Care Quality Commission

Queensbridge Care Limited

Queensbridge House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Queensbridge House is a residential care home providing accommodation and personal care. It is currently registered with the Care Quality Commission to support a maximum of 27 people.

The service supported younger people who live with complex mental health needs. Some received treatment under the Mental Health Act 1983 and some also had forensic backgrounds. This meant they had offended and been through the criminal justice system. The service supported people to step down from more secure settings such as prison or secure mental health units, to live again in the wider community.

The service also supported older people who lived with dementia. At the time of our inspection 8 people with mental health needs and 6 people with dementia care needs were receiving support.

People were accommodated in one adapted building on two separate units according to their needs.

People's experience of using this service and what we found
The provider had not adhered to their admissions and referral policy regarding the admission of people with mental health needs. This had resulted in the admission of some people with behaviour and risks which the provider's policy stated the service could not meet.

We made a recommendation in relation to what needs to be considered when supporting people with complex mental health needs and forensic backgrounds.

Risks associated with people's mental health and complex histories had not been sufficiently assessed and action taken to mitigate risks and keep people safe. People's care records, which included risk assessments and care/support plans did not always provide staff with the detail they needed to be able to support people safely. There was limited guidance, for example, on when restraint maybe applied and what action staff should take to de-escalate people's distressed or challenging behaviour, effectively and safely.

The environment had not been adequately assessed or managed in a way which ensured people's safety. Risks related to fire, falls from windows, substances hazardous to health and ligature points were not sufficiently managed to ensure people's safety.

Incidents were not always identified as needing to be reported to external agencies or as part of the provider's incident reporting process. This meant incidents had occurred without relevant agencies awareness and therefore ability to follow these up to ensure, people were safeguarded, or that appropriate action had been taken to ensure people's safety. The provider had not effectively monitored incidents to ensure they were appropriately reported and managed.

People's medicines were not always managed safely.

On the mental health unit care/support plans were not sufficiently developed to show people's care had been planned, developed and reviewed with people's collaboration, and in accordance with necessary national standards and best practice guidance. People's records relating to their care needs lacked detail for staff on how they should support people.

The provider did not have effective governance arrangements in place. The services policies, procedures and practices were not always aligned to relevant national guidance and standards for the care and support of those with complex mental health needs and forensic backgrounds. The provider did not have effective systems or processes in place to assess and monitor the safety and quality of the services provided. Many of the shortfalls identified during this inspection had not been identified through the provider's own monitoring processes. There were ineffective arrangements in place to drive improvement.

People on the mental health unit were provided with opportunities to take part in activities which supported their physical and social wellbeing. However, there were limited structured and therapeutic activities. For example, unless incorporated into a person's treatment plan by commissioners, people did not have access to a trained counsellor or psychologist.

Records required to be kept were not always completed or maintained making it difficult for the provider to effectively audit and drive improvement. This included records related to incidents, complaints and cleaning.

On the dementia care unit, people's risks were assessed and necessary actions taken to reduce and manage risks. The action staff needed to take to support people was incorporated into people's care plans for staff guidance. This included, for example, needs associated with risks of falls, pressure ulcer development, malnutrition and choking.

People were supported to make choices and to regain control of their lives. People were supported in the least restrictive way possible and in their best interests.

People on the mental health unit told us they felt safe and well supported. We spoke with the relatives of people who lived on the dementia care unit and they told us their relative was safe and the care provided benefited them and suited their needs.

People and their representatives knew who the registered manager was, and they found them to be helpful and supportive. People's representatives told us communication from the staff, about their relative, could be improved; this was not always forthcoming unless they asked first.

We found the environment to be clean and people's representatives confirmed the environment was always clean when they visited, although poorly decorated.

Relatives told us there had been limited opportunities for providing formal feedback. However, they told us if they needed to raise a complaint or concern, they were confident this would be acted on. Feedback was sought from people who used the service, on an individual basis. There was no evidence to show there were opportunities, such as organised meetings, for people and relatives to provide feedback and make suggestions for improvement.

Staff told us the registered manager and senior staff were supportive and there were arrangements in place to formally support staff.

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

Rating at last inspection
The last rating for this service was good (published 11 April 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. This included the provider's decision to add mental health needs to the needs the service stated it would meet and an incident involving medicines.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook a focused inspection to review the key questions of safe, responsive, and well-led. This inspection therefore only covers our findings in those key questions. We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to the assessment of risks, planning and delivery of safe care and treatment, person-centred care and the governance of the service, at this inspection.

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

In response to our inspection findings we (the Care Quality Commission) have applied conditions to the provider's registration which require the provider to seek agreement from us prior to admitting people to the service. We also required the provider to ensure care plans for people with mental health needs, gave staff enough detail to ensure they could support people in line with the care commissioned by commissioners and people's assessed needs.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

We will work with the provider and local authority to monitor progress on the action taken by the Care Quality Commission in relation to this inspection. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below	**Requires Improvement**

Queensbridge House

Detailed findings

Background to this inspection

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

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

Inspection team
Three inspectors (one being a Medicines Specialist), an Operations Manager and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Queensbridge House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Queensbridge House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 3 relatives to gain their views of the service provided. We spoke with 11 staff which included the registered manager, deputy manager, 6 support/care workers, 2 housekeeping staff and the maintenance person. We also spoke with 4 visiting mental health professionals. We spoke with the nominated individual by telephone. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed 5 people's care files which included care related records and records related to the Mental Health Act and Deprivation of Liberty Safeguards (DoLS). We reviewed 5 medicine administration records and medicines-related care plans. We reviewed storage, audits, and policies related to medicines. We reviewed 3 staff recruitment files including records related to staff training and support.

We reviewed a selection of records and documents related to the management of the service and the commissioning of services. This included a selection of audits, accident and incident records, complaints record, maintenance records and a selection of provider policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- We found shortfalls in how people's risks were assessed, monitored, and managed which put people at significant risk of harm.
- The provider had not adhered to their referral and admissions policy which clearly stated what needs and types of forensic histories the service could not support. This included for example, histories where others had been harmed or put at risk of harm. Although people had been assessed prior to admission, people who fell into these categories, had been admitted. The registered manager told us they planned to admit more people with similar, highly complex mental health needs and backgrounds. This put people at significant risk of harm as the service was not set up to manage these levels of risk.
- The provider's policies and procedures, processes and practices had not been aligned with relevant national standards and best practice guidance to ensure the people they admitted could be supported safely.
- Observations of people were not completed in line with relevant national guidance. Observation records lacked the detail required to help senior staff identify emerging risks and patterns in people's behaviour, which may require intervention to support and keep people safe.
- One person's care records contained 2 incidents, where the staffs' record of their intervention clearly described the use of restraint. The use of restraint had not been agreed by commissioners of this person's care and treatment and guidance on its use was not in their care/support plan. The registered manager told us they had spoken with the staff involved in these incidents and what the staff had recorded was inaccurate and misleading. However, we remained concerned this person had potentially been subjected to unlawful restraint.
- The provider failed to use an appropriate and safe framework to inform their policy on the use of restraint. The provider's 'restraint/de-escalation policy did not reflect national guidance provided by NICE - Guidance, Violence and Aggression: short-term management in mental health, health, and community settings (ng10) or the Mental Health Act 1983 Code of Practice. Restraint was referenced in people's risk assessments as a risk management option, without detailed guidance for staff on how this would safely and appropriately be applied. This put people at risk of potential harm through unsafe and unlawful interventions.
- People's risk assessments referred to the need to de-escalate people's distressed behaviour/s without any clear guidance on how and when this should be done for individual people. This put people at risk of unsafe or inappropriate care and treatment.
- The service supported people with significant histories of self-harm and substance abuse (misuse of drugs and alcohol), some of whom had a forensic history of harming others. The provider did not have a process set out and agreed with people, in accordance with the Mental Health Code of Practice, that when people who had restrictions applied to them, for example, by the Ministry of Justice, and there was cause for concern, they could be searched, for harmful items, to protect them and others. Consequently, there had

been incidents where people with these restrictions in place, had been absent without leave and had returned under the influence of a substance and had not been searched. This potentially put people at risk of significant harm.

● Fire related risks had not been sufficiently assessed and action taken to reduce these. The fire risk assessment, completed in November 2022, had not been reviewed and updated to include all known fire risks. Not all practicable action had been taken to reduce and mitigate known fire risks. We observed practices which did not support fire safety. These included obscured access to a fire extinguisher, a fire door propped open, (despite a sign on the door stating it must be kept closed), and a lack of individual, personal emergency evacuation plans (PEEPS) for people on the mental health unit. PEEPs provide staff with the guidance they need to safely support an individual in the event of a fire. We observed staffs' reaction to the fire alarm which sounded during the inspection. Staff were unclear who the fire marshal was. Inspectors referred their concerns to the local authority's fire safety team who subsequently visited the care home.

● People were at risk from falls from windows of height. Window safety had not been assessed or managed in accordance with the Health and Safety Executive (HSE) relevant guidance for provider's: "Health and Safety in Care Homes". This guidance recognises that people who are confused or who live with mental health needs are more at risk from falls from windows of height, be it intentional or unintentional. Windows on the mental health unit (first floor) were restricted, apart from one alongside a person's bed, which had a broken restrictor. The restrictors, however, were not of a type referred to in the guidance and the type in place had not been risk assessed to ensure they were sufficient to keep people safe. Windows on the dementia care unit (ground-floor), were not restricted. The reason given to us on inspection was because these windows did not pose a risk of falls from a window of height. At the time of the inspection, we did not identify anyone who would be at risk from this, but people who were confused had not been risk assessed against unrestricted windows.

● We were informed various ligature points had been removed when the service had started to support people with mental health needs and that no-one was currently a ligature or suicide risk. During this inspection however, we observed numerous potential ligature risks throughout the environment and became aware the service supported people with significant histories of self-harm. As this is not a secure mental health facility, the Care Quality Commission would expect a proportionate approach to the assessment and management of ligature risks. The provider had a document called Ligature Policy and Risk Assessment. This referred to another company/provider (not Queensbridge House) and did not contain a risk assessment. We spoke with two staff who were unaware of this policy. People's risk assessments did not include assessment against ligature risks. There was no information telling us how people had been screened out of being a ligature risk. The document stated all staff should be trained in ligature risk management. We spoke with one member of staff who had worked at the care home for over 6 months and they told us they were not sure what constituted a ligature risk; they had not received ligature training. We were not assured the provider's arrangements for assessing and managing ligature risks were sufficient to keep people safe from harm. The provider had a ligature release device on site which the document referred to and both staff spoken with were aware of this and knew how to use it.

● The provider's arrangements for the safe storage of substances, which could be harmful to people's health, and which come under the Control of Substances Hazardous to Health regulations, were not being adhered to. We observed such substances unattended and not secured, adding risk to people who were confused or who may want to self-harm.

The provider had not done all that was reasonably practicable to assess and mitigate risks related to people's care and treatment and the environment they lived in. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend the provider refer to best practice guidance in relational security (the knowledge and understanding of people, staff, and of the environment, and the translation of that information into

appropriate responses) to support them with their work with people with highly complex mental health needs and forensic backgrounds.

● Following the inspection, the provider confirmed the actions they planned to take to improve fire safety and window safety. This included completing the recommendations within the fire risk assessment, providing more staff with fire marshal training, and fitting more appropriate window restrictors. The local authority's fire safety team completed an inspection of the service and subsequently gave the provider advice and guidance on how to improve their fire safety for individuals who posed a fire risk.
● People who lived on the mental health unit and who enjoyed helping in the preparation of food, had been risk assessed for the use of knives, and kitchen knives generally were kept secure.
● Staff had been provided with Prevention and Management of Violence and Aggression (PMVA) training by a trainer certified to deliver this in line with the Restraint Reduction Network (RNN) standards.

Using medicines safely
● Medicines were not always stored securely. The lack of safe storage of medicines had been one of the reasons for this inspection as in a recent incident, a person who lived in the care home, had accessed medicines not prescribed for them, putting them at risk of harm. We found medicinal eye drops prescribed for a member of staff stored insecurely. One of the two controlled drug (CD) cabinets did not meet the safe storage requirements. This was not installed securely to the wall as required.
● Stock checks of CDs prescribed to people were not always carried out as per the provider's own policy. This meant if there was a discrepancy this could not be identified in a timely manner.
● The staff did not always record the date of opening for prescribed liquid medicines. This meant it was not always possible to ascertain the shelf life of these medicines. Medicines if used outside of the shelf life specified by the manufacturer may not be effective.
● Some people were prescribed medicines such as pain killers to be taken on a when required (PRN) basis. Guidance for staff on the use of PRN medicines, either in a PRN protocol or people's care plans, was not always in place to help staff give these medicines consistently and safely. Where information about these medicines was in place, it was not personalised or person-centred.
● Medicine care plans were in place; however, these were not always person-centred. For example, one person living at the home was prescribed a medicine as part of their treatment plan but there was no information in their care plan, for staff guidance, on how to monitor or manage the side effects of the prescribed medicine.
● Some people's medicine administration records (MARs) were handwritten (not type printed by the supplying pharmacy). These were not always signed and checked by a second member of staff. This meant there was a risk of transcribing errors not being identified. These shortfalls mean the provider's medicines arrangements/processes do not meet with national guidance issued by The National Institute for Health and Care Excellence (NICE).

The provider had not ensured the proper and safe management of people's medicines which put people at risk of risks associated with medicine errors and the unsafe storage of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the third day of the inspection we saw action had been taken to improve the storage of medicines and a system for ensuring dates of opening liquid medicines and creams had been implemented. Staff were due to commence regular stock counts of CDs.

Systems and processes to safeguard people from the risk of abuse
● Although the registered manager was aware of the local authority's (LA) multi-agency safeguarding

reporting arrangements and the Care Quality Commission's notification requirements, not all incidents had been recognised by the registered manager as needing to be reported. Some of these incidents had required information to be shared with LA safeguarding teams so, they, could determine if actions were required to safeguard people. Incidents of significant verbal abuse and threatening behaviour towards staff, which had necessitated the redeployment of some staff to protect them from potential significant harm, had not been reported or recorded in the services incident log. Not all required missing persons incidents had been reported appropriately or an unexplained injury on someone who returned from absence without leave.

We recommend the provider take advice from a suitable and reliable source on what information requires to be shared with which external agency if they are in doubt about this.

● Staff had received safeguarding training and they knew how to report safeguarding concerns.
● Senior staff worked with relevant external professionals, such as the police and health and adult social care professionals to support people who had been subjected to abuse.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. At the time of inspection there were no conditions related to any authorised DoLS.
● A person detained under the Mental Health Act 1983 and who also had authorised DoLS in place was visited regularly by their consultant psychiatrist who was supporting them, along with the staff in the care home, to make informed decisions about their future care, treatment and accommodation.
● We found the service was working within the principles of the MCA and people's consent was sought before staff provided care or treatment. Where people could not make independent decisions about their care and treatment, and this was required to preserve their safety or maintain their health, these decisions were made on their behalf and care delivered in their best interests.
● Where there were restrictions on people's liberty, staff had submitted applications under DoLS to the local authority (the supervisory body) for assessment.

Staffing and recruitment
● There were enough staff in number to meet people's needs. Lone working in the mental health unit did not take place, staff worked in pairs or in groups only for safety reasons.
● Staff completed the provider's induction training when they were first employed, as part of this they shadowed more experienced staff and were not counted in the staffing numbers until assessed as competent to be so. The registered manager said, "There are no restrictions on the length of shadowing time." A new member of staff said, "There has been more support than I anticipated for me. There is always a senior [member of staff] around to help me. They [staff] are really supportive."
● Staff were provided with one-to-one supervision sessions where staff could discuss their learning needs, work progress and performance. They were also provided with opportunities for debrief. These sessions

provided staff with an opportunity to talk through issues which had maybe left them feeling upset or where they had experienced a loss of confidence.
● Ongoing staff recruitment was in taking place at the time of the inspection. Staff recruitment records showed staff had been recruited safely. Checks prior to starting work with vulnerable adults included DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● During the inspection the environment looked clean and the housekeeping staff told us how this was achieved although no cleaning records were being maintained.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● There were no visiting restrictions which aligns with current government expectations in care homes.

Learning lessons when things go wrong
● A recent medicines incident had been recorded in the provider incident log and we were shown what actions had been taken to address this. Staff were also able to tell us what lessons they had taken from this. The incident had also been a subject of conversation in staff meetings.
● The registered manager took opportunities to reflect with staff when things did not go to plan, to support staff learning and development and promote team working. Staff told us this took place and how helpful they found it; staff debrief sessions also supported learning.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● On the mental health unit people's care records did not always demonstrate if people had been involved in planning, developing, and reviewing their care/support plans. There was little information about people's preferences and wishes.
● Care/support plans were often not in place for risk management interventions recorded on people's risk assessments such as restraint and the need for de-escalation support when people were distressed. This meant there was a lack of detailed guidance for staff on how these interventions would be applied for individual people. This put people at risk of unsafe or inappropriate care and treatment.
● The content of people's care records did not always reflect the care which had been commissioned for them and how this should be delivered in accordance with the Mental Health Act 1983 and other relevant standards and best practice guidance. One person's mental health care plan made no reference to the need for their rights to be read to them; there was no record of this having been done. The person told us their rights had not been read to them since their admission to the care home. The same person's care records made no reference to them having been assigned a mental health advocate (as is required), although it was verbally confirmed to us that one had been assigned and was involved.
● Care plans for the management and administration of medicines were in place but these were not person centred. This included when medicines were administered by another route other than orally, for example, by a tube inserted into the person's stomach. As required under the Mental Health Act this person's consent to treatment forms were not present in their care records or sitting alongside their medicines administration record. These were later found but their consent for treatment had not been incorporated into the person's care/support plans.
● One person's risk of violence had been formally assessed by professionals as part of their step down from a more secure environment. Following admission to the care home there had been no specific care plans developed on how staff should support this person's specific areas of risk, so they and others were kept safe.

● We reviewed five people's care records on the mental health unit and there was no evidence of care planning related to people's preferred social activities, giving guidance on their choices and preferences. There was no evidence of the provision or planning of structured/therapeutic activities to support people's mental health.

People's care was not always planned in a person-centred way and in a way which took into consideration relevant national standards and best practice guidance. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care needs on the dementia care unit were reflected in their care/support plans, including information for staff on how to meet these needs. These care/support plans had been regularly reviewed and updated as required.
● On the dementia care unit there was evidence of collaboration with people's representatives when people could no longer express a view about their planned care. This ensured care remained planned in accordance with people's wishes and in their best interests. One person's eating and drinking care plan had been reviewed and developed further with the involvement of the person's legal representative. This ensured the person's dietary wishes were considered when also needing to mitigate the person's risk of choking.

Improving care quality in response to complaints or concerns
● The provider had a complaints and concerns policy in place which people and relatives were aware of. An easy read pictorial version could be provided to people if needed.
● We reviewed the complaints record and no complaints had been recorded since 2017. However, there had been two recent complaints; one notified to the Care Quality Commission and another to the registered manager. The registered manager told us these had been acknowledged and investigated but the necessary records had not yet been completed. It was therefore not possible to assess if complaints were managed in accordance with the provider's complaints policy or to people's satisfaction.
● Relatives told us they had never needed to make a complaint but felt if they ever needed to, their concerns would be listened to and acted on. A relative said, "I wouldn't have a problem talking to [registered manager]. I've seen nothing that worries me."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Care records for people who lived with dementia included guidance for staff about people's communication needs. Care plans reflected people's needs, for example, if they lived with reduced hearing or sight and how they should be communicated with.
● Information could be provided in different formats and languages for people where needed. The complaints policy and procedures for example, could be provided in easy read format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The registered manager told us social activities took place on both units daily. We saw these recorded in both unit diaries; a list of what these entailed was seen. On the mental health unit this included outings into the wider local community for shopping, coffee and lunches, local walks, swimming, yoga, watching films and various beauty and pampering activities in-house. People on this unit were supported to go out most days to support their mental well-being and confidence. Where needed staff provided one-to-one support to achieve this safely.
● People on both units had access to visits from church leaders to support their religious beliefs and pastoral well-being.
● People who lived on the dementia care unit were supported to take part in activities which supported their well-being, which were meaningful to them and were within their abilities. One person showed us how they maintained a longstanding hobby whilst living on the unit. We observed one person independently

enjoying designing hair styles on a head manikin and saw staff supporting others to colour in pictures and to enjoy singing and music. One person's well-being was supported through doll therapy.
● People on both units enjoyed visits from external entertainers and the Pets As Therapy (PAT) charity also visited.
● People on both units were supported to maintain contact and connections with family and friends in accordance with their personal wishes. One person detained under the Mental Health Act 1983 had conditions applied regarding the length of time spent with family, away from Queensbridge House, which were clearly recorded on their 'Leave of Absence from Hospital' documentation. Staff supported this person to adhere to these conditions.

End of life care and support
● At the time of the inspection no-one was receiving end of life care, but staff on the dementia care unit were aware of whose frailty had increased and who was approaching end of life.
● People's care records on the dementia care unit gave brief information about their end of life wishes and who to contact when approaching end of life. One person's care plan had been reviewed with the person's legal representative as there had been recognition that the person's frailty had increased. This person's care/support plans therefore focused on keeping the person comfortable.
● When people's frailty declined staff ensured they liaised regularly with the person's GP surgery to ensure medical reviews took place as needed. Staff and the GP surgery worked closely with Pharmacists to ensure end of life medicines were prescribed and ready for use by the community nurses, if required to maintain a person's comfort leading up to end of life.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The provider had not implemented effective governance arrangements when deciding to support people with mental health needs. They had failed to implement robust policies and procedures and ensure these were followed, such as their admissions and referrals policy.

● When making the decision to admit people with highly complex mental health needs and forensic backgrounds, the provider had not reviewed their policies sufficiently to ensure these referenced and adopted relevant standards and best practice guidance. The provider, through their policies and procedures, did not have a robust enough framework for the service to operate against, when supporting these types of needs and risks. This put people at risk of unsafe and inappropriate care and treatment.

● Although some audits and monitoring reports were completed by the registered manager, they acknowledged there was no clear audit schedule in place. These audits and reports were not sufficient in supporting the ongoing monitoring of a service, which was now more complex in terms of its risk management requirements. These did not provide the provider with sufficient information to effectively identify shortfalls and make improvements. The provider was unable to produce evidence of their own monitoring audits or checks.

● The provider had failed to implement processes to ensure ongoing assessment and monitoring took place of existing risk management actions, to ensure these remained effective in mitigating risks to people. This included environmental risks such as those we identified during the inspection in relation to fire safety, falls from a height (from windows), substances hazardous to health and ligature points.

● The provider had failed to ensure care/support plans were properly developed on the mental health unit, to ensure staff were provided with sufficient and clear guidance, in accordance with relevant standards and best practice guidance, to support people safely and ensure their human rights in relation to privacy and freedom were upheld. For example, in relation to observations, use of restraint, de-escalation of people's distressed behaviour/s and the management of medicines.

● The provider's monitoring processes had not been effective in identifying the shortfalls we found in incident reporting. There was no evidence to show the provider had processes in place to subsequently follow up if appropriate notifications were made and actions were taken.

● The provider's quality monitoring processes had not identified the shortfalls identified during this inspection, in relation to medicines management and had not driven the improvements needed in respect of these.

Systems and processes had not been fully implemented by the provider to ensure they could effectively ensure compliance with the necessary regulations and standards and to ensure they could assess, monitor, and improve the quality and safety of the services provided to people. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us they were reviewing their policies to ensure they reflected best practice guidance and standards.
● The provider had employed a quality and compliance manager who, following the inspection, would be supporting the service to make improvements.
● Following the inspection, the provider organised the support of a specialist consultant to support improvements with medicines management.
● The registered manager was aware of their responsibilities regarding duty of candour and the need to be open and honest when things went wrong or when mistakes were made. This was evidenced through a notification to the Care Quality Commission and commissioners of care following an incident involving medicines.
● On the dementia care unit, accidents and incidents were recorded in the provider's accidents and incidents log, including the actions taken following these. Notifications of deaths and serious injury were made to the Care Quality Commission and commissioners.
● Staff also understood their responsibility to be open and honest and they told us they would feel comfortable in discussing any mistakes or actions which had not gone to plan with managers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although care/support plans on the mental health unit did not show how people were involved in planning and developing their care so this achieved good outcomes for them, people were regularly visited by members of the multidisciplinary teams who supported them. Members of these teams told us people's mental health had improved since their admission to Queensbridge House. One person told us they felt very supported, they said, "They [the staff] go the extra mile to support me." A mental health professional told us the person they had come to visit was "doing brilliantly well."
● There was no evidence to show people were involved in the running of the home, for example, regular group meetings involving people who used the service were not held in respect of this.
● Two out of the 3 relatives spoken with told us they had not been invited to provide feedback or to a relative meeting. However, they knew who the registered manager was and told us they found them to be helpful when spoken with. All 3 relatives considered the service to be well managed and benefiting their relatives. Comments on the quality of the service included, "It's fair", "It suits [relative]" and "It's very good."
● Staff told us the senior care staff and the managers were always visible and promoted fairness and team working. They told us they felt valued by the registered manager. One member of staff said, "The support provided to us by [registered manager] is intense. If something is done wrong [registered manager] will tell us, however, will often send a thank you message to us, by [social media], saying thank you for today."

Working in partnership with others
● Staff worked in partnership with a wide range of professionals and agencies when supporting people's needs. The registered manager regularly attended multidisciplinary meetings, with and without people who used the service, to review people's care and treatment with the professionals involved.
● Staff ensured people had access to the service when required by working with commissioners of care, across different integrated care boards (ICBs) and local authorities. The registered manager had a good

understanding of the contractual agreements in place with commissioners.

● The service worked in partnership with community groups and leaders of faiths to support people's religious and pastoral needs.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not always planned in a way which demonstrated their collaboration, and which ensured all their needs were met safely and in accordance with relevant national standards and best practice guidance. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not implemented effective systems and processes to ensure the service operated safely and remained compliant with necessary legislation and regulations, so people were protected from unsafe and inappropriate care and treatment. The provider had not implemented systems and processes which would drive improvement. Records relating to the management of the service were not always maintained as required. This related to incidents, complaints and cleaning. Regulation 17 (1) and (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to assess and mitigate risks related to the needs and risks people presented with. People who used the service had not been sufficiently protected from environmental risks which could impact on their health and safety health. Regulation 12

The enforcement action we took:

The Care Quality Commission issued urgent conditions on the provider's registration in relation to admission to the service.