Barchester Healthcare Homes Limited

Queens Court

Inspection report

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14 February 2018
16 February 2018

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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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 13, 14 and 16 February 2018.

Queens Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Queens Court provides care for up to 43 people including people with dementia and is located in the Wimbledon area of west London.

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 and associated Regulations about how the service is run.

At the last inspection in January 2016 the overall rating was good.

At this inspection the overall rating was good.

The people and their relatives that we spoke with said the care and support provided was good and delivered in a friendly atmosphere. There were enough staff available to meet people's needs and they did so in a skilful, friendly and kind way.

The home's records were thorough, comprehensive and up to date with regularly reviewed information recorded in a clear and easy to understand way.

People and their relatives were encouraged to discuss health needs and they had access to community based health professionals as well as nursing and care staff. People had balanced diets that also met their likes, dislikes and preferences and protected them from nutrition and hydration associated risks. People and their relatives told us the meals provided were of excellent quality and plenty of choice was provided. Staff prompted people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy their meals.

The home was clean, well-furnished and maintained and provided a safe environment for people to live and staff to work in.

Staff were knowledgeable about the people they supported and had the appropriate skills and training to meet people's needs competently. They focussed on providing people with individualised care and support and this was provided in a professional, friendly and supportive manner.

Staff were aware of their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

Staff thought the registered manager and organisation provided good support and there were opportunities for career advancement.

People and their relatives said the registered manager and staff were approachable, responsive and encouraged feedback from people.

The home had systems that consistently monitored and assessed the quality of the service provided.

The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation.

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 remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Queens Court

Detailed findings

Background to this inspection

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

This was an unannounced inspection and took place on 13, 14 and 16 February 2018.

This inspection was carried out by one inspector over three days.

There were 40 people living at the home. We spoke with seven people, six relatives, eight staff, and the registered manager.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for five people and three staff files.

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

Good

Is the service safe?

Our findings

People were safe living at Queens Court and their relatives commented that they felt happy and safe leaving people in the home's care. The home had a relaxed atmosphere and there were enough staff to safely provide the care people needed and made them feel safe. One person told us, "I feel safe there is always someone [staff] around." Another person said, "I'm safe and staying for the duration." A relative told us, "[relative] is well looked after and I don't have to worry."

During our visit there were suitable numbers of staff to meet people's needs and the numbers on the staff rota matched those on duty. Relief staff cover was provided by bank staff from within the home and organisation. This meant the home met people's needs in a safe, enjoyable and unrushed way, demonstrated by people's positive body language, familiarity with and responses to staff. The home was currently recruiting to vacant posts.

Staff had received safeguarding training and knew how to raise a safeguarding alert and when this was required. Staff received a handbook containing safeguarding information and local authority contact numbers were also accessible to staff. There were no current safeguarding alerts. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. Staff were aware of the procedure to follow and agencies to contact to make sure people were safe.

Staff had access to the provider's policies and procedures regarding protecting people from abuse and harm and were trained in them. This was reflected in their care practices during our visit. Staff outlined their interpretation of what abuse was and the action they would take if it was encountered. Their responses corresponded to the provider's policies and procedures. Staff said that protecting people from harm and abuse was included in their induction and refresher training and an essential part of their jobs.

People were enabled to enjoy their lives safely, by their care plans containing risk assessments. The assessments identified areas of risk relevant to people that included all aspects of their lives that included their health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Relevant information was shared by staff, during shift handovers, staff meetings and when they occurred. Risk assessments were also used as opportunities for discussion if something had gone wrong so that lessons could be learnt. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and understood.

The building risk assessments were very comprehensive, regularly reviewed and updated. The home's equipment was regularly checked and serviced. This included a fire evacuation plan.

The home carried out infection control checks and staff had received infection control training that was reflected in their working practices. The home also held a good stock of equipment including gloves and aprons for giving personal care to minimise the risk of infection.

The staff recruitment procedure was thorough with all stages of the process recorded. This included

advertising the post and providing a job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's communication skills and knowledge of the service the home provided. During the interview prospective staff were given the opportunity to experience if this was the type of work they wished to embark upon, by spending a couple of hours with a member of staff during a general activity. It also enabled the home to ascertain the level of commitment of prospective staff. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a three month probationary period. The home had disciplinary policies and procedures that staff confirmed they understood.

Staff had received training in and understood de-escalation techniques in instances where people may display behaviour that others could interpret as challenging. These were focussed on people individually and staff had appropriate knowledge to do this successfully. Staff actions were recorded in people's care plans.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records for all people were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited. The drugs were safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

People and their relatives were involved in deciding about the care and support provided and way it would be delivered. Staff had communication skills that enabled people to understand them and enhanced the ability of staff to meet people's needs in a way that was appropriate to them. People were spoken with in an unrushed way so that they could understand what staff were saying. This was done at eye contact level and using appropriate body language that people responded to. People and their relatives said that the way staff provided care and support was what was needed and delivered in a friendly, relaxed, patient and professional way. One person said, "I left and came back, that says a lot." Another person told us, "I can't think of anything that can be improved, always someone around." A relative said, "This is a well-run place with happy staff who are welcoming and always say hello." Another relative told us, "Good stimulation with an excellent music therapist."

Staff were given induction and annual mandatory training. The induction was comprehensive, included core training aspects and information about staff roles, responsibilities, the home's expectations of staff and the support they could expect to receive from the organisation. All aspects of the service and people who use it were covered and new staff shadowed more experienced staff. This increased their knowledge of the home, people and provided a good standard of quality care. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards' and included dementia awareness, duty of candour, customer care, manual handling, medicine, food safety and health and safety. Staff meetings included opportunities to identify further training needs. Bi-monthly supervision sessions and annual appraisals were partly used to identify any gaps in training. There was also access to further topic specific training. During February the topics were infection control, continence management, nutrition and induction folder review.

Staff received equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected in positive staff care practices and confirmed by people and their relatives. People were treated very respectfully, equally and as equals with staff not talking down to them. One relative told us, "Very good, what a care home should be. [Relative] looked after and I don't have to worry here."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this 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).

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The MCA and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in the MCA and DoLS. Staff we spoke with understood their responsibilities regarding the MCA and DoLS safeguarding. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout our visit.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. The records demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams, GPs and physiotherapists, making referrals when required and sharing information. The registered manager also attended local authority hosted provider forums where information was shared.

People's care plans contained a section regarding health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. This was using the MUST tool to assess a person's nutritional status. If required, weight charts were kept and staff monitored how much people had to eat and drink. There was also person specific information regarding any support required at meal times, including any possibility of choking. Staff had also received training regarding choking and dysphagia. Dysphagia is difficulty or discomfort in swallowing, as a symptom of disease. Further training in respect of choking was also provided as part of the basic life support training. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. Staff, including the catering team provided nutritional advice. People had annual health checks. Records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

During our visit staff encouraged people to eat meals in a patient and supportive way, making the effort to ensure people, who needed encouragement to eat, received it. This included people with dementia who had their needs met by staff in a re-assuring and encouraging way. People's meal choices were explained and staff revisited them as many times as people required to help them understand what they were. They also spent time explaining to people what they were eating during the course of the meal and checked they had enough to eat. This made mealtimes an enjoyable experience for people. When serving staff brought out a selection of the available choices to make sure people got what they wanted. The meals were of excellent quality and special diets on health, religious, cultural or other grounds were provided. They were well presented, nutritious, hot and monitored to ensure they were provided at the correct temperature. Staff supported people in a timely way at mealtimes and no one had to wait for their lunch. They were also encouraged to dine with people, if people were happy to do so and this was reflected by two staff having lunch with people during our visit. Regular meetings took place between people and catering staff to discuss the quality of the meals, how they were served and choices. People said they enjoyed the meals. A relative told us, "[relative] had a 94th birthday party and the home did the catering which was very good." People also had pancakes to celebrate Shrove Tuesday.

The home was clean, well decorated, well-maintained and with no unpleasant odours. The layout was conducive to providing people with a homely atmosphere and suitable communal and personal accommodation. This meant people had the space to socialize as much or as little as they wished.

Good

Is the service caring?

Our findings

The service people received was based on treating them with dignity, compassion and respect. Attentive staff responded to them promptly, addressing people by their preferred name or title and knocked on their bedroom doors and waited for a response before entering. People and their relatives thought staff listened to and acknowledged them and valued their opinions whilst delivering support in a friendly, patient and helpful way. One person said, "Staff are excellent." Another person told us, "Staff are all very pleasant and I haven't met any that aren't. Really, really good." A further person commented, "You can always have a laugh with the staff." A relative said, "Staff are welcoming and very friendly." Another relative told us "Overall this is an excellent place for someone who needs care. Staff say hello and everyone is treated with respect and patience."

The home celebrated a 'Dignity in Action' day on 1st February that included people completing a dignity tree that contained their feelings about how they wished to be treated. Comments included respect, pride, kindness and politeness.

Staff made a real effort to ensure people's needs were met, that was reflected by their care practices. People were stimulated and encouraged to have conversations with each other as well as staff in a patient and skilled way. Staff applied their knowledge of people and their needs and preferences enabling them to lead happy and rewarding lives. This was individually and as a team. People were treated with kindness and understanding with staff taking an interest in them. Their approach to care was supported and underpinned by the life history information contained in people's care plans that people, their relatives and staff contributed to and regularly updated.

There was an advocacy service available that people had access to if required.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People and their relatives confirmed that the registered manager, staff and organisation sought their views and opinions. This was done formally and informally. Staff enabled people to make decisions and took action on them. The registered manager and staff made themselves available to people and their visitors when they wished to discuss any problems or if they just wanted a chat. If people had any issues they were quickly resolved by staff. This meant people had the opportunity to decide the support they wanted and when. One person said, "The [registered] manager is very helpful." Support was delivered by friendly staff, in a timely and appropriate way that people enjoyed. One person said, "Staff are easy [friendly] and always around when you need them." Another person told us, "I came here for respite and have been here ever since. There are loads of activities and staff are very caring and great fun." A relative said, "Staff are welcoming, well-trained and very friendly."

Queens Court operated a whole home approach. This required all staff being involved as a team, irrespective of their roles and sharing information with each other. This ranged from maintenance of people's rooms, discussions with the Head Chef and kitchen staff regarding dietary needs and menu suggestions, care planning updates, making sure there was enough staff to meet people's needs individually, as well as collectively and social involvement reviews. The system ran throughout the home, complemented the key worker system and extended the sharing of people's issues and concerns with the teams. Talents that staff possessed that were not part of their job descriptions were also identified and put to use such as singing and art.

The written information about the home, including pre-admission was provided for people and their relatives in a format that was easy to understand. It was in sufficient detail to enable them to understand the type of care and support they could expect. It also laid out the home's expectations of them.

People were invited to visit as many times as they wished before deciding if they wanted to move in and fully consulted and involved in the decision-making process. These visits were also used to identify if they would fit in with people already living at the home. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person.

People mainly referred themselves or referrals were made by their families. Many people had first experienced a respite stay at the home prior to moving in permanently. If a service was commissioned by a local authority or the NHS, assessment information would be requested from these bodies or from a care home if they had been transferred. The home carried out assessments of people's needs with them and their relatives, and if it was identified that needs could be met people and their relatives were invited to visit.

People's assessments were the basis of their initial care plans. The care plans were focussed on people as individuals and were live documents that contained social and life history. They included people's interests and were added to with staff when new information became available. The information gave people the opportunity to identify activities they may wish to do. People's needs were regularly reviewed, re-assessed with them and the care plans updated to meet any needs that had changed. People agreed goals with their

lead staff that were reviewed and daily notes also fed into the care plans. The daily notes confirmed that identified activities took place. People were encouraged to take ownership of their care plans and contribute to them when they wished. Care plan goals were underpinned by assessments of risk to people.

The home provided a variety of activities based on people's wishes and staff knowledge of people's likes and dislikes. The communal activities were reviewed annually to make sure they were focussed on what people wanted. The success of this approach was reflected in the high participation of people in the activities. People were also kept informed by a seasonal newsletter. One relative said, "We are kept informed including invites to the care plan reviews." During the inspection people were consulted, by staff about what they wanted to do and when. During activity sessions people were encouraged to join in but not pressurised to do so.

A timetable of weekly activities was available that took into account people's interests and ability to participate. One person said, "I do get a programme of activities and it is up to me what I do." Staff reminded people of what was taking place during each day. The activities co-ordinator facilitated a programme of activities that people had chosen. These included 'slow' yoga, chair exercise, coffee and sherry mornings, book club, poetry readings, music therapy, painting and general knowledge quizzes. There was also visiting entertainers such as an opera group and a weekly hairdresser. People also went on excursions including one during the inspection to Battersea Park. There was also a family party. One person said, "It is all here if anyone wants it [activities]." Another person told us, "There is plenty to do and the time goes quickly." A relative said, "[relative] is always kept busy." Other relatives told us that they thought people enjoyed the activities provided and they were appropriate.

The home ran a 'Resident of the Day' activity that was focussed on a specific person and activities they wished to do as well as all aspects of their care and the environment they live in. One person had chosen to go shopping in Wimbledon as an activity.

The home provided end of life care and staff had received appropriate training from the organisation. Qualified nursing staff also attended external training for end of life competencies at a local Hospice and a palliative care nurse visited the home to provide training. There was specific reference to end of life in people's care plans including guidance and people's wishes. When providing end of life care, the home facilitated relatives to be involved in the care, if they wished during a distressing and sensitive period for them. This included an end of life brochure that expressed condolences, things that need to be done when someone dies, such as a doctor signing the medical certificate, arranging funeral directors that the home could undertake on relatives behalves and a list of useful contacts. The home liaised with the appropriate community based health teams and organisations such as palliative care teams.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew of their duty to enable people to make complaints or raise concerns.

People and their relatives were invited to general home meetings and those specific to themselves. One relative said, "I attend the meetings when I can." Another relative told us, "I am kept informed and invited to the care plan reviews." The meetings were minuted and people were supported to put their views forward including complaints or concerns. The information was monitored and compared with that previously available to identify that any required changes were made.

Good

Is the service well-led?

Our findings

People and their relatives said the registered manager operated an open door policy. This meant they felt comfortable in approaching the registered manager as well as staff. One person told us, "The [registered] manager always says hello and has a chat." Another person said, "Everyone knows each other, wonderful care and a fantastic place." One relative told us, "The [registered] manager clearly wants the best for the home." Another relative said, "We are very impressed, are very happy customers and would recommend it." People's conversation and body language showed that they were very comfortable with the registered manager and staff.

The organisation had a clear vision and values that staff understood and embraced. The vision and values made clear what people could expect from the organisation, home, its staff and the home's expectations of them. Staff said the vision and values were described and explained as part of their induction training and revisited during staff meetings. The management and staff practices reflected the vision and values as they went about their duties.

The home worked in partnership with other agencies, including Kingston and City Universities, who had students on placement and St Georges Hospital who provided nursing associates. These relationships and others that were research based with Kings College and UCL enabled the home's staff to attend complementary courses and lectures and have access to university libraries. This included 12 weeks of learning new evidence based skills and strategies of working with people with dementia who required agitation management to improve their quality of life. This system was called 'MARQUE' and run by UCL and helped staff understand the importance of non-pharmacological interventions for people who have high levels of anxiety. The home also made use of available community training programmes such as diabetes, Parkinson's disease and tissue viability.

The home was part of the Merton Business Alliance, a professional network of local businesses that support each other with advice and meetings with a speaker. The seminar topic for February was 'Paying for your Care' and hosted by the home.

The organisation provided staff with opportunities for personal advancement and to develop knowledge and skills including student nurse training and many of the senior posts at Queens Court were filled by staff that had been promoted internally. Staff had personal development plans. One staff member told us, "I started as a carer, moved on to admin and am now doing a nursing degree sponsored by the organisation."

There were clear lines of communication and areas of responsibilities throughout the home and organisation and staff were aware of their areas of responsibilities. Staff said they would be comfortable using the whistle-blowing procedure if they needed to.

People living at Queens Court engaged with the local community attending and hosting various activities. These included the Merton Seniors Forum, a choral group, local church that provided monthly dementia friendly services and receiving visits from local schools. There were also a number of volunteers. The home

was also part of 'Love Wimbledon' that promotes events in Wimbledon that can accommodate people from the home.

Staff felt well supported by the registered manager and management team. They thought that the suggestions they made to improve the service were listened to and given serious consideration. This was partly facilitated by a quality review meeting for all staff each Thursday and care staff and nurses and clinical practitioners meetings. They said they really enjoyed working at the home. A staff member told us, "We work as a team and pull together." Another member of staff told us, "I've been here 20 years and love it."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The quality assurance system contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. This included a quality circle meeting each Friday. There were audits for care plans, medicine, behavioural and psychological dementia symptoms, pressure care and ulcer management, falls, nutrition, health and safety, people's involvement and activities. There was also a business continuity plan. An organisational quality review took place during the inspection. These take place quarterly and visits from the regional director take place in the intervening months. Annual policy and procedure reviews were carried out.