Central and Cecil Housing Trust

Queens Court

Inspection report

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Date of inspection visit:
19 February 2016

Date of publication:
17 March 2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Queens Court is a care home with nursing that is based in a residential area of Windsor, Berkshire. The location is registered to provide care and support for up to 62 people. Queens Court is located in a modern built, fit for purpose premises with three floors. The building is not owned by the provider and another company gives support to the provider regarding the premises.

At the time of the inspection, there was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new home manager commenced in post on 18 January 2016, but at the point of the inspection had not registered.

The last inspection was conducted on 2 November 2015 and 5 November 2015. At that inspection, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took both civil and criminal enforcement against the provider. We issued the provider two warning notices; one for safe care and treatment and one for staffing. We also issued the provider with two fixed penalty notices. This was a focused inspection to follow up the two warning notices from the prior inspection. This inspection looked at only one key question; "Is the service safe?"

After the last inspection, the provider established a series of steps to immediately ensure people's welfare and safety. These included liaising with the local authority not to admit further people to Queen's Court, submitting regular action plans to the local authority and providing senior staff input in the operation of the service. Further steps included temporarily increasing staffing numbers to ensure sufficient staff deployment and increasing training for staff to gain the knowledge, skills and competencies they needed to ensure safe care for people.

We found improvements had been made at Queens Court following the last inspection and further changes were planned. Not all aspects of the changes had succeeded but further time was required to implement them and ensure sustainability.

Risk assessments and care plans were fully moved from computer based entries to paper based records. This meant the review and rewriting of everyone's care documentation. Steps had been taken to ensure better review of people's planned care. During our inspection however, we found planned care was not always the care that people received.

We found changes in the safe management and handling of medicines. Documentation and control processes around medicines administration had been strengthened by the management. Support workers and registered nurses received training and competency assessments to ensure they safely delivered medicines to people.

Safe staffing deployment was reviewed. Some new care staff were recruited and had commenced in post, including a new home manager, but the vacancy rate of permanent registered nurses was still unsatisfactory. The provider demonstrated they used strategies to attract more registered nurses to work at Queens Court but despite three months since the last inspection, just one new registered nurse had started working at the service. Further effort is required to fill the vacant posts. In the meantime, the provider continued to deploy agency registered nurses.

Staff had the ability to attend and participate in comprehensive training topics since the last inspection. A larger proportion of staff had received training in important topics like safeguarding, moving and handling and infection control. Some staff were booked to attend training in the months following this inspection. Staff had commenced supervision sessions with management, but more staff needed to participate and regularity in supervision meetings was required.

Further improvement in the prevention and control of infections is required at the service. Most areas of the building were clean and tidy on observation, but attention was not paid to handwashing, effective cleaning practices throughout the entire premises and the management of chemicals. However, we found better documentation of cleaning completed and training of cleaners had occurred.

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 was better information and completion of people's risk assessments, care plans and evaluations. However care planned did not always match that received by people.

The provider made efforts to improve the deployment of staff. Registered nursing shortage continued to affect safe staffing deployment at the service.

Medication safety had improved and ensured people were at less risk of medicines errors.

Staff training and development had improved and was planned to continue to enable staff with appropriate knowledge and skills.

Infection prevention and control still required improvements to decrease the risks to people, staff and others who came to the service.

Queens Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 19 February 2016 and was unannounced.

This was a focused inspection to check compliance with two previously issued warning notices.

The inspection team comprised of two inspectors and two specialist advisors in adult social care. All four of the inspection team were registered nurses.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Prior to the time of the inspection a Provider Information Return (PIR) was not requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke seven people who used the service and two relatives or visitors. We also spoke with the provider's home manager, nominated individual, operations manager, quality and compliance manager, clinical services manager, clinical lead and six other staff. We also contacted the local authority for feedback prior to the inspection.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection. We reviewed five people's care records and the care that four of them received. We looked at people's medicine administration records (MAR) and medicine rooms. We reviewed records relating to the running of the service such as staffing information, documents associated with staff training and quality monitoring audits.

Observations, where they took place, were from general observations. We also used the Short Observational

Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service that could not communicate with us.

We asked the provider to send further information to us after the inspection.

Requires Improvement

Is the service safe?

Our findings

At the November 2015 inspection, we found that people's risk assessments, care plans and evaluations were not safe. This meant that risks regarding people's care were not always effectively assessed, acted upon or recorded. We served a warning notice to the provider for Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to be compliant by 31 January 2016.

We spoke with people who used the service throughout the inspection about whether they felt safe at Queens Court. Two people we spoke with had just completed a communal exercise class. We asked them if they enjoyed the event. They told us: "Oh yes great fun, keeps me moving. We are off to the sherry meeting next!" Another person we spoke with said: "It's a good class and it keeps me moving". The two people confirmed they felt safe living at the service and that they were enjoying themselves on the day of the inspection. Another person we spoke with told us: "I have been well looked after here. The new manager seems very nice". A person that had transferred from the residential care unit to a nursing unit in 2015 commented: "It's a lot better here now. They look after me very well". One relative we spoke with stated they thought standards had "generally improved".

One person we spoke with was dissatisfied with their care and treatment. They told us: "I was woken at 6am for my pad to be changed. They only left a sheet to cover me and I was left feeling very cold". They told us they had reported this to the registered nurse, but told us they weren't confident that anything would be done. They also told us that some of their clothes had gone missing but that relative was involved in resolving this. They further commented that apart from these issues, they felt that things were "…getting better" and the staff were pleasant.

We also spoke with staff. One staff member told us they she liked working as a team leader with the people on their unit. When asked what they knew about individual people's needs, they told us: "I know their little ways".

No people were admitted to Queens Court since the November 2015 inspection. Despite this, during this inspection, we carefully examined four people's entire care documentation on one unit to look for improvements. We found there was a definite improvement in planning people's care based on their individual risks, but the delivery of care by staff did not always match what was planned in records. There was mixed evidence that care and treatment was consistently safe for people.

We spoke with the registered nurse in charge on the unit. We found that the registered nurse knew people's risks and the care they should receive from themselves and the support workers who worked with them as part of the team on the day of the inspection.

For one person, we found all of the pre-admission information was in place. The risk assessments and care plans were up to date and linked with other written care files for the person. We compared one person's care plan for pressure area care with the actual care they received during the inspection. We observed the care plan stated that the person needed repositioning every two hours to prevent skin breakdown. The last entry

on the turn chart was recorded as 7am. When we checked at 10,15am, the person had not been turned by staff and was still waiting for their breakfast. When the person's breakfast was delivered soon after our check, they were not provided the support they needed to eat it. However, all of the person's holistic medical needs were met, including support from allied health professionals to GP reviews.

Another person's care we reviewed showed their preference was to be assisted out of bed during the day. On the day of the inspection, the person wanted to stay in their bed and staff explained there was no risk for the person to do so. We saw that all assessments and risk assessments were in place for the person. The person explained to us they were experiencing difficulty with elimination and we found staff were monitoring this appropriately. The person's records showed they had lost some weight recently. However, we found staff were aware and were actively managing this aspect of the person's care. All referrals to support agencies were up to date. The person's fluid intake requirements were not met during the inspection and the person had not eaten any lunch at 2pm.

Another person's care we reviewed showed they required two staff to meet their needs. When we spoke with the registered nurse, they explained a number of people on the unit required two staff to attend to their needs. Our observation of this person's care was that they were sometimes left waiting for the second staff member to assist the first staff member with the care. However, despite delays, their care was carried out according to the care plan. The person had a medical problem with their leg. We observed the nursing care for this condition was satisfactory. When we reviewed the care documentation, we found all. We found most assessments and risk assessments were in place. The person required care in a wheelchair or mainly in a sitting position as they were small in stature but obese. The person did not have a weight management plan in place.

The provider had instituted "resident of the day" where staff would review one person's care and information each day throughout the month. The purpose was to look for and correct gaps in information and also to make sure staff knew people's risks and care requirements to a better degree. In the example we looked at, this was a positive manner of ensuring that safe care and treatment for people was promoted to and by staff on a regular basis.

The provider's action plan sent to us after the inspection showed that monthly evaluations and updates of people's risk assessments and care plans had commenced. The action plan also showed that management conducted care plan audits to check for accuracy and quality. Further improvements for safe care and treatment were planned, but had not yet been completed.

At the November 2015 inspection, the medicines management processes in the care home did not assure us that people would always receive their medicines safely.

Following the previous inspection, the provider deployed an additional registered nurse continuously on the residential care unit until they could organise for team leaders (senior support workers) to attend medicines training and pass competency assessments. At this inspection, on the residential care unit staffing on the unit had reverted to the team leader and support workers. The team leader was responsible for the administration of medicines to people. We examined the staff training records and found that 12 staff (including some registered nurses) had attended and successfully completed medicines administration courses. This meant that people who lived at Queens Court were at less risk because more staff had the knowledge and skills to manage and administer medicines in a safe way. The management assured us that annual competency testing of medicines administration by staff would continue. The location's training records also showed that the majority of nursing and care staff were booked to attend medicines awareness training in March and April 2016.

For a period of time, we observed two staff members at this inspection administering medicines on different floors of the building. One staff member was a team leader (senior support worker) on a residential care unit and one staff member was an agency registered nurse on a nursing care unit. Both staff members wore tabards that advised other staff not to disrupt them during the medicines round. Other staff respected the need not to disrupt the staff administering medicines, although we noted occasional distraction of their attention. We observed both staff members worked quietly and systematically and avoided errors in their procedures. The staff ensured that the medicines trolley was locked each time they left it to walk to a person who would take the medicines.

Neither staff member washed their hands or used hand sanitiser between each person they administered medicines to. We also noted the medicines rounds by staff commenced later than should be expected and continued for considerable time during the morning, meaning that people's doses of the same medicines were potentially received too close together. We had found the same practice occurred at the last inspection. We pointed both issues out to management so that improvements could be considered.

We looked in medicines rooms on all three floors of Queens Court. With the operations manager, we checked the controlled drugs book entries and count of stock in the cupboard. The stock numbers we counted together matched the records in the book. We saw that at the start and end of the staff shifts, counts of the controlled drugs were conducted and recorded. Checks of the controlled drug balances were conducted by management, but kept in records away from the medicines rooms, which made it difficult to determine the frequency of checking and level of oversight. In the medicines rooms, we observed that these were clean and mostly decluttered, although some equipment not needed in the room was still stored there. Medicines fridges were locked with a key, and daily checks of the fridge and room temperatures were recorded. Although there were a couple of days in one room where the fridge temperature was not recorded, medicines were stored at appropriate temperatures. Medicines kept in the fridge, for example eye drops, had the date written on the box to prevent use beyond the recommended date they were kept open. Medicines for destruction and return to the pharmacy were appropriately handled.

We checked a series of the medicines administration records (MAR) after the medicines rounds by staff. We saw that there were no gaps in the administration of medicines in the sample we looked through. Staff used the correct codes on the MAR to indicate when people did not take the medicines, for example if they refused or were absent from the building. Maps of the body were used to indicate where creams and lotions were applied. People who received warfarin were assessed and monitored by the 'anticoagulation service' and this ensured their safety through frequent dose adjustment and blood tests to ensure the blood level of the medicine was correct for them.

Medicines administered 'as required' (PRN) now had protocols in place which ensured staff knew when the medicines, such as pain relief for people, should or could be used. We found some gaps in information contained in the protocols and pointed these out to management.

The clinical commissioning group (CCG) pharmacist continued to work with Queens Court to manage overstocking of some medicines and dietary supplements. We noted that the effect of this was that some previously overstocked products at the care home had diminished in quantity; however some were still on the shelf in excessive amounts. The management assured us that they were combatting this issue with the pharmacist and further work was required to ensure stock ordering was better controlled. After the inspection, we asked that the provider send further documents to use regarding medicines safety. We found that the Queens Court service development plan and local authority action plan contained steps to further improve the safe handling and administration of medicines. We saw some of the medicines safety goals were already achieved, with work continuing on others.

At the last inspection, infection prevention and control was unsafe. People were placed at risk of infection due to poor practice and the failure of the staff and management to follow established guidance about infection prevention and control.

At this inspection, we found most areas of the care home, such as communal areas like lounge and dining areas clean. We noted the provider made an effort to discard some furniture and fittings that were worn, malodorous or stained. New carpet had been installed in a large part of one unit. There were some examples of furniture that still were stained or needed cleaning. We observed and examined evidence that deep cleaning in all areas was performed. However, we found that some surfaces and items had not been cleaned. Those areas missed included high, harder to reach areas and extraction fans, for example in bathrooms and toilets.

Since the last inspection, a number of care staff and cleaning staff had attended infection control training. We saw five staff had received training in how to deliver infection prevention and control education to other staff at Queens Court. However, there were still a number of staff who had no recorded infection control training. We noted from the training records that some staff were booked to attend after this inspection. We found dirty utility rooms (sluices) were cleaner and less cluttered than at the last inspection. Cleaners' rooms however had not improved in their appearance or tidiness. They were observed to be dirty, with chemicals inappropriately stored and wet mops in buckets.

Control of substances hazardous to health (COSHH) like cleaning chemicals still required improvement to reduce risk to people. We observed when cleaners went into people's bedrooms, and left their trolley outside, there was free access to chemicals which could cause harm. During inspection, we found chemicals not locked away in a communal bathroom. People with dementia or confusion could mistake the chemicals for drinks and had the potential to ingest them. Cleaners still required training in the safe management, handling and storage of COSHH, although we observed safety data sheets for them was now available. There was no housekeeper in post at the time of the inspection to provide supervision and management of cleaning. There were insufficient cleaners to meet the needs of the entire building, although we noted the cleaners in post worked hard to maintain cleanliness as best as possible. The provider's action plans confirmed the findings from our observations and staff interviews and showed that work continued to safely prevent, detect and control infections.

When we asked management, no one who used the service at the time of the inspection had infections. However, hand hygiene is a key principle to preventing infections in people. We observed satisfactory hand hygiene by most staff, although the premises fittings were unsatisfactory to enable better hand hygiene throughout Queens Court. A number of the hand soap dispensers we examined were old or broken, which rendered them inoperable. There was also not an effective distribution of instant hand sanitiser, for instance alcohol-based hand gel, throughout the building. We observed a few staff wearing long sleeve garments, which increased the risk of cross infection and discouraged handwashing. We pointed this out to management at inspection so that they could take action.

There were some improvements evident in the providers attempt to prevent and control infections at Queens Court. These included weekly infection control audits, and new weekly and monthly cleaning recording. However, in one infection control audit we reviewed, the scoring was not complete and did not indicate what level of risk or compliance the location had achieved. The audit also did not demonstrate areas for improvement and how these had been transferred to the provider's action plans. An example we saw in place was that additional signage regarding infection control was installed and visible to staff.

At the last inspection in November 2015, the care home was subject to a registered nurse recruitment and

employment problem where there were no permanent nurses deployed, except the deputy manager. This meant that the used only external agency nurses on the two floors where nurses worked alongside support workers. Queens Court had also not established what a safe staffing ratio or pattern was. We served a warning notice to the provider for Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to be compliant by 31 January 2016.

Since the last inspection, genuine efforts have been made by the provider to ensure safer staffing deployment. In November and December 2015, an initial increase of an agency nurse deployed on one floor was undertaken both day and night to ensure people's safety. After focused training and deployment of team leaders (senior support workers) on that floor, the third registered nurse on every shift was able to be reduced. A recruitment drive was utilised to try and fill existing posts and reduce the use of agency staff deployed. The provider had reviewed and increased the salary for the home manager and for registered nurses, in line with competition from other nearby locations and to account for the high cost of living in Windsor and surrounding areas. Additional salary enhancements such as subsidised formal qualifications were instated to attract more applicants for employment at Queens Court. The provider also attended and promoted their location at a recent job fair. The management reported that interest was shown in applying for positions at Queens Court.

One registered nurse was recruited since the inspection in November 2015. The provider has advertised their vacancies widely in paper and internet based publications. A number of applications were received at the location for registered nurse posts, however applicants either did not attend interviews or the provider refused them a position because of their competence, knowledge and skills. This has meant that multiple registered nurse vacancies remain unfilled and the provider deployed continued high amounts of agency registered nurse staff to care for people. However management have confirmed that their effort to recruit permanent and bank registered nurses would continue and considered alternative options like overseas recruitment of eligible available candidates. Support worker recruitment and deployment at the location has however been more successful with a number of offers and acceptance of the posts.

At this inspection, the deputy manager had transferred to the new post of clinical lead. This role meant the staff member was deployed on the floor beside care staff and registered nurses to have better oversight of the care that people who used the service received. The clinical lead was also more involved in auditing and detecting and reporting when care was inefficient or deficient. The post of deputy manager had therefore become vacant and not filled, although recruitment efforts were underway. Managers had a rota to cover after hours on call and were able to remotely ensure that safe deployment of staff could occur if unexpected absence of staff occurred.

The provider had established an overall care staffing deployment model to ensure sufficient numbers of staff provided care for people. We saw a 48 hour dependency tool was utilised to take a snapshot of time and calculate the number of minutes per day and per week each person that used the service required for care. This was in conjunction with a person-specific dependency tool. This method also determined when peaks and troughs in staffing were required throughout a 24 hour period. The provider had determined that there was a high dependency level for staff from people during meal times. The provider had determined that by staggering meal delivery and assistance over a two hour period, more staff were available to assist people with their meals in a relaxed and sustainable manner.

We observed staff response times to people's requests for help during the inspection day. We noted that people did not have to wait excessive periods of time. We saw people's call bells were answered within approximately two minutes in most cases. We also examined a weeks' worth of call bell records from February 2016. These records confirmed that most people's call bells were answered in less than five

minutes.

A satisfactory implementation of staff supervision, training and development had commenced by the provider since the last inspection. This was to ensure that staff were qualified, competent and skilled to meet the care needs of people who used the service. We spoke with the manager regarding staff supervision. We observed that staff had started to participate in appropriate supervision with a focus on their strengths and areas for improvement. The manager indicated that some individuals may require performance management and they would consult human resources if this became necessary. Not all staff had participated in supervision sessions at the time of the inspection and a formal planner was not in place, but the home manager confirmed these aspects of staff supervision were under review. We observed no staff had commended performance appraisals.

We saw that staff had participated in a higher incidence of training through a variety of formats. Training was completed both internally and externally, and several staff were skilled to become trainers in certain mandatory subjects, This was evidenced by the information in the training matrix and individual staff training certificates. New support workers had commenced Skills for Care's 'Care Certificate' and this was an improvement since the last inspection in November 2015, although more support workers needed to be offered the opportunity to commence and complete it. Further bookings for staff training were viewed for various topics.