appropriate masks and we observed some staff wearing their masks below their nose. We saw some open waste bins, one containing discarded Personal Protective Equipment. (PPE).

There was no effective process in place to ensure that accidents and incidents, safeguarding incidents and complaints were analysed to look at trends and themes. The manager was addressing this to ensure lessons were learned when things went wrong.

Quality monitoring checks were not always effective at identifying areas that required improvements. For example, they had not identified the issues with out of date risk assessments and care plans. Records management was disorganised, and different records were stored in various areas. The manager had

identified this as an area that needed to be addressed.

People told us they felt safe living at the service. Staff told us they had completed safeguarding training and understood what whistle blowing was. They said they would report any matters of concern. Robust recruitment checks had been completed to ensure only suitable people were employed to work at the service.

The environment was visibly clean and hygienic. Housekeeping staff completed cleaning routines throughout the day of our inspection. All people using the service had in place a COVID-19 care plan, risk assessment and testing consent form. Staff were trained in infection control, hand hygiene and COVID 19.

Systems were in place to ensure the proper and safe management of medicines. People received their medicines as prescribed.

There was a manger in post who was in the process of registering with the Care Quality Commission. They were supported by a deputy manager who was four weeks into her role. We found they worked well together and shared the same vision for the service.

The manager had introduced some improvements at the service which staff were positive about. We found good working relationships with other health care professionals when people needed support with their care.

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

Rating at last inspection
The last rating for this service was Good (published 12 March 2019)

Why we inspected:
We received concerns in relation to the safe use of restrictive interventions and safeguarding people from abuse. In addition, we received concerns about a lack of staffing, infection control practices and a lack of training for staff to support people to manage their behaviours. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Queens Park Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified one breach of regulation in relation to good governance.

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

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Queens Park Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Queens Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have had a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection as well as recent safeguarding concerns that had been raised. We sought feedback from the local authority and other professionals who worked with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
On the day of our inspection we spoke with four people who use the service to gain feedback about their experience of the care provided. During the site visit we had discussions with the manager, the deputy manager and a senior staff member. We also contacted four relatives and six care and support workers by telephone to gain feedback about the service.

We reviewed a range of records. These included four people's care records and risk assessments. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance checks and safeguarding information was also examined during the inspection.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested records in relation to training data, behavioural charts, audits, the statement of purpose and a Speech and Language Therapy (SALT) action plan for one person.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risk assessments and care plans were not reviewed regularly and were sometimes contradictive. For example, one person's care plan recorded they were at very high risk of developing a pressure sore, but their risk assessment recorded this was a low risk.
- Another person was at risk of falling out of bed and had sustained a serious injury following a fall from their bed. There was a risk assessment in place for this person, but it did not mention the risk of falling from the bed. The risk assessment also recorded the risk as low.
- We saw that one person's mobility needs had changed but the risk assessment and care plan had not been updated to reflect the changes. This meant they were at risk of receiving unsafe and inappropriate care.
- In three care plans we saw that updates and changes to people's needs had been written on scraps of paper. These were at risk of getting lost and may not be read by staff. This meant people may not receive the care they needed to meet their needs.
- Risk assessments and care plans did not contain enough guidance for staff to know how to respond to people's behaviour to keep themselves and people safe. For example, in two behavioural care plans it directed staff to use distraction techniques, however there was no guidance about what those were.

The provider had not ensured people received safe care and treatment. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staffing and recruitment

- People told us there were enough staff on duty to meet their needs. One person said, "Yes there are plenty of staff to help us." Relatives felt unable to comment about staffing numbers because visits had been infrequent since the start of the Covid pandemic.
- Staff told us there were often staff shortages and a high use of agency staff. We found that agency staff were used to cover gaps on the staff rota where there were insufficient permanent staff available. One staff member told us, "The manager is doing the rota, and this has been a concern. Absences are not covered because senior staff can't call the agency directly to get agency staff."
- The behavioural chart for one person recorded that on several occasions they had become distressed when being supported by an agency staff and had requested a permanent member of staff to support them.
- In the behavioural monitoring chart for another person it recorded on one occasion they had become distressed and requested to go to bed. The recorded response from the staff member was to inform the person that they couldn't go to bed because there were not enough staff on duty.

● A dependency tool to assess people's needs and determine staffing numbers was being developed by the manager and the deputy manager. The manager told us the required number of staffing was five in the morning and five in the afternoon. The staff rotas demonstrated that there were numerous gaps in staffing numbers, and these had been covered with agency staff on most occasions.
● There were numerous occasions where the night shift consisted of three agency staff and one permanent staff member. This does not ensure consistency of care by staff who know people well and understand their needs and preferences. The manager told us they were in the process of recruiting more permanent staff to reduce the use of agency staff.
● The provider followed safe recruitment and selection processes to ensure the staff employed were suitable to work with people who use care services.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were not assured that the provider was using PPE effectively and safely. We saw that some staff were not wearing appropriate masks. The providers policy states that staff should wear a type II surgical mask. However, we saw that some staff wore fabric masks. In addition, we observed some staff wearing their masks below their nose which is not in line with best practice. We brought this to the managers attention and sign posted them to the PHE guidance.

Learning lessons when things go wrong
● Systems were in place to record accidents and incidents. However, there was no process in place to ensure that accidents and incidents, safeguarding incidents and complaints were analysed to look at trends and themes. The manager had already recognised this and told us they were going to implement a system to address this and share lessons learned with staff to improve practice.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at Queens Park Care Home. One person said, "Yes it's very safe here. There's always staff around to help."
● Relatives felt unable to say if their family members were safe because visits had been infrequent since the start of the Covid pandemic. However, three relatives told us they had no concerns about the care their family member received. The fourth relative said their family member always looked happy when they had face to face calls with them.
● Staff told us they had completed safeguarding training and understood what whistle blowing was. One told us, "I feel confident to whistle blow if I witnessed something was not right or proper."
● The registered manager was aware of their responsibility for making safeguarding referrals and reporting concerns to the Care Quality Commission (CQC) or other relevant authorities.

Using medicines safely
● There were systems in place to ensure the proper and safe management of medicines. Staff followed the provider's medicines policies and procedures which gave guidance to staff on the safe management of

medicines.

- Medicines were stored securely and safely at the correct temperatures.
- Protocols were in place and followed with regards to medicines prescribed 'as and when required'.
- The provider completed medicines management audits and any actions were identified and addressed.
- Staff received training in the safe administration of medicines to ensure people received their medicines safely.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

- The provider had not taken steps to ensure that risks to people were regularly assessed and their safety monitored. Risk assessments and care plans had not been reviewed and care plans updated to reflect people's current needs.
- Quality monitoring checks in place to assess, monitor and improve the overall quality of the service had not always been effective at identifying areas that required improvements. For example, they had not identified that staff were not using PPE effectively and safely.
- Records management was disorganised, and different records were stored in various different areas. The manager had identified this as an area that needed to be addressed. They told us they wanted to implement an electronic records management system to ensure records were easily accessible, and organised.
- There was no system in place to regularly assess people's needs and determine safe staffing numbers. This had been identified by the manager and deputy manager who showed us a dependency tool they were working on and hoped to implement it in the very near future.
- Systems in place to ensure lessons were learned and improvements made when things went wrong were not always effective in ensuring accidents and incidents were analysed and reviewed.

The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received specialist training to help support people living at the service which included Huntingdon's, Positive Behavioural Support, Epilepsy and First Aid.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The manager had been in post since August 2020 and was supported by a deputy manager who was four weeks into her role. We found they worked well together and shared the same vision for the service.
- People and relatives we spoke with were overall positive about the service and said the staff were open and friendly. One person told us, "[Name of staff member] is very good. Very helpful to me." A relative commented, "I'm happy where [name of family member] is and I know they are getting the best care. Staff know how to manage [Name of family member] mental health needs. They keep me updated as I don't visit

often."
● Staff gave mixed views about the leadership at the service. Comments included "I feel [manager] has been open from the start with me. Changes have been introduced to make it better for the residents and staff. I think this is good as [manager] has set out what is happening, and this gives us a chance to have a say." Another said, "There is a lack good communication with staff and residents from the new management."
● The manager had recently introduced several schemes to ensure people were more involved in their care such as weekly chats and a 'resident of the day' initiative whereby each month people experienced an extra special day and their whole care package was reviewed. Staff were positive about the improvements.
● The provider informed us that managers were on call every day for 24 hours. They worked with staff by working alongside them on a shift and they completed spot checks through the night to provide an oversight of staff practice. They also informed us that they were
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives we spoke with felt that communication with them could be improved. Two told us they had been unaware of the new management arrangements. We were informed by the provider following the inspection that a letter had been sent to all relatives regarding the new management arrangements.
● One relative commented, "I've not been asked for feedback via surveys or questionnaires to complete." Another commented, "I call the home about three times a week. I'm concerned about some of the staff responses e.g. "We're busy now call back later or tomorrow" or "Can you call after 3pm" or "Please call later, we're busy" or "I'll call you back soon" but they never do."
● Following the inspection the provider informed us that service satisfaction surveys were due to be sent out in January 2021, so they could gain the views of people using the service and their relatives to drive improvement at the service.
● Staff meetings and staff supervision meetings had not been consistent. However this had improved since the present manager had commenced employment at the service. Staff told us there had been one meeting with the new manager and one senior staff meeting. Some staff also said they had not received a supervision meeting with a line manager for a long while and felt there were few opportunities to give feedback.
● Meetings for people using the service had not previously been held regularly so people could contribute to the running of the service. However, the manager told us they had recently introduced a scheme called 'catch up Sunday' where staff had conversations with people one a one to one basis, to gather their views and opinions about the service. Records we looked at confirmed this took place.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Working in partnership with others
● There were systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
● Policies and procedures were in place and were updated periodically to ensure information was current and supported best practice.

Working in partnership with others
● The manager worked in partnership with other agencies and referred people to specialist services when they needed extra support to meet their needs. We found good working relationships with other health care professionals that included the dietician and speech and language therapist, physiotherapist, community

psychiatric nurse and occupational therapist. This ensured people received joined-up care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people received safe care and treatment and risks to people's safety had not always been reviewed and updated.

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 effective systems and processes were in place to assess, monitor and improve the service.