Althea Healthcare Properties Limited

The Queen Charlotte

Inspection report

432 Chickerell Road
Chickerell
Weymouth
Dorset
DT3 4DQ

Tel: 01305773128
Website: www.kingsleyhealthcare.com

Date of inspection visit:
31 August 2017
01 September 2017

Date of publication:
10 October 2017

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 31 August and 1 September. The first day was unannounced and the second day was announced.

The Queen Charlotte provides accommodation and personal care for up to 51 people. There were 34 people living at the home at the time of inspection. The service is located in Chickerell and is a large detached four storey building. The accommodation offers bedrooms over three of the floors and has wheelchair accessible lifts for all levels. There are communal lounges and dining areas on three of the floors. There is also an accessible garden.

There was a registered manager in post. 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 had access to a range of group activities but there were limited options for people who preferred one to one time with staff or who were in bed and not able to take part in the group opportunities offered.

Quality assurance measures were regular and used to identify gaps and trends. However this information was not consistently used to plan actions to improve the service.

Recruitment at the service was safe but there were some gaps in the consistency of information about applicants conduct in previous employment.

Risk assessments were in place and identified the risks that people faced and provided guidance about how to manage these. Staff knew peoples individual risks well and the service planned to build on the existing risk assessments to ensure they reflected the person centred details for people.

Some people had DoLS authorisations in place and one person had conditions attached to their authorisation which were being met. However another person had an expired DoLS which had included conditions which the home had not met. They advised that they would ensure that conditions for DoLS authorisations were consistently recorded and met in line with legislation.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of how to whistle blow if they needed to and reported that they would be confident to do so.

There were enough staff available and people did not have to wait for support. People had support and care from staff who were familiar to them. Staff were consistent in their knowledge of people's care needs and

spoke confidently about the support people needed to meet these needs.

People received their medicines as prescribed and these were securely stored. Medicines were administered using an electronic system which alerted staff if a person had not received their medicines within two hours of the expected time.

The home had good links with health professionals and regular visits and discussions meant that people were able to access appropriate healthcare input promptly when required.

People were supported by staff who had the necessary training and skills to support them. Training was provided in a number of areas and refresher sessions were booked for certain topics on a regular basis.

Staff understood and supported people to make choices about their care. People's legal rights were protected because staff knew about and used appropriate legislation. Where people had decisions made in their best interests, these included the views of those important to the person and considered whether options were the least restrictive for the person.

People spoke positively about the food and had choices about what they ate and drank. The kitchen were aware about people's dietary needs and where people required a special diet or assistance to be able to eat and drink safely this was in place.

Staff knew people well and interactions were relaxed and caring. People were comfortable with staff and we observed people being supported in a respectful way. People were supported to make choices and decisions for themselves.

People were supported by staff who respected their privacy and dignity and told us that they were encouraged to be independent.

People were supported by staff who knew their likes, dislikes and preferences. Staff told us that they communicated well and there were daily handovers which were also provided to staff in writing. There were clear processes in place for each shift and staff knew their roles and responsibilities.

People had care plans which were person centred and included details about how they wished to be supported. Care plans were regularly reviewed with people and their loved ones where appropriate.

Relatives spoke positively about the staff and management of the home. They told us that they were always welcomed and visited when then chose. Both relatives and people told us that they would be confident to complain if they needed to.

Feedback was gathered both formally and informally and used to drive improvements at the home.

We have made a recommendation about occupational activities in care homes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People had risk assessments and staff were aware of the individual risks people faced and how to manage these.

People were protected from the risks of abuse because staff understood their role and had confidence to report any concerns.

People were supported by staff who had generally been recruited with appropriate pre-employment, reference and identity checks.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about the people they weresupporting and received relevant training for their role.

People who were able to consent to their care had done so and staff provided care in people's best interests when they could not consent.

People enjoyed a choice of food and were supported to eat and drink safely.

People were supported to access healthcare professionals appropriately.

Is the service caring?

Good

The service was caring.

People had a good rapport with staff and we observed that people were relaxed in the company of staff.

Staff knew how people liked to be supported and offered them appropriate choices.

People were supported to maintain their privacy and dignity.

People's confidential information was stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had access to a range of group activities, but there were limited opportunities for people who remained in bed or did not wish to take part in group opportunities.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

Is the service well-led?

Good

The service was well led.

Quality assurance measures provided a picture of trends or gaps in practice however actions required were not consistently identified.

People, relatives and staff felt that the management team were approachable and responsive.

Staff felt supported and were confident and clear about their roles and responsibilities within the service.

Feedback was used to highlight areas of good practice or where development was needed. Information was used to plan actions and make improvements.

The Queen Charlotte

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.

The inspection took place on 31 August and 1 September 2017. The first day was unannounced and the second day was announced. The inspection was carried out by a single inspector on the first day and by a single inspector and a specialist advisor on the second day. The specialist advisor had a nursing background and knowledge and experience in training and general clinical skills.

Before the inspection we reviewed information we held about the service. We reviewed information the provider had included in their 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. In addition we looked at notifications which the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to obtain their views about the service.

During the inspection we spoke with five people who used the service and five relatives. We also spoke with nine members of staff, the deputy manager, operations manager and clinical lead. We spoke with four professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection. These included eight care records and five staff files. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, meeting minutes and staff training records.

Good

Is the service safe?

Our findings

People and relatives told us that the service was safe. One person said staff "always knock and keep an eye on me. I feel safe here because of that". Another explained that staff tried to make them feel safe and provide them with reassurance. Relatives felt that their loved ones received safe care at the service. One told us "I don't have to worry; I know (name) is safe here". Another explained "we have complete peace of mind… we know (name) is looked after". We observed staff supporting a person to walk using an aid. They gave clear guidance and reassurance to support the person to sit in a dining chair. Another staff member checked the temperature of a drink to ensure it was not too hot before giving it to a person.

Staff were aware of the possible types of abuse and how to report. One staff member told us that they would look for signs of "bruising or any signs of neglect. Any changes to their presentation and behaviours". The service had a safeguarding and whistleblowing policy in place and staff meeting minutes indicated that staff were reminded about where these were kept. A staff member told us that they would be confident to whistle blow if they needed to and we saw that where there had been whistleblowing reported, these had been recorded and investigated. The deputy manager and operations manager told us about safeguarding incidences at the home and we saw that these had been raised with external agencies and clearly documented. Where actions had been taken, these were clearly recorded.

Staff were aware of the risks that people faced and their role in managing these. For example, a member of staff spoke with us about one person who was losing weight. They were able to explain what actions they had taken to identify the risk and manage this by offering smaller snacks more frequently and considering the persons daily routine. Another staff member told us that a person had a sore area of skin that had been noted on the day of inspection. This had been communicated to staff and the person was resting in bed, being assisted to move regularly and monitored to manage the risk of developing a pressure area. We checked and saw that the person was being supported to move as we had been advised. Risk assessments included generic detail about how to manage the risks people faced but these could have been improved by including more person centred details. For example, one person had a risk assessment around their diabetes and provided standard information about the diagnosis and risks. Additional information about the expected blood sugar levels for the person and signs if this was too high or low would provide guidance for staff about how to manage this risk if they were not familiar with the person. Staff spoke with confidence about how identified risks affected people living at the home and the deputy manager confirmed that they were planning to build on the generic information recorded with more person centred details.

There were enough staff to support people and the operations manager showed us the tool they used to determine whether there were sufficient staff to meet people's needs. They explained that they took into account the layout of the home and where people required one to one support from staff as part of this process. People and relatives told us that staff were familiar to them and that they general saw the same faces. This was important because the majority of people living at the home had a dementia. Where agency staff were used, these were generally the same staff.

Recruitment at the service was safe but there were some gaps in the consistency of information about

applicants conduct in previous employment. Staff files included references from previous employers, application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. We saw one file which did not have sufficient information about an applicant's previous conduct and another file where employment gaps had not been checked. The operations manager assured us that there was a checklist in place to highlight any employment gaps and we saw that this was the case for the other records we reviewed. Where gaps had been identified, the operations manager explained that they would use a risk assessment if they were unable to gather sufficient information from applicants and we saw another instance where this was the case and a risk assessment was in place. This demonstrated that the service had processes in place to ensure safe recruitment of staff.

Accidents and incidents at the service were reported and used to identify patterns and trends and take actions where appropriate. We saw that where appropriate, incidents had been raised with external agencies and actions taken were clearly recorded.

Fire evacuation procedures were in place and each person had a personal emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks of the fire alarms, fire doors and fire safety equipment and any maintenance issues were raised and dealt with by the maintenance staff at the service.

People received their medicines as prescribed. Medicines were administered using an electronic system which raised alerts if they were not given within a two hour time frame. Although this was safe because it provided clear oversight, the two hour window would not be sufficient where people required medicines which were time specific. For example, one person needed a medicine for Parkinson's which was required to be given at specific times. The clinical lead advised that they would follow this up with the company who managed the system to ensure that the oversight of time specific medicines could be provided more robustly.

Some people had medicines prescribed 'as required'. People had 'as required' medicines forms which provided clear and specific instructions for staff including why the medicine was prescribed and frequency and maximum dosage. Some people were unable to verbally communicate if they were in pain and there were clear pain assessment charts in place which enabled people to use visual tools to communicate if they needed pain relief. Some people had prescribed creams which staff supported them to apply. Again there were body maps in place indicating where creams needed to be applied. Medicines were stored safely and where some medicines required additional checks, these were in place.

Good

Is the service effective?

Our findings

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

We saw that people had MCA assessments in place and that these were decision specific and provided evidence about how the decision had been made. For example, one person had an assessment relating to a decision about whether they should move to a different room within the home. The person's family were involved in the assessment and consideration was given to the best interests of the person and whether the decision proposed was the least restrictive option.

There was clear monitoring of DoLS and where authorisations had expired, new requests had been submitted. One person had a DoLS which had been in place for six months and expired in July 2017. Although a new application has been submitted, the conditions to which the authorisation had been subject had not been recorded in the person's care plan and had not been met. The deputy manager told us that they would ensure that any conditions were accurately recorded and that this was monitored. At the time of inspection another person had a current deprivation of liberty safeguard in place with attached conditions. We checked and saw that these were being met.

Staff had the correct knowledge and skills to support people. One person explained how staff understood how to use a piece of equipment they needed to assist them to move safely. A relative explained that their loved one was at risk of infections and staff knew the signs to look for and were able to quickly identify and involve the GP if they noticed any signs that their relative was becoming unwell.

Staff received training in topics which were relevant to the people they supported. Training was completed in a number of topics which the service considered essential, these included infection control, moving and assisting and how to protect people from abuse. Some training was completed via e-learning and others offered as face to face sessions. Staff were provided with logons for e-learning and the operations manager showed us how they monitored whether staff were progressing through their training and were sent reminders and prompts if areas needed completion. Other learning opportunities were offered in areas which were relevant to the needs of people at the home and also where staff expressed and interest. A staff member explained that they had received training in a feeding system used by one person at the home which had helped them to understand how to monitor and manage this. Other learning staff had

undertaken and future sessions booked included tissue viability, catheter care, diabetes and managing distressed behaviour.

New staff received an induction into their role and if they did not have previous experience in health and social care, they were supported to complete the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff told us that their induction had been positive and they had spent time shadowing and were observed in areas of their practice including communicating effectively with people and assisting people to move safely.

Staff received regular supervision and were supported to consider their own learning and development needs. Supervision documentation encouraged staff to consider and reflect on their practice. For example, one question asked "how have you improved an individual's well-being?". This encouraged staff to reflect and discuss interactions with people and consider what impact they had on the person. For example, one staff member described how they had decided to support people to access the garden as it was a nice day and had drinks and snacks which people had seemed to enjoy. Staff told us that they felt supported to learn and develop and several staff had or were undertaking national qualifications with support from the service.

People and relatives spoke positively about the meals at the service and had choices about what they ate and drank. A relative told us, "The food is good, varied and interesting". The cook explained about people's dietary needs and had clear systems in place to identify where people required a soft diet to eat safely. Meals and drinks were fortified where there were concerns about weight loss. We observed that soft diets were well presented and appetising and that people had a choice about where they wanted to eat their meals.

Where people required support to eat, this was provided. Staff were attentive and ensured that people had the support they needed. Lunchtime was well organised with the meals being served at different times on each floor to enable them to be delivered fresh from the kitchen. People were offered condiments and choices of drinks with their meals and adapted crockery and utensils were provided to enable people to manage independently.

People had access to healthcare promptly when required. The home had weekly visits from a GP and used a communication book to record who had been visited and any notes which needed to be handed over. This worked well and meant that staff were up to date with people's changing health needs. A health professional told us that "regular carers and regular nursing staff have a good knowledge of their residents and recent events". They explained that the clinical lead or one of the managers was generally available when they visited.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring and we saw that there was good rapport and that people were relaxed in the company of staff. One person told us "staff are very good, they are helpful". A relative explained that they had been impressed by the commitment staff had shown to caring for their loved one and said "the way they look after (name) is how I would want to be looked after".

People were actively supported to make decisions about their care and staff understood their role in supporting people to make choices. A staff member told us about one person who was not able to verbally communicate their choices. They explained how they had worked with the person's family to help them to offer choices which were appropriate for the person. Another person's care plan detailed that they could choose if offered visual options which staff were aware of. Another person told us that staff had been respectful of their choices about how they wished to spend their time and offered them choices about their care and treatment. We saw that people's records included choices offered to people including when they got up and how they spent their time.

Staff knew people well and were aware about peoples' likes and dislikes. Where people were unable to express their preferences, records included person centred details and people's rooms had photos and information which guided staff about interests people had or how they liked to spend their time. One staff member explained how they used tactile contact if a person became upset because they knew that the person liked physical contact and found this reassuring. Another person's documentation showed that they disliked staff invading their personal space. Staff were aware of this and we observed a staff member supporting the person and then giving them space in line with their preferences.

People were supported to maintain their privacy and dignity. One person explained that staff always knocked and sought consent before entering their room and another told us that staff closed their curtains and covered them while providing intimate care. We observed staff knocking on bedroom doors and ensuring doors were closed if intimate care was to be provided. One person told us that they preferred to have their bedroom locked and their wishes had been respected.

People's information was stored confidentially. All electronic records required secure login information for access. Other information was stored securely in areas which were locked and where people had food or fluid charts of other daily checks, this private information was kept in people's own rooms.

Requires Improvement

Is the service responsive?

Our findings

There were a range of activities available for people who lived at The Queen Charlotte, but these were often offered on a group basis and there were limited opportunities for one to one time with people who were in bed all of the time or who did not want to participate in group activities. Group activities included skittles, floor games and a film night. Two people told us that they enjoyed the activities or that they had been offered to join group activities but did not feel they needed any additional social activities. However another two people commented that there was not much going on and another hadn't wanted to participate in the group activities that had been offered. The deputy manager provided us with records about activities which had been offered to people who remained in bed. These largely recorded that people had been listening to music or watching television. This meant that people who stayed in their rooms did not have opportunities for regular activities which were meaningful for them. We discussed this with the deputy manager and operations manager and identified this as an area for improvement.

We recommend that the service seek advice and guidance from a reputable source, about person centred activities in care homes.

The service had a full time activities co-ordinator post but this was a vacancy at the time of inspection. The home were proud to show us outings they had arranged for people and other activities which included making bird feeders, holding a vintage tea party, a visit from local college students and other planned events.

People had care plans which provided detail about what support people required and also how staff needed to support people. There were electronic summaries in place which gave an overview of information about a person and these were also stored in paper format to ensure that any new or agency staff were able to access person centred information about people. Information about what was important to people included details such as "provide reassurance and a clear and gentle explanation…likes to sing songs which is an effective distraction technique". Reviews were carried out regularly and care plans showed where changes had been made as a result of these reviews. A relative told us that they had been sent an invite to a review about the support their loved one was receiving.

Relatives told us that they were kept updated by the home if there were any concerns or changes in their loved ones. For example, one relative explained that when their loved one had been unwell, the home had contacted them promptly to make them aware and provided reassurance. Relatives and visiting professionals also told us that staff were able to provide updated information about any changes to people when they visited. One told us staff were "always able to let me know how (name) has been when I come in".

We observed that relatives and visitors were welcomed at the home. They consistently told us that they visited when they chose and that staff were always helpful and welcoming. One relative explained they were "always welcomed when I arrive". Another relative explained that they visited regularly and "stay as long as I want". Several people in the home had spouses who visited daily. They were supported to stay as long as

they wished and offered meals and drinks if they wanted.

The service held residents and relatives meetings regularly which were used to discuss the home and any feedback. Minutes showed that these meetings were used to share information including staffing updates or other changes within the home. People were encouraged to make suggestions and contact details were updated so that minutes could be circulated if relatives were unable to attend.

People and relatives were confident about how to raise concerns if they had any and the service had a complaints policy in place. People and relatives consistently told us that they would be confident to raise any concerns with the management of the home if they needed to. We saw that where complaints had been received, these had been recorded, investigated and responses sent. Where actions came from this, these were outlined and learned from. For example, after investigating one complaint the registered manager had spoken with staff to ensure that they had clarity about recording processes.

Good

Is the service well-led?

Our findings

Quality assurance measures were in place. Audits were completed regularly in areas including infection control, nutrition, tissue viability and care plans. The nutrition audits included an action plan which considered the information gathered and identified where actions were required. For example, someone who had an increased risk of malnutrition was identified as requiring a referral to a dietician. We noted that this had been completed. However other audits consisted of the information gathered but did not have any analysis to determine whether any learning or actions were required. The deputy manager and operational manager confirmed that they would ensure that the audit information was consistently used to identify patterns and drive improvements.

People, relatives and staff told us that they felt the home was well managed and that the management were approachable and effective. The registered manager had been in post for a few months and had made changes to drive improvements at the service. For example, some people had moved onto different floors of the home which was done in consultation with people. Feedback about this change was positive and people appeared settled and relaxed in their environment. One relative told us "the registered manager is very efficient and the deputy manager is great. They work on the floor and know the service well". A staff member described the registered manager as "hands on and proactive".

Staff were clear about their roles and responsibilities and communicated well. There were regular handovers which were done verbally but also included written updates about people which ensured that staff knew relevant information about the people they were supporting. One staff member told us "we have a good rhythm and get on well". Another explained "there is always the clinical lead or support if needed in the office or via the phone". We observed an incident where a person was unable to move and was blocking a doorway and becoming upset. Staff worked together to try to provide reassurance and support the person to move safely. When this didn't appear to be effective, they called for support and the deputy manager and a care co-ordinator promptly responded. The person responded well to this approach and was safely assisted to move. This demonstrated that staff were able to communicate effectively and were confident to ask for assistance and support if this was needed.

The home held regular staff meetings which were used to drive best practice and to discuss any changes or issues. Minutes showed that staff were encouraged to suggest ideas and updates were shared. Where actions were identified, these were recorded. For example, a trained nurse staff meeting highlighted that staff felt they required additional learning in one area. An action was then recorded to check the competencies of staff in this area and we saw that related training had been arranged.

The management team were supported by operational managers and they attended regular management meetings and sought advice and support from other registered managers and the operational staff. The operations manager explained that the management also received support from the local Clinical Commissioning Group and Local Authority and had good links with the local acute hospital discharge team.

There were development plans in place which included the implementation of a further electronic system

to provide staff with access to care planning on mobile tablets. Further social events and a continued focus on stabilising the staff team were also priorities for the service.

Feedback was sought from people through the use of surveys which were sent out annually. A relative told us that they had received one of these and we saw that responses to both the resident/relative surveys and staff surveys had been collated and used to consider areas for further improvement. Responses were generally positive in both surveys and actions had been taken in response to the feedback. For example, staff survey responses had prompted checks to be completed of all equipment used to assist people to move safely and there were ongoing monthly checks in place for this. Online feedback through a web based service also had positive reviews about the service with comments including "The home is clean and comfortable, staff are patient at all times and caring" and "the staff not only looked after (name) but also supported me".

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.