Care Quality Commission

Queensbridge Care Limited

Queensbridge House

Inspection report

63 Queens Road
Cheltenham
GL50 2NF
Tel: 01242 519690
Website: www.queensbridgecare.co.uk

Date of inspection visit: 30 October 2015
Date of publication: 10/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement

Overall summary

We carried out an announced comprehensive inspection of this service on 10 and 13 April 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) gaining people's lawful consent to their care and support; Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) managing people's risks and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) supporting and training staff.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Queensbridge House on our website at www.cqc.org.uk.

This focused inspection took place on 30 October 2015 and was unannounced. Queensbridge House provides accommodation for 27 people who require nursing and personal care. 21 people were living in the home at the time of our inspection. Most of the people living in the home have been diagnosed with a type of dementia.

The provider and registered manager of Queensbridge House had introduced and planned several changes to the home to ensure people who lived there remained safe and had a good quality of life. The registered manager had sought specialist advice on running a home for people with dementia and had reviewed the format of people's care records.

Staff were kind and their care and approach focused on people's needs and preferences. People's health care risks were now being routinely identified however records of how people should be supported to reduce the risks were not always consistent. Some people had not been

Summary of findings

assessed for the support they would require in the event of a fire. Staff supported people who lacked mental capacity with choices about their day. However the documentation of the assessment of people's mental capacity had not been completed in line with legislative guidance.

Staff had now received update training. Their training needs and personal development was now being monitored. A one year programme was in place to provide all staff with additional training on dementia awareness. Staff had started to receive regular support meetings. Further plans were in place to review how staff would be supported in the future.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

This service was not as safe as it should be.

Staff knew people's risks and the actions to take to support them. However, people's care records did not provide staff with adequate guidance about their needs and how to reduce the risks.

Whilst staff supported people to make decisions about their care; people's consent to their care and support had not always been lawfully obtained and documented.

Is the service effective?

Requires improvement

The service was now effective.

People were being cared for by staff who had been trained and supported to meet their needs. Plans were in place to further improve staff development and training.

We could not improve the rating for Is the service effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Queensbridge House

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 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focus inspection took place on 30 October 2015 and was unannounced. The inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 10 and 13 April 2015 had been made. We inspected the service against two of the five questions we ask about services: Is this service safe and Is the service effective. This is because the service was not meeting some legal requirements.

Two inspectors carried out the inspection. We reviewed six people's risk assessments and related care records and how the service had obtained people's consent to their care. We also looked at staff records relating to their support and training development. We spoke with the registered manager, a senior carer and a staff member responsible for the monitoring of staff training. We observed staff interacting with people throughout our inspection. The majority of people living at Queensbridge House were unable to communicate their experience of living at the home in detail as they were living with dementia.

Requires improvement

Is the service safe?

Our findings

At our inspection in April 2015, we found that people were not safe as their personal needs and risks were not being managed effectively. The provider sent us an action plan to tell us how they would ensure people were kept safe in the home. On 30 October 2015, we revisited the home to check if they had met their legal requirements.

At this inspection we found that new processes had been put into place to improve the safety of people, however this was not consistently recorded on people's care records. The provider and registered manager had taken an organised approach to reassess the service being provided. They had commissioned an organisation who specialises in developing services that support people with dementia. The registered manager said, "We are now working through a detailed action plan to ensure residents receive the best possible care here and they remain safe with us". The registered manager had also reviewed how people's care needs were being recorded and maintained. All staff now had access to the electronic care planning system and paper copies of the records were available for staff to use. People's care records were now clear and accessible to staff. People's risks had been identified by using assessment tools. For example, an assessment tool was used to identify people who were at risk of falling. A key worker system had also been implemented which ensured people's needs were regular monitored and updated. A key worker is a staff member who has more detailed knowledge about people's care needs.

Staff knew people well and provided them with the support they required to reduce risks to their health and well-being. However, whilst improvements had been made to the system to identify people's health and care risks; the guidance for staff and records on how to monitor and support people to reduce their risks was not always consistently recorded. For example, one person's eating and drinking care plan and related assessment tool had identified they were underweight but there were no guidance of how staff should support this person to gain weight. Another person had experienced several falls which had mainly been recorded; however there was no information about the reasons of the fall or actions to be taken to further prevent this person falling.

Not all people had a personal evacuation and emergency plans in place which would give staff guidance on how to support people in the event of a fire.

The consent of people who lacked mental capacity to make decisions about their care and support was not always lawfully obtained. The assessment of people's mental capacity had not been consistently carried out in line with the code of practice of the Mental Capacity Act 2005 (MCA). 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. For example, one person had been assessed as not having the mental capacity to manage and handle their own money; however the detail of what part of their inability to manage their money was not recorded. Records of meetings were not always in place where best interest decisions had been made on behalf of people.

Daily records of how people spent their day and their physical and mental well-being were not consistently captured. There were gaps in the recordings of the people's daily records. This daily information was recorded on the electronic care planning system and periodically printed off. The registered manager told us she would be reviewing this process.

Whilst processes had been out into place to identify people's risks; their risk assessments and associated care plans did not give staff adequate guidance on how people should be supported to reduce risks to their health and well-being. Assessments of people's mental capacity to make decisions about their care and support were not adequately completed. **This is a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

However, staff knew people well and were able to tell us the actions they had taken to reduce the risk of harm to people. Staff encouraged people to make choices about their day and were aware of their preferences. Staff held a regular hand over between shift changes where information about people were shared and documented in a daily communication book.

Requires improvement

Is the service effective?

Our findings

At our inspection in April 2015, we found that staff skills and knowledge to care for people were not always checked and monitored and staff did not fully understand the principles and concept of the Mental Capacity Act and how this impacted on the right of people to make decisions about their care. The provider sent us an action plan to tell us how they would ensure staff practices would be kept up to date and how they would ensure people were involved in decisions about their care. On 30 October 2015, we revisited the home to check if they had met their legal requirements.

At this inspection we found that actions had been taken to improve the knowledge and skills of staff. However, the involvement of people in their decisions about their care was not always recorded adequately which is addressed in 'Is the service safe?' part of this report.

The majority of staff had completed training as deemed as mandatory by the provider. They had carried out training with work books on specific topics with some supplementary practical sessions on moving and handling, first aid and medication training. When the work books were completed, they were sent way for assessment and staff were then issued with a certificate. We were told that plans were in place to issue staff with the food hygiene work book which would coincide with action plan from a recent food hygiene inspection.

The provider had engaged with an organisation which specialises in developing services that support people with dementia. The registered manager and three senior staff had subsequently attended a leadership course on supporting people with dementia. Plans were in place for all staff to attend ten days of dementia training during the next 12 months. This would run alongside with implementation of recommendations given by the specialist organisation to provide a home that suitably supports people with dementia. Other staff were actively encouraged to undertake national qualifications in health and social care.

The registered manager had started to implement regular formal support meetings with individual members of staff, however some staff had not yet received these meetings. We discussed this with the registered manager who told us the aim was to mentor and develop senior staff members to give them the skills and responsibility to undertake these meetings.

Whilst we saw improvements had been made in how staff were trained and supported, we could not improve the rating for 'Is the service effective?' from requires improvement because to do so requires consistent good practice overtime. We will check this during our next planned comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People's care records did not provide staff with adequate guidance about their risks and their consent to the care and support they received.