Care South

# Queensmead

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on the 6 June 2016 and was unannounced. The inspection was carried out by an inspection manager and an inspector.

Queensmead is a residential home that provides care for up to 40 older people some of whom are living with a dementia. At the time of our inspection there were 40 people living at the service. People had their own bedroom and shared bathrooms, a lounge, conservatory, dining room and gardens. The home has a 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.

Pre-employment checks were undertaken. However, gaps in employment history had not always been fully explored. One member of staff, who had started work on a DBS First check of the barred list. This member of staff had a criminal conviction and a risk assessment had been completed which incorrectly indicated that a full DBS had been received when it was still pending.

We discussed this with the registered manager and director who told us they would ask their human resources team to review the process immediately."

There were enough staff to meet the needs of people including during periods of staff holiday or absences.

Staff had the knowledge and skills to recognise potential risks of abuse to people and actions they needed to take if they suspected abuse. Risk assessments had been completed and where risks had been identified there was a plan in place that described actions that were needed to minimise the risk. People had been involved indecisions about risks and had the freedom and choices to live in ways they chose. Processes were in place to manage any unsafe practice.

People received their medicines safely.

Staff received an induction and ongoing training that enabled them to carry out their roles and responsibilities. They were supported and had regular supervision. They had opportunities for personal and career development.

Staff demonstrated a good understanding of consent ensuring people had choices about how they lived. Mental capacity assessments had been completed and people were being supported in the least restrictive way. Files contained copies of power of attorney (POA) legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

People received the care and support they needed to eat and drink safely. Staff had a good understanding of people's eating and drinking requirements and
any identified risks had been included in people's nutritional care plans. Referrals had been made to the GP, dietician or a swallowing and language therapist (SALT) when needed.

People had good access to healthcare including district nurses, physiotherapists and specialist health professionals.

We observed positive caring relationships between staff and the people. People had call bells and drinks in their rooms. Staff had a good understanding of people's interests, likes and dislikes.
People were involved in decisions about their day to day life. People had their dignity respected. Staff positively encouraged and supported people to maintain their independence. Information was available on advocacy services people could access if they needed somebody to speak on their behalf.

The home was registered with the Gold Standard Framework for end of life care and had achieved beacon status. The Beacon status is the highest award in the Gold Standards Framework programme, for end of life care. This meant that people could expect their physical, spiritual and emotional needs met with a focus on the management of symptoms, comfort, dignity, and respect.

Care plans included information that was specific to individuals and detailed their care preferences.
Staff had a good understanding of the support people needed. Care plans were reviewed at least monthly.
People were supported to carry out activities that were meaningful to them and supported to achieve personal goals. Links with the community had been maintained.

A complaints procedure was in place and included details on how to escalate a complaint. This included CQC the local authority and local government ombudsman. We pointed out to the provider that CQC do not deal with complaints although we encourage people to contact us at any time. The provider changed their literature immediately to reflect our comments.

The service was well led and had a positive culture that enabled staff to feel part of the team and empowered. Communication was effective with people, staff and other professionals. Staff had opportunities to discuss ideas or concerns and felt listened too and appreciated. They understood their roles and responsibilities and the level of decisions they were able to make.

The registered manager had developed links with the community and was involved in a local dementia friend's strategy group for Christchurch.

Audits had been carried out by that effectively captured the level of detail sufficient to provide reliable data and lead to positive change. A quality assurance survey had been completed in November 2015. The service was liaising with a local university to produce a bespoke dementia friendly survey that will better capture feedback from people living with a dementia.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service is safe.

Checks were carried out before staff started work.

There were enough staff to meet the needs of people including during periods of staff holiday or absences.

Processes were in place to manage any unsafe practice.

Risk assessments had been completed and where risks had been identified there was a plan in place that described actions that were needed to minimise the risk. People had been involved indecisions about risks and had the freedom and choices to live in ways they chose.

People received their medicines safely.

### Is the service effective?

Good

The service is effective.

Staff received an induction and ongoing training and supervision that enabled them to carry out their roles and responsibilities.

Staff demonstrated a good understanding of consent ensuring people had choices about how they lived.

Mental capacity assessments had been completed and people were being supported in the least restrictive way.

People's nutritional needs were assessed and met. Referrals had been made to the GP, dietician or a swallowing and language therapist (SALT) when needed.

People had good access to healthcare.

### Is the service caring?

Good

The service is caring.

There were positive caring relationships between staff and

people.

Staff had a good understanding of people's interests, likes and dislikes.

People were involved in decisions about their day to day life.

People had their dignity respected and supported to maintain their independence.

The service had achieved a recognised award for providing a high standard of end of life care.

## Is the service responsive?

Good

The service is responsive.

Care plans included information that was specific to individuals and detailed their care preferences.

People were supported to carry out activities that were meaningful to them and supported to achieve personal goals. Links with the community had been maintained.

A complaints procedure was in place. People and their families were aware and felt able to raise concerns with staff.

## Is the service well-led?

Good

The service is well led.

The service had a positive and open culture where people felt listened too and appreciated.

Staff understood their roles and responsibilities and the level of decisions they were able to make.

The registered manager had developed links with the community and professional bodies that supported learning.

Audits were carried out that effectively captured a level of detail sufficient that provide reliable data and lead to positive change.

A range of opportunities were available to provide feedback about the service.

# 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 6 June 2016 and was unannounced. The inspection was carried out by an Inspection Manager and an Inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We looked at information on the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with four people who used the service and two people who were visiting. We spoke with the operations manager, the registered manager, deputy manager, The chef and five members of the care team. We also spoke to a two health care professionals and a trainer who had experience of the service.

We reviewed five peoples care files and discussed with them and care workers their accuracy. We checked four staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.
We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

# Is the service safe?

## Our findings

Pre-employment checks were undertaken. Details of relevant checks were on files which included employment history, references, criminal record checks and
verification of why previous employment had ended. However, gaps in employment history had not always been fully explored. One member of staff, who had started work on a DBS First check of the barred list. This member of staff had declared previous criminal conviction which had been disclosed at interview. A risk assessment had been sent from the head office that indicated that the conviction detailed on the criminal record check was an acceptable risk. We pointed out that they had not yet seen the criminal record check to make this assessment. We discussed this with the registered manager and director who told us they would ask their human resources team to review the process immediately.

Staff told us and we observed that there were enough staff. One care worker said "When people are on sick leave or holiday the team are asked to cover additional shifts. If this is not possible then they all muck in including the management team". The registered manager told us the service had not used any agency staff since 2013.

Staff had completed safeguarding training. This had provided them with the knowledge and skills to recognise potential risks of abuse to people and actions they needed to take if they suspected abuse. One care worker said "There could be a change in a persons' behaviour, they could be withdrawn or have bruises. I would tell care team leaders and escalate until the issue was resolved. This could include external agencies such as the police or social services". People told us they felt safe. One said "I feel as safe as houses. I felt safe from the moment I moved in".

Risk assessments had been completed and included mobility, nutrition, and skin care. Where risks had been identified there was a plan in place that described actions that were needed to minimise the risk. Staff understood the risks that people lived with and how they could support them to keep safe. One care worker told us about a person who had periods of agitation that could lead to them getting angry with others. They explained how they recognised changes in the person's behaviour when they were becoming agitated. This enabled them to reduce the risk of the agitation escalating by distracting them with activities they knew they enjoyed. We observed a care worker letting a team leader know that whilst providing care they noticed the person had a red area on a pressure point on their skin. The team leader went and immediately checked the area and was satisfied the persons' skin was not at risk of deteriorating.

We observed staff transferring people between a chair and wheelchair on three occasions using a hoist. All transfers were consistent with the care plan and risk assessments. Two staff were present and explained to the person what was going on. They ensured that slings were removed when finished so not to cause skin pressure damage. Pressure relieving cushions moved between the seating on transfer. Individual named hoist slings were used. We looked at two moving and handling plans which detailed information such as size of sling, loops to use, numbers of staff and types of equipment. This matched what was observed for two people. Risk assessments were reviewed monthly or more frequently if a person had changing needs.

People had been involved indecisions about risks. One person was at risk of skin damage. Staff had explained the risk and discussed actions the person could take that would reduce the risk. The person had the mental capacity to understand the risk but decided they were happy to live with it. This meant that people had the freedom and choices to live in ways they chose.

Medicines were ordered, stored and administered safely. Staff had received medicine training and their competency had been checked. Five people took medicines that were covered by the Misuse of Drugs Act. This meant they had to be stored and administered with more security than other medicines. We checked the storage and administration records for one person and found the service was meeting the legal requirement.

Some people had medicine prescribed for "as and when they required it" such as paracetamol for pain or a laxative for constipation. We discussed with a senior care worker how they would recognise if a person needed their medicine but was unable to communicate verbally what was wrong. They told us "We would notice a change in their normal behaviour and be looking at why. Are they constipated, do they have an infection, are they in pain. We would check with the GP if necessary". When as required medicine was administered additional records were kept that recorded the reason why. A senior care worker said "If pain medicine was given to a person we would be discussing with the next shift at handover". This meant that people were only receiving these medicines when they were needed and there effectiveness was being monitored.

We observed a staff member giving a person their medicine. They used a spoon to put the tablet in the person's mouth. They remained with them until they had swallowed the tablet and offered them a drink. We observed staff wearing aprons indicating they should not be disturbed when administering medicines. The medicine trolley was locked when staff not with it and the keys kept with a member of staff administering medicines.

Good

# Is the service effective?

## Our findings

Staff had received induction and ongoing training that enabled them to carry out their roles and responsibilities. The registered manager told us that as part of staff induction new members of staff buddy up with an experienced staff member. They also complete five days training at head office which included essential training required to carry out their roles effectively. Within the first three months staff completed the Care Certificate. The Care Certificate is a national induction for people working in health and social care who do not already have relevant training. Moving and handling training was carried out six monthly in the service which enabled staff to learn in real life situations in rooms in the home. We spoke to one care worker who said "I got enough training to do my job. Had 'tomorrows another day' training which was really useful. It helped me to understand dementia and getting to know how the brain works and why people behave in certain ways". Another told us "I did a week of shadow shifts and then a week at head office doing training such as moving and handling and health and safety".

We looked at a training spreadsheet which indicated that all staff were up to date with their training. It included a colour coding system that highlighted when staff training was due to expire. The registered manager told us that 46.3% of staff had completed a diploma or an equivalent NVQ. This meant that people were being supported by staff who had demonstrated a nationally recognised good standard of knowledge in social care.

A senior carer explained how the service had engaged with a training organisation and had put a programme together based on learning needs that focused on the people they were supporting. The aim of the learning was to meet with groups of staff and relate the training to real life people and situations. We saw a training session planned for the 23 June to learn about dysphasia. Dysphasia is a communication disorder that occurs when parts of the brain responsible for language are damaged.

Staff told us they felt supported and received regular supervision. A member of staff told us "I had supervision a couple of weeks ago. Very good and they are always telling me how I'm doing". Another said "I feel supported. (Senior) supervises me but I can talk to any of the senior staff. They always are there to help, even if they're busy they are there". Staff told us they had opportunities for personal and career development.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service was working within the principles of the MCA. Capacity assessments had been completed. One example had been a capacity assessment in relation to a person accessing the community and had concluded the person had capacity to make this decision. Another example was in relation to a pressure sensor mat. It detailed consultation with the person and the consideration of other options. Staff demonstrated a good understanding of consent. One said "I help people make choices by showing them items such as food or clothing. I will use the least restrictive way and would support a person at a different time if they are reluctant to receive support. Consider a persons' previous wishes if they are unable to make a choice". We observed staff asking people for consent before providing any support and giving people time to consider and reply.

Files contained copies of power of attorney (POA) legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. One person had a POA and a care worker said "(The person) is involved in day to day decisions and the (relative) in bigger decisions about finance and property. (The person) still has capacity to decide about their welfare".

Care and kitchen staff had a good understanding of people's eating and drinking requirements. The chef said "The best way often to find out is observation. We work as a team". Each person had a nutritional care plan that had been shared with the chef. There had been a new admission the day before our inspection and we saw that information about the person's diet had been shared with the kitchen. People spoke highly of the chef and the quality of food. One person said "(Chef) is a gem. He gives you nice food. I said how about sweet and sour and we got it. I mentioned croissants and he made them and mini donuts".

A risk assessment had been completed for people and any identified risk of malnutrition had been included in people's nutritional care plans. One person had been losing weight. We looked at their nutritional plan and it had included a discussion with the person about their food likes and dislikes. When risks had been identified referrals had been made to the GP, dietician or a swallowing and language therapist (SALT). We spoke with a SALT who was visiting two people. They told us "I felt (staff) knew both people very well and were consistent with their reports".

The service had been involved in a project organised by a local university that looked at supporting people with a dementia to eat and drink well. Learning had been used to make changes to people's dining experience. Examples we observed included a breakfast bar displaying cereals and other breakfast choices. People who were unable to independently access the bar were taken in their wheelchair to choose what they would like. We observed at lunchtime staff showing people the meal choices plated. This meant that people with poor communication had visual prompts to help them make decisions. The organisation had awarded the service 'Best Dining Experience 2015".

Each dining table had a menu for the day. Breakfast, lunch and supper included hot options. We observed one person being offered the lunch choices and they declined. The care worker offered them other choices and they decided on an omelette. Another person when shown the lunch options was worried the portion was too big. The care worker reassured them and said "not a problem I will get you a smaller portion". Some people had equipment to help them maintain their independence. This included a change of cutlery, guarded dinner plate and a drink being served in a lidded beaker. People had a choice of where they would like to eat their meals. We saw two people enjoying their lunch outside on the sun terrace.

People had good access to healthcare including district nurses, physiotherapists and specialist health professionals. We read one file where a person had experienced a number of falls. A referral had been made to their GP and an occupational therapist which resulted in change of their walking aid from a stick to walking frame.

Good

# Is the service caring?

## Our findings

People and their families told us the staff were caring. One person said "They listen to all our moans and groans. They are so kind, their brilliant". Another said "The staff are very caring". A relative said "They make sure (my relative) is always smart and has a bath every week". Another person told us "The night staff are lovely. I have to get out of bed a lot. They come and empty my commode". Another said "The staff are excellent. I was so poorly when I came here and they brought me back to life".

We observed positive caring relationships between staff and the people living at the service. One staff member checked that a person was ok after a fall they had the previous day. They showed real concern for the person. Another roused people gently when it was lunchtime. A staff member sat next to one person and used touch appropriately as well as words to support communication. They offered the person the choice to remain in the lounge if they wanted. One staff member commented positively about a persons' appearance and it bought a smile to their face.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A care worker told us about a person who had just arrived at the service. "When they arrived we had one to one time asking them about their likes and dislikes. A new resident likes gardening and being active". A care worker said "There's plenty of time to have a chat with people. One person likes me to sit and look at their photos with me. Sometimes I read the newspaper or we attempt the crossword". Staff also knew the informal names people had chosen to be addressed by and used these appropriately.

Relationships between staff and people were considered when staff were allocated to support people. A care team leader explained that one person didn't interact with other people and often didn't want to be supported with personal care. It was noticed that they responded particularly well to one male carer. We spoke to the carer who said "I found my own way with (person). We talked about going for a beer, we've just clicked. I sometimes sit and have a sandwich with (person) and they eat better. If I find new strategies I share them with the other staff as I'm not here all the time". The deputy manager told us about how a person had gelled with a new member of staff and they had been out shopping together.

People were involved in decisions about their day to day life. We observed staff asking people where they would like to sit, how they would like to spend their day, offering options and choices. Information was available on advocacy services people could access if they needed somebody to speak on their behalf.

People had their dignity respected. We saw staff knocking on doors prior to entering rooms. One care worker explained "I use a blanket if hoisting a person who wears a skirt. Change people's clothes after dinner if they have spilled food. Cover people with towels or a blanket during person care". One person said "Staff respect my dignity. I always get respect".

Staff positively encouraged and supported people to maintain their independence. One care worker explained that one person when they first arrived at the service had been very reliant on staff. They told us

the person had become increasingly independent and that this was because they had settled in and felt more at home.

The home was registered with the Gold Standard Framework for end of life care and had achieved beacon status. The Gold Standard Framework is a standard of care that people can expect when they are near the end of their lives. It is designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect. The Beacon status is the highest award in the Gold Standards Framework programme, for end of life care.

Good

# Is the service responsive?

## Our findings

Assessments had been carried out before a person moved to the service and had been used to complete care and support plans. The assessments had included people, their families and information from other professionals. Care plans included information that was specific to individuals and detailed their care preferences. We read in one person's night care plan that they liked two pillows and a duvet and didn't mind if the light was on or off. Another person's read no light, curtains closed and the time they liked to go to bed.

Staff told us they had time to read the care plans and they had a good understanding of the support people needed. A care worker said "I tend to flick through care plans especially if somebody is new. The plans are in depth. Best to know what they say so that you don't say anything that upsets them". Another care worker said "We have a handover at each change of shift. Care team leaders go through each person and any changes and risks".

Care plans were reviewed at least monthly. A care worker said "If somebody has a change in mobility I will talk to them and get them to do exercises and see how strong they are. Ask them what they think. If concerned I'd go straight to the person who does the care plans". We spoke with a nurse from a local GP surgery who said "The home will ring me. They are responsive to people's needs".

Life histories were recorded in each person's care file. They generally included information about a person's family, previous occupations, places they had lived, pets and other information of significance to them such as bereavements.

People were supported to carry out activities that were meaningful. The service had regular access to a mini bus. One person had spent holidays in Lymington and asked if they could go which was organised. We saw photographs on the wall of the day out. Participation of activities was recorded in people's files. We read one that said 'Took a stroll to the florist to buy some flowers'. One person had wanted a special piece of clothing. Staff took them out for lunch and shopping. The registered manager told us there's a themed day once a month. She said "It's all about having fun".

People were supported to achieve personal goals. One person wanted to attend a well- being course in the community. They found the initial experience daunting. To help the person achieve their goal the deputy manager attended with them to provide support and help with confidence. This enabled the person to achieve their goal. Another person told us how they had a fear of water. They told us "Staff gave me the confidence to have a bath".

We saw photographs along the corridor walls that showed a range of activities people had enjoyed the previous month. The registered manager explained that the photographs showed families the activities people had been doing and showed them the relationships they had with staff.

Links with the community that were important to people had been maintained. One person went to their

local church each Sunday. Another person enjoyed going to see their favourite football team play. A premier league football club had a community partnership with Care South and had visited the service to share a coffee morning. They had played walking football and people had enjoyed reminiscing with the players.

A complaints procedure was in place and included details on how to escalate a complaint. This included CQC the local authority and local government ombudsman. We pointed out to the provider that CQC do not deal with complaints although we encourage people to contact us at any time. The provider changed their literature immediately to reflect our comments. The complaints procedure captured information from written complaints.

We discussed with the registered manager processes in place to capture complaints or issues raised verbally. They gave us an example of where a family had noticed their relative had painted nails. Knowing the persons history they felt it was something they wouldn't have wanted. The outcome was that the care plan was changed to reflect this. Another example had been a person waking in the night and seeing a staff member in their room. They raised with the staff that although the person was a nice lady they didn't recognise them. In response the registered manager had photographs taken of night staff to show to people who were new to the service. The registered manager told us that they had spoken to staff asking if they could write down issues raised in order to fully capture people's experiences and feedback.

Good

# Is the service well-led?

## Our findings

People, staff and visitors all told us they felt the service was well led. A care worker said "I can always make suggestions it is very open. It doesn't feel like work. There is a lovely atmosphere. The residents are amazing. It's a lovely home, I consider them as family". Another said "It's a lovely place to work and the residents are like a second family. Very good teamwork. All round I think it's excellent. Feel I can express how I feel. Their door is always open. I do feel listened too". We spoke with a visiting health professional who said "The home is very organised. The (registered manager) has a good rapport with the GP surgery. Communication is good". A visitor told us "The (registered manager) is brilliant and very flexible. Always makes herself available even if only for a couple of minutes".

A staff survey had been conducted by an external lifestyle coach. They spoke to staff on a one to one basis to gather their feedback and views. An outcome had been staff had expressed they would like more contact with the chief executive of Care South. In response an e-mail address had been created for staff to use to contact them.

The Manager had a good understanding of her responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

People, their families and staff felt communication was good. One relative said "When I email the manager I always get an immediate response". A senior care worker told us "Everything runs like clockwork". We saw that staff had a relaxed but respectful relationship with the manager. The manager demonstrated a good knowledge of people, their families and the staff team. Meetings were held with the staff team. We read that they included updates from around the wider company and specific areas to improve such as cleanliness and reminders of the importance of supporting new staff. There was a resident committee and we read that they had discussed food and activities. The meetings were attended by the chef and activities co-ordinator and people's ideas were included in menus and the activities planned.

Staff understood their roles and responsibilities and the level of decisions they were able to make. They told us that they felt their achievements were recognised. The organisation operated a staff awards scheme. Nominations were made for staff who went the extra mile. A senior worker told us about a staff member who had won an award for making a difference. They had been taking people shopping in their own time. They said "Their approach with each person is different. It is very person centred".

The registered manager had developed links with the community. They were involved in a local dementia friend's strategy group for Christchurch. Dementia friends aim to promote awareness of dementia within local communities. The registered manager had visited a local cafe with people living with a dementia to assess how dementia friendly they were. The visit had highlighted a number of challenges for people and their aim was to work with local cafes to help them become dementia friendly. Dementia friends had been promoted at the summer fayre and some staff had taken up the opportunity.

Audits had been carried out by the organisations quality and compliance manager, the operations manager and the registered manager. The system effectively captured the level of detail sufficient to provide reliable data and lead to positive change. A quality assurance survey had been completed in November 2015 and gathered feedback from people, their families, staff and professionals with experience of the service. We were told by the registered manager that with a local university the quality assurance survey is being reviewed. The aim is to produce a bespoke dementia friendly survey that will better capture feedback from people living with a dementia.

In the foyer we saw CQC 'Share your View' forms and also Carehome UK forms for people should they wish to share feedback outside of the organisation.