Care South

Queensmead

Inspection report

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Date of inspection visit:
04 December 2018
05 December 2018

Date of publication:
08 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Queensmead is a residential care home for up to 40 older people, some of whom have dementia. There were 40 people living at the home at the time of inspection. The building offers accommodation over three floors with lift access to each floor. People have access to communal lounge and dining areas, an accessible garden and outside space.

Queensmead is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Queensmead has a registered manager but they had transferred to another location and so were not present during 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. At our inspection a manager had been appointed who was overseeing the service and would be making a registered manager application to CQC.

People and their families described the care as safe and were safeguarded as staff understood their role in recognising and reporting any concerns of abuse or poor practice. Staff had been recruited safely with checks including their suitablility to work with vulnerable people. People were protected from discrimination as staff respected people's individuality. Staffing levels were flexible which meant they were able to respond to people's changing care needs. Staff had completed an induction and had on-going training and support that enabled them to carry out their roles effectively.

People had their risks assessed and were involved in decisions about the actions needed to minimise risks of avoidable harm. Staff were knowledgable about people's risks and understood their role in keeping people safe from harm. Staff understood the actions they needed to take to minimise the risk of preventable infections. Medicines were ordered, administered, recorded and disposed of safely by trained staff that had completed medicine administration training. Accidents, incidents and safeguardings were reviewed to see how service delivery could be improved and when actions had been identified they were dealt with in a timely way.

Pre admission assessments had been completed that captured people's needs, choices and equipment required. This information had been used to create person centred care plans that reflected people's individuality and life style choices. People felt involved in decisions about their care and were involved, with

their families when appropriate, in care reviews. Working with other agencies such as district nurses and community mental health teams enabled effective care to be provided. People were supported to access healthcare both in planned and emergency situations. People had opportunities to be involved in their end of life planning and had their last wishes respected.

People had their eating and drinking needs understood by both the catering and care teams. People enjoyed the food and were offered choices at mealtimes with snacks and drinks available throughout the day and night. When people had risks associated with choking safe swallowing plans were in place and followed.

The building and secure gardens were accessible to people and provided opportunities for both social and private time. There was a lack of signage around the home such as the location of toilets which impacted on some people's ability to orientate themselves independently around the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Working with other professionals had enabled people to get the care and support they needed including appropriate equipment and access to healthcare. A complaints procedure was in place that people felt able to use and be listened to with actions taken to solve any issues.

People spoke positively about the level of care and had their privacy, dignity and independence respected by the staff team. We observed kind, patient, friendly interactions with people and staff demonstrated they understood people's communication needs.

The culture of the home was open and friendly with people, their families and the staff team feeling able to contribute to the development of the service. Staff understood their roles and responsibilities, spoke proudly of teamwork and felt appreciated in their roles. Auditing processes were robust and provided effective oversight of service delivery enabling actions to be taken when improvements were identified. Partnerships with other organisations enabled continual learning and provided best practice guidance that supported good standards of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Queensmead

Detailed findings

Background to this inspection

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

The unannounced inspection began on 4 December 2018. The inspection team consisted of an inspector 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. The inspection continued on 5 December 2018 with one inspector and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with 16 people who used the service and four relatives. We spoke with two operational managers, manager and deputy manager, nine care staff, two activities staff, administrator, head chef and the housekeeper. We reviewed three people's care files and discussed their accuracy with them and care workers. We checked three staff files, care records and medication records, management audits, staff meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

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

After our inspection we spoke with a community nurse who had experience of the service.

Good

Is the service safe?

Our findings

People and their families spoke positively about the care and felt the care was safe. One person told us, "I wouldn't have been able to cope alone so here I feel safe". Another said, "I feel safe here as there is always someone around to help if I need it". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. The registered manager understood their responsibility ensuring concerns would be raised appropriately with external agencies such as the local authority and CQC. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Assessments had been completed that identified risks people experienced and staff understood the actions they needed to take to minimise the risk of avoidable harm. Where equipment such as specialist pressure relieving mattresses were in place daily checks were made to ensure their effectiveness. One person had been losing weight and their relative explained, "(Relative) had an eating issue and was losing weight but thanks to the home they've got them to take a supplement drink and have encouraged them to eat so they have now started to gain weight". People were involved in decisions about how risks they lived with were managed. One person was at risk of skin damage but had made a decision not to have staff help them change position at regular intervals. This had been respected and was being monitored and reviewed monthly with the person.

One person experienced agitation and distress that at times placed them and others at potential risk. The risk assessment identified triggers to the behaviour. A care worker told us, "They like a walk in the garden or down to the local shops and that normally helps". When people needed a specialist involved this had taken place. This included speech and language therapists when people had swallowing problems, community mental health nurses and community nurses. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand cleansing facilities were available around the building. All areas of the home were visibly clean and odour free.

Staff had been recruited safely including checks with the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable adults. People and their families told us there were enough staff to meet their care needs and that call bells were answered quickly. A carer told us, "If we were short staffed everybody would come to help including the management and staff from the kitchen".

People had their medicines, including topical creams, ordered, administered, recorded and disposed of safely. Staff who administered medicines understood how people liked to take their medicines, any known allergies, how to report an error and considerations when people had medicines prescribed for as and when required.

Lessons had been learnt when things went wrong. Incidents, accidents and safeguarding's were seen as a way to improve practice and action had been taken in a timely way when improvements had been identified.

Good

Is the service effective?

Our findings

People and their families had been involved in a pre-admission assessment which had been used to gather information about their care needs and lifestyle choices. The assessment gathered information about a person's medical and life history and how they needed support whilst reflecting their level of independence. The information had been used to create person centred care plans which had been developed in line with current legislative standards and good practice guidance. Where people had needed specialist equipment such as bed rails this had been organised prior to admission.

Staff had completed an induction and on-going training that enabled them to carry out their roles effectively. A carer told us, "The induction was very clear and precise. Cared before but things change and felt up to date afterwards". Staff received support through supervision and an annual appraisal and had opportunities for professional development including diplomas in health and social care.

People had their eating and drinking needs understood and met by both catering and care staff. We observed people enjoying a relaxed mealtime experience in the dining room. Examples of the meal time choices were plated and shown to people to provide a visual aid when deciding what they would like to eat. One person told us, "The meals are very nice. I don't go downstairs and so the carers bring my meals up to my room; they don't mind". Another told us, "The food is good, nice and varied".

The service worked with other organisations to ensure people had effective care. This included community district nurses when people needed support with diabetes or wounds and community mental health teams when people needed support with their dementia. Each person had an emergency grab sheet which provided essential care, communication and contact information should they need to be transferred to another service such as a hospital admission. People had been supported to access healthcare both in planned and emergency situations. Records showed us people had access to a range of health professionals including chiropodists, opticians, dentists and audiologists.

There was a lack of signage directing people to various areas of the home including the lounge, toilets and bathrooms. This meant people with sensory problems were not always able to orientate themselves independently around the building. We observed one person unable to locate the toilet and staff quickly came to their aid helping them maintain their dignity. We discussed this with the manager who told us they would review signage around the building and discuss options with the operational director. A communal lounge, dining room and sunny foyer area provided an area for people to socialise and meet others. Level access led into a secure garden with seating which people told us they enjoyed in the summer months. People used their rooms for private time.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found the service was working within the principles of the MCA. We observed staff seeking consent from people and offering choices before providing any interventions. When people declined an intervention we saw this was respected. Care records showed consent had been obtained appropriately for photographs, use of bed rails and administration of medicines. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a person's behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families spoke positively about the caring nature of the staff team. One person told us, "The carers are lovely here, very friendly and helpful". Another told us, "The carers are very nice and help me when I need it". Another said, "I like the staff, they are lovely to me and that's nice". A relative told us, "They (carers) are very good here and seem to know my (relative's) needs". We observed friendly, relaxed interactions between people and the staff team. One person was tearful and staff gently placed an arm around them and guided them somewhere more private for a chat and to offer support.

Staff spoke enthusiastically about people and were able to share with us stories about people's lives, their families and events important to them. This meant people could have conversations that were important and meaningful to them. A carer told us, "It was (name's) birthday yesterday and we bought them a paint brush as we know they like to be busy". A carer explained, "It's a lovely home and the important thing is for people to feel at home". Another shared with us, "I love talking to the residents and making them smile". Families told us they were able to visit whenever they chose with one relative telling us, "Staff make me feel welcome".

People had their diversity respected. One carer explained, "We treat each person as individuals so you need to know how they like to live their lives". People's clothes and personal space reflected a person's individuality. A carer told us, "We know who likes make-up and jewellery".

People had their communication needs understood and met. One person had poor sight and a carer told us, "We have to describe it to (name). Things like meals and clothes so they can choose". Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, by talking with people at eye level and using hand gestures and facial expressions.

People were involved in decisions about their care and how they spent their day. We observed people making decisions about where and how they spent their time and staff respecting people's choices. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. One person told us, "I have a nice room where I can go (for private time)". We observed staff knocking on doors and waiting to be invited into people's rooms. We observed one person whose clothing was not fitted properly and staff quickly helped them straighten it up to preserve the person's dignity. When staff helped people they were patient and went at the person's pace. One person was walking with an aid and we observed staff walking by their side, gently resting a hand on their arm and providing support and encouragement aiding their independence.

Information about people and staff was stored securely to ensure their right to confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Information in care plans included the cultural and religious needs of people. Care staff were able to demonstrate a good knowledge of the actions needed to meet people's care needs and choices. A relative told us, "The carers know (relative's) needs and they are all lovely people". A carer explained, "With people we normally get told of changes as they happen at handover. It's always written in care plans and if you don't understand then the (senior staff) help".

People's communication needs were assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them.
During our inspection the service sourced NHS guidance on the implementation of the Accessible Information Standard (AIS). The Accessible Information Standard is a law which requires that services make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The manager told us they would review the guidance with a view to fully implementing the standard.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. We observed people enjoying baking biscuits, playing skittles and having fun. We observed staff spending one to one time with a person sharing stories about a remembrance parade they had attended. One person chose to spend most of their time in their room and told us, "I have the door ajar and they (staff) always wave. I definitely don't feel lonely". People had daily newspapers and sat reading them, whilst others enjoyed sitting in the foyer "watching all the comings and goings".

Staff were knowledgeable about people's past histories. A carer explained how one person had been a dancer and could become unsettled; "I sat with (name) and on my phone found a video on social media of a ballet. They sat for twenty minutes which was, for them, a lot of concentration". The activities co-ordinator told us how four men had always enjoyed woodwork - "We have a shed and we all went and emptied it and cleaned it up together so now we can use it". Links had been made with the community and people had enjoyed outings to the local football club, a local bird sanctuary and the remembrance parade in the local town.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. One complaint had been received since our previous inspection and records showed us this had been investigated appropriately and led to improved outcomes for the person. The manager told us they would be putting a suggestion box in reception for people, their families, visiting professionals and staff to use to share feedback and ideas.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to

be attempted. These decisions were discussed and reviewed every six weeks. Queensmead had been awarded a national accreditation for the end of life care provided to people in the management of symptoms, comfort, dignity and respect.

Good

Is the service well-led?

Our findings

Queensmead has a registered manager but they had transferred to another location and so were not present during 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. At our inspection a manager had been appointed who was overseeing the service and would be making a registered manager application to CQC.

People, their families and the staff team all spoke positively about the management of the home describing the culture of the service as open and transparent. A carer told us, "The management are very easy to approach". Another told us, "The manager seems nice and approachable. I have nothing to complain about and I know I can speak up if I do".

The registered manager understood the requirements of the duty of candour that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They would fulfil these obligations where necessary through contact with families and people. We saw examples of this during our inspection.

Staff felt appreciated and there was a strong team spirit which staff described as a strength of the service. One senior carer told us, "It wouldn't be Queensmead without the cleaner and the cook. We help the staff and they help us. Staff are part of the whole team. When you respect the staff they equally respect people".

Staff told us they felt appreciated. One carer explained, "They (staff) were very welcoming. They already had my photo in corridor (name board) and introduced me to everybody; that really made me feel welcomed". Staff described communication as good and demonstrated they understood their roles and responsibilities and level of their decision making.

Systems and processes were in place to ensure effective communication and engagement with people, their families and staff in developing the service and sharing information and learning. Regular meetings were held with staff, residents and their relatives providing an opportunity for sharing ideas and information. We read meeting minutes and topics had included discussions about making a complaint, new data protection standards, home security and activities. Community links included visits from local school children and a local church that visited fortnightly.

Audits were completed monthly including accidents and incidents, infection control, health and safety and medicines. When improvements were identified actions happened in a timely manner. One audit had identified a keypad door entry system was needed for the kitchen and we saw this had been completed. Feedback had also been collected from a national on-line care home website which was used to support reflective practice and when appropriate shared with the staff team.

The staff team worked with other organisations and professionals to ensure people received good care. These included 'Skills for Care', health and social care commissioners and CQC to keep up to date with best practice guidance. Information had been shared appropriately with other agencies such as local authority safeguarding teams and social care commissioners.