Methodist Homes

Queenswood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected the service on 7 February 2017. The inspection was unannounced. Queenswood provides accommodation for up to 41 older people. On the day of our inspection 38 people were using the service.

The service did not have a registered manager in place at the time of our inspection. 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. The registered manager had recently deregistered with us and the provider was in the process of recruiting a new manager.

We carried out an unannounced inspection of this service on 23 February 2016 and a breach of legal requirement was found in relation to having systems in place to assess, monitor and make improvements to the service. We told the provider they must send us a written plan setting out how they would make the improvements and by when. The provider sent us an action plan and we looked at whether the improvements had been made during this visit. We found that some improvements had been made but these had not been sustained and the systems were still not fully effective in bringing about the required changes in the service.

Staff were not always deployed in a way which ensured people's requests were responded to in a timely way. People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to protect them from harm. People were given their prescribed medicines.

People were not supported to eat enough. There were no systems in place to assess if people would need an application for a Mental Capacity Act 2005 Deprivation of Liberty Safeguard. People were supported to make decisions, and people who lacked the capacity to make certain decisions were supported with this. People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support.

People were supported with risks relating to their health needs. Referrals were made to external professionals when people's health needs changed and they were supported to attend appointments.

People were treated with respect and cared for by staff who recognised the importance of spiritual and emotional wellbeing. People were involved in planning their care and support and were supported to live as independently as possible. People enjoyed an active social life and were supported to maintain and develop their hobbies and interests.

Systems in place to monitor and improve the quality of the service provided were not always effective in identifying and bringing about improvements needed. People were given the opportunity to have a say in

how the service was run.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff deployed to meet the needs of people in a timely way.

People could be assured they would receive their medicines as prescribed.

People were protected from the risk of abuse because the provider had systems in place to recognise and respond to allegations or incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not fully supported to maintain their nutrition.

People made decisions in relation to their care and support and were supported when they lacked the capacity to make certain decisions. There was a lack of system to assess if people would need a Mental Capacity Act 2005 Deprivation of Liberty application.

Referrals were, made to external professionals when people's needs changed. People were supported by staff who received appropriate training and supervision.

Is the service caring?

Good

The service was caring.

People were treated with respect and cared for by staff who recognised the importance of spiritual and emotional wellbeing.

People were supported by staff who treated them with kindness and cared about the individuals they were supporting.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support and were supported to live as independently as possible.

People enjoyed an active social life and were supported to maintain and develop their hobbies and interests.

People were supported to raise issues concerns and these were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality of the service were not always effective in identifying and bringing about improvements.

People were supported to give their views on the way the service was run.

Queenswood

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was also done to check that improvements to meet legal requirements planned by the provider, after our 23 February 2016 inspection, had been made.

We inspected the service on 7 February 2017. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. 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.

During the visit we spoke with 14 people who used the service and the relatives of four people. We spoke with members of the management team, two care staff, a senior carer and maintenance and catering staff. We also spoke with a health and social care professional who regularly visited the service. We looked at the care records of four people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered provider.

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.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 14 April 2015 and again on 23 February 2016 we had concerns about how staff were deployed in the service as people told us they regularly had to wait for assistance when they needed it. Following both inspections we told the provider they must make improvements to this. Following our inspection in February 2016 the provider increased the staffing levels during the day and provided staff with allocation sheets so that staff had responsibility for certain areas of the service. This was aimed at ensuring all areas of the service were covered and to make staff accountable for ensuring people received care and support when they should. However, during this visit we found this had not been successful and people still reported having to wait for support.

A relative told us, "They are always short of staff." One person who used the service told us, "There are not enough staff to be honest. People are often kept waiting if they want to go to the toilet. Staff are tired as well because they are often asked to do two shifts which isn't good for them or us." Another person told us, "They (staff) are just overloaded. If they are busy with somebody else then you just have to be patient."

A further person told us, "It's like the Marie Celeste in the afternoon. I don't know where all the staff go, but there is never anyone around." Another person described being concerned that all of the staff had gone home on one afternoon as they could not find any staff when they looked. We observed this to be the case in the afternoon when there was a lack of staff presence in the main lounge area. We observed one person, who suffered with low moods, sat passively with their eyes closed for a period of 40 minutes whilst there were no staff present. When the activity organiser entered the lounge the person opened their eyes and appeared interested in a conversation the activity organiser had with another person and then engaged in a conversation with the activity organiser. We saw this had a positive impact on the person for the short time the activity organiser was in the room. However the room was then left without staff presence again for a period of 20 minutes. On two occasions we observed near miss incidents due to a lack of supervision, for example, one person entered the lounge on a motorised wheelchair and collided with another person's walking aid. There was a cup of tea on the tray of the frame which spilled, but fortunately not onto the person.

The provider told us in the PIR that staffing levels were reviewed bimonthly or as people's needs changed. Staff we spoke with told us that staffing levels had improved since our last inspection but said they still felt they could do with more. One member of staff told us, "We always meet people's needs but it would be good to have more time to sit with people." We looked at the staff rota and saw there were six or seven staff throughout the day. The management team told us that they were able to increase staff if needed but that they had felt staff organisation was more a factor than the levels. They had initiated allocation sheets so that staff had responsibility for certain areas of the service; however these had not always been adhered to. Call bell response times had also been monitored and this had resulted in an extra member of staff during the evening. Feedback had been sought from the staff following this as to the effectiveness of this and the response had been positive.

The last time we inspected the service we had concerns about people receiving their medicines as

prescribed and audits had failed to address this. During this visit we found this had improved. People we spoke with told us that staff gave them their medicines when they were supposed to and we observed staff supporting people with their medicines appropriately. One person said, "I only have paracetamol because I sometimes get a bit of pain in my legs but that's fine and the staff bring them to me regularly in the morning, at lunchtime and bedtime which is all I want." We observed staff administering medicines and they did so following safe practice staying with people whilst they took the medicine.

We saw medicines were stored safely and staff had received training in the safe handling and administration of medicines and had their competency assessed regularly to ensure they were following best practice. We identified a recent issue with one person's medicines and the management team quickly addressed this following our inspection. Medicines audits were carried out and these had improved and we saw evidence that medicines errors were investigated and lessons were learned from this.

People felt safe from abuse and avoidable harm. All of the people we spoke with told us they felt safe in the service. One person told us, "We are all kept very safe here." The provider told us in the PIR that safeguarding contact numbers were at various points around the service with an emergency number which gave immediate contact with an MHA area manager. Staff we spoke with had knowledge of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the management team or to external organisations such as the local authority. Staff had received training in protecting people from the risk of abuse and this training was repeated annually.

The registered manager had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the registered manager carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

Risks to individuals were assessed and staff had access to information about how to manage the risks. Where people had been assessed as being at high risk of falls there were care plans in place informing staff how to monitor the risk and to minimise the risk of further falls. This included the use of pendants around people's neck connected to the alarm call system. People told us they used these to summon staff if they needed assistance. One person told us, "I can do most things for myself but they've given me this (an alert pendant) because I had a nasty fall in my room." We saw staff supporting people to mobilise using a hoist from wheelchairs to armchairs and the transfers were undertaken safely and appropriately.

We spoke with a health professional who was a regular visitor to the service to support people who were at risk of falling. They confirmed that people who had recent falls had been referred to the team and that staff had received training from the falls team. They commented positively on staff saying they were "fantastic" and told us that staff made referrals as soon as a person sustained a fall. They were complimentary of support staff provided to motivate and support people following a fall, saying that staff recognised falls hazards, would follow advice given and source appropriate equipment.

Systems were in place to learn from accidents and incidents in the service through the use of a system called time critical reporting. This reporting took into account whether the incident required any actions to be taken following the accident or incident. For example one person had sustained a fracture following a fall and the record showed this had resulted in a referral to the falls team and the physiotherapist. Another person had fallen from their bed and this was followed through the time critical reporting, resulting in specialist equipment being sourced to minimise the risks of a reoccurrence.

There were assessments in place guiding staff on what level of support individuals would need if they

needed to evacuate the building in an emergency, such as an outbreak of fire. Staff had been trained in relation to health and safety and how to respond if there was a fire in the service. Ongoing maintenance of the service ensured there were systems in place to reduce risks to people in relation to the environment.

Requires Improvement

Is the service effective?

Our findings

The last time we visited the service we had concerns that people were not protected under the Mental Capacity Act 2005 (MCA). The 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 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 had concerns at our last inspection that one person may have needed an application for a DoLS making to the local authority. Although the provider took action to make the application systems had not been implemented to ensure that where other people may be having their freedom restricted, the required applications would be submitted. Although, at the time of this visit, the majority of people living at Queenswood had capacity to make decisions, a small number of people were living with a dementia related illness. The care plan of one person showed it had been determined they lacked the capacity to make certain decisions. Due to a lack of systems in place there had been a failure to recognise that an application for a DoLS may be needed. This meant the provider could not be assured they were providing care to people in the least restrictive way.

Staff we spoke with had a basic understanding of the MCA and their role in relation to this. We saw that where a person's capacity to make a certain decision was in question, the management team had completed an assessment to ascertain if the person had capacity and what decision needed to be made in their best interests. The record showed how the person's capacity had been tested and such as what questions had been asked. The best interest decisions made when a person had been assessed as lacking capacity had been made in consultation with other people involved in the person's care such as their relatives and healthcare professionals.

People were not always supported to eat and drink enough. The last time we visited the service people raised concerns about the food they were given. We received information of concern about the quality and quantity of the food prior to and during this visit. We found that despite the provider taking action to address this, the food was still an issue. Queenswood dining experience was intended to be a restaurant type experience in an attractive dining room with tables laid out with linen tablecloths and napkins, and people provided with vegetables in tureens. However the dining experience was not always a positive one for people as the quality of the food was not always good. The people we spoke with told us there were still issues with the food.

Although the provider was working towards improving the dining experience, at the time we visited this had not brought about all of the improvements needed. The choices of food on the day we visited were poached fresh salmon with vegetables or a vegetarian option. We sampled the food people were given and found that the potatoes and vegetables were undercooked, as was the pastry on the vegetarian pie. One person

told us, "These potatoes and carrots are undercooked. I can't eat these." Another person who barely touched their meal was asked if they would like the vegetarian option instead and they replied, "No, I don't want anything. I don't want to swop this for a plate full of undercooked vegetables." A third person told us, "Meals here are a joke. We are supposed to have a roast on Sundays. You can't even tell what the meat is supposed to be and you can't eat it because it's so tough. Yorkshire puddings will be burnt black and vegetables are always undercooked. Potatoes sometimes are almost raw." This put people at risk of poor nutritional intake and weight loss.

Records showed that two people had some recent unplanned weight loss. We looked at the care plan of one of these people and there was a risk assessment which detailed they needed encouragement to eat their meals as the person was underweight but there was a lack of guidance in the nutritional care plan for staff on how to support the person and reduce the risk of further weight loss. We observed this person at lunch and they were not given any support or encouragement to eat their meal, despite there being a number of staff in the dining area. They did not eat any of their meal and staff did not tempt them with an alternative or ask if there was anything else they would like to try.

We looked at the care plan of the second person and records showed the person's GP had been contacted about weight loss. However the nutritional care plan had not been updated to reflect how staff should support the person to reduce the risk of further weight loss. We observed the person at lunch and they were sitting in the dining room sleeping on and off and they barely touched their food. Staff removed the plate, without asking if the person wanted an alternative and left them to eat their dessert. The person had a few mouthfuls of the dessert and then went back to sleep. This meant these two people were not being given appropriate support to eat enough.

The last time we inspected we had concerns about people being supported with issues relating to their healthcare needs. During this visit we found there had been improvements made in this area. The care records of one person instructed staff to ensure the person was sitting on a pressure ulcer prevention cushion at all times during the day as they were at high risk of developing a pressure ulcer. We observed this person during our visit and they were sat on a pressure ulcer prevention cushion. The person's care plan stated they needed to be supported to reposition at set intervals and their records showed that staff were giving this support. Staff had received training in pressure ulcer management since our last inspection.

People told us and we saw from records that people were supported to attend regular appointments or to be visited in the service to get their health checked. Staff also made referrals to external professionals such as the falls prevention team, the dementia outreach team and the district nurse when people's needs changed.

People were supported to make decisions on a day to day basis. People we spoke with told us they made decisions about their care and support. They told us they decided what to do and where to go. One person told us, "It's entirely up to me what I do. I get up early and sit and read for a bit and that is my choice." Another person said, "If I feel like going into the lounge and joining in with things then I do but other times if I just want to be quiet in my room, then nobody bothers me at all."

People were able to make drinks in small kitchens intended for people who used the service to use and we saw there was fresh fruit available in these areas. We saw that where people needed adapted equipment such as cutlery to enable them to eat their meal independently these were provided.

People were supported by staff who were trained to support them safely. People we spoke with told us they felt staff knew what they were doing and felt they were well trained. We observed staff followed safe practice

when using equipment to support people to transfer and staff looked confident in their role.

Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support the people who used the service. One member of staff commented that they had requested extra training from the management team and felt that this request would be responded to. We saw records which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control.

People were supported by staff who were supported to have the skills and knowledge they needed when they first started working in the service. Staff were given an induction when they first started working in the service. Staff we spoke with confirmed that they had received an induction and we saw evidence of this in staff records. During the initial probationary period staff had their performance monitored. The management team told us that a number of staff were working towards the care certificate as part of their induction. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the service overall and commented positively on the staff telling us they felt they were kind and caring. One person told us, "Nothing is too much trouble for them. They will bend over backwards to help us." Another told us, "The staff are all brilliant. They are all really kind." We observed staff interactions with people and we saw staff were respectful and professional and showed kindness and compassion towards the people they supported.

People looked comfortable with staff and staff we spoke with told us they enjoyed working with the people who used the service. One member of staff told us, "We are one big family people (who use the service), staff, volunteers and relatives." We informed staff about one person who was upset and the staff member went straight to the person's room and gently asked the person, "What is troubling you." Another person was feeling unwell on the day of our visit due to a cold. A member of staff was compassionate about this and suggested a honey and lemon drink and this was promptly provided.

People had developed and maintained relationships with other people who used the service and during our observations we saw people frequently chatting and laughing with each other. There was a vibrant atmosphere at times when people came together, such as for meals or activities with people supporting each another. People told us they were able to have visitors and we observed relatives visiting and being made welcome.

We saw the staff had received numerous written compliments about the work they did. One person had written, 'Thank you for your care and support.' One relative had written saying, 'You are all brilliant at what you do. I cannot thank you enough for your care, kindness and compassion' Another relative had written, 'We have absolute confidence in the Queenswood staff and their commitment to the residents.' A third wrote, 'Once again your care and support reminded us that [person] was still part of the Queenswood family.'

People were supported with their religious and spiritual needs. The ethos of the service was centred on people's faith and some people described moving into the service due to this. The service had a designated 'chapel' for people to attend and a Chaplain was employed. There was a service held twice a week and services were also taken by ministers of different denominations so that people could follow their chosen faith. During the morning of our visit there was a bible class and we saw this was well attended. There were interactive discussions between people who used the service and the chaplain. We spoke with people about how they were supported to maintain their faith and received positive comments. One relative told us, "It has made such a difference. [Relation] can no longer get to church but having services here and a good network of (religious) support, [relation] is very content." We observed that prayers were said before each meal and people who used the service took a turn to lead the prayer if they wished.

People wishes for when they reached the end of their life had been explored and planned for. The provider told us in the PIR that end of life care was based on the individuals previous wishes, where known, with people who used the service, family and friends being supported through this process. People told us that

they had been supported as part of the chaplain's work to plan ahead and that they felt comforted by this. One person told us, "I was able to have a good discussion about what I want for my funeral and what I would like them to do for me when the end comes. That has been very comforting." Written compliments received by relatives of people who had reached the end of their life in the service showed that staff extended their compassion to relatives. One relative had written, 'Thank you for all the care, love and support you have shown my family whilst my [relation] was with you.' Another relative had written, 'Thank you for the lovely memorial service. It was so special to come back to Queenswood and to remember my [relation] and all the times spent together.'

People we spoke with told us they were in control of making choices and decisions, for example about when and where they ate, how they spent their time and what activities they did. One person told us, "You can join in as much or as little as you want with things." We observed people's choices were respected on the day of our visit. People chose where they went and what they did, with some people sitting in the lounge areas and others spending time in their bedrooms. We observed staff communicating with people effectively by establishing eye contact and making sure they took into account any difficulties the person may have, such as hearing loss. At lunchtime the maintenance engineer employed by the service spoke with people and explained the progress of a new garden room. They asked people to express the choice of coloured sand ended saying, "It's your home so your choice."

We saw from records that people were asked for suggestions on future activities and the food menus. Staff we spoke with were aware of the need to give people choices and ascertain their preferences. Information about individual preferences was recorded in people's care plans along with details about their lives and achievements.

People were supported to maintain independence. People had a range of communal areas to choose from and there were small kitchen areas for people who used the service and their visitors to help themselves to drinks and snacks independently. Some people made their own breakfast and this was encouraged.

The provider told us in the PIR that people were encouraged to maintain full control over their lives and daily activities. They told us they put people in touch with a local representative from Age UK if needed and that a representative had been into the service and spoken with a number of people. The management team told us that two people were currently using an independent advocate. We saw there were leaflets displayed in the service so that people would know how to contact the advocacy service if they wished. Advocates are trained professionals who support, enable and empower people to speak up and express their views.

People were supported to have their privacy and were treated with dignity. All of the people we spoke with told us they felt that staff were respectful and that they could spend time alone if they wished. People told us that staff always knocked on their bedroom doors before entering and we observed this to be the case. We observed that staff were respectful towards people, referring to them by their chosen name and being respectful of their space. We observed staff talking to people discreetly about issues of a personal nature, such as the support they required with personal care and support with medical appointments.

The provider told us in the PIR that staff treated people with the same dignity and compassion that they would as if they were looking after their own relatives and encouraged people to personalise their rooms in a way that reflected them as an individual. Staff we spoke with showed they understood the values in relation to respecting privacy and dignity and were able to give examples of how they supported people with this. The management team told us that staff were given training on the dignity values and that the Chaplain was planning to develop a dignity forum.

Good

Is the service responsive?

Our findings

People's care was planned for from the point of assessment after applying to move into the service and their needs and preferences were documented on a pre-admission record. The provider told us in the PIR that before a person moved into the service a full assessment of their needs was carried out, involving the person wishing to move in and their representatives to ensure the service could meet their need. Records showed the assessment included discussions with people about how they wished to be supported. Upon admission people were allocated a named member of staff who was the first point of call for people and their relatives to discuss their care planning.

People were then involved in planning their care and support via six monthly reviews held with people who used the service and their significant others. The review included discussions about how the person was supported and any changes they wished to happen. People told us they felt involved in their care planning, if they wished to be, and we saw that people had signed various documents in their care plans to show they had been consulted. Relatives told us that staff communicated with them if their relations needs changed.

Staff described when people first moved into the service, sitting with them to complete a personal profile and spending time talking to people about their likes, dislikes, preferences and background. We looked at the personal profiles in place and these detailed people life history and relationships that were important to them. There were details of their hobbies and their likes and dislikes in relation to aspects of their life such as food and how they liked to receive care and support. Care plans also contained details of people's physical and mental health needs. We saw that some elements of two people's plans had not been updated with their changing needs, however staff were supporting both people safely and the management team had a plan in place to address the care planning.

People were supported to follow their interests and take part in social activities. All of the people we spoke with praised the range and amount of activities. The provider employed designated activity staff and had activity fundraising events. This had a positive impact on people being supported to have a stimulating lifestyle. People described an active life with opportunities for taking part in activities and socialising. One person told us, "'There have been some super outings. We've been to museums and garden centres. It's lovely to have a change of scenery from time to time." Another person told us, "We have a knit and natter session which I really enjoy. I've learnt to knit since I've been here." A third said, "We have games and quizzes and music." One relative told us, "We have been really impressed with what goes on here. They have some volunteers who come in and spend time talking to people or getting involved in the games. In fact, everybody is encouraged to get involved in the games, visitors as well."

People commended on the activity organiser who had worked in the service for a number of years. One person said, "She is marvellous. There is a buzz about the place when she is here and there is such a lot going on all the time." Another told us, "We play a ball game and one of the residents can't roll the ball and was getting upset and feeling left out so the activities coordinator devised a method of putting a book on [person's] knee sloping downwards so [person] could drop the ball on to it and it rolled across the floor. Everybody clapped when [person] was able to join in and [person] was so pleased." Our observations of the

activity organiser on duty the day we visited were very positive. They were very much in evidence around the home and clearly well thought of by the people who used the service, who lit up when the activity organiser interacted with them.

People told us of a recent event held in the service called the great British bake off. Staff had baked cakes and some people who used the service had decorated these. People who used the service had been the audience for the show and had clearly enjoyed this event. On the day we visited one person was enjoying looking at the photographs taken. Another person told us, "Last week [activities coordinator] organised a 'bake off' competition which was good fun." We observed activities during our visit and we saw there was a bible study class during the morning and an interactive basketball session in the afternoon. These were well attended and other people who chose not to take part played board games or were engaged in looking at photographs of a previous activity in the service. Some people chose to read books and magazines and one person was engaged in doing a large jigsaw.

People knew what to do if they had any concerns. People we spoke with told us they knew how to raise concerns and were aware of the complaints policy. One person told us, "My family are really on the ball and my daughter will raise any concern I might have." We looked at complaints recorded in the service and saw these had been responded to appropriately and in line with the organisations policy. Staff we spoke with were aware of their responsibility to record complaints and pass these on to the management team. There was a clear complaints procedure in the service informing people how to raise concerns and what the process would be.

Requires Improvement

Is the service well-led?

Our findings

The last time we inspected the service we had concerns about the way the service was monitored as the systems in place were not effective in bringing about improvements. We asked the provider to send us an action plan detailing what they would do to make improvements to their systems and the provider sent us an action plan as requested. However changes in the leadership of the service had led to the improvements not being sustained and we found similar concerns during this inspection.

The registered manager was no longer employed at the service and since our last inspection there had been a lack of stability of management in the service. The provider was aware of the importance of consistent management and had taken the appropriate steps to recruit another manager. A team of senior managers from Methodist Homes had been placed in the service in the interim and each had different roles and responsibilities, with action plans to work towards. However at the time of our inspection, this had not yet been effective in improving the food, care planning or staff deployment. The issues we found during this visit in relation to food and staff deployment were already known about by the management team. They told us, and records showed they were taking steps to address the issues but needed further time to deliver their actions.

At the time we visited, there were systems in place to analyse falls, near misses and incidents in the service, however these were not always being used as intended. The analysis showed an overview of the accidents but the action taken to control the risk of accidents of a similar nature was not always recorded and so was not a robust recording of what was happening in the service.

There were systems in place to address shortfalls in care planning. However we found that these had not identified issues with the care plans of two people who used the service in relation to the plans not being kept up to date with their changing needs. Both people's needs had changed in relation to their mobility and this information had been added to an evaluation of the care plan but the main part of the care plan was not updated. Additionally there was conflicting information about the type of sling one of these people needed to be supported safely when staff used a hoist to mobilise them. Although we observed both people were given the support they should, a lack of up to date plan posed a risk they might not receive appropriate care and support.

During the change in manager there was a lapse in oversight of submitting some statutory notifications to us. These are important as they ensure we have an oversight of what is happening in the service in between our inspections. The area support manager addressed this following our visit.

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

People who used the service and their relatives we spoke with commented positively about the interim management team and told us they were open and approachable. One person commented on one of the management team saying, "Oh they are very good." Another told us, "Very friendly people." Staff told us they

felt supported by the management team, who they reported to be approachable and 'hands on'. One member of staff told us, "I do feel listened to and supported now." Another told us, "(Management team) are very supportive." Staff told us they felt they were a good team with one saying, "We are a team and support each other." There was a new deputy manager who had been employed at the service and following our visit the provider informed us they had appointed a new manager.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the management team and were given feedback on their performance and we saw records which confirmed this.

People who used the service, their relations and other visitors were given the opportunity to have a say about the quality of the service. There were meetings held for people who used the service so the provider could capture their views and get their suggestions and choices. We saw the minutes of the last meeting and saw people had been given the opportunity to have their say. The meetings were also used to communicate any changes to people such as the recent planned change of chaplain employed. There was an action plan put in place following the meeting called, 'you asked, we did' and this informed people of what action had been taken in response to their requests. We looked at a suggestion made at the last meeting and saw this had been acted on in line with the action plan. The provider told us in the PIR that an annual satisfaction survey
was conducted by an independent external company. We saw that following surveys the results were analysed and an action plan developed to make improvements.

Since our last inspection the provider had implemented a central quality business team to monitor standards. Queenswood was allocated a quality business partner (QBP) to carry out assessments of quality in the service and to provide additional training for managers and all staff as identified. Visits by the QBP had resulted in issues being identified and action plans being implemented and reviewed at regular intervals.

There were audits being carried out in relation to different areas of the service and these led to action plans already in place being updated to show improvements or where further improvements were needed. For example there were audits undertaken on the health and safety of the service and infection control. There were also regular observations carried out to check the quality of the service people were receiving and checks undertaken of records such as the completion of food and fluid charts and medicines records.

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 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service people received were not effective. Regulation 17 (2)(a)(b)(c)(f)