Dr Jawed Hamid

Alexandra Lodge Care Centre

Inspection report

355-357 Wilbraham Road
Chorlton
Manchester
Greater Manchester
M16 8NP

Tel: 01618605400
Website: www.alexandralodgecarecentre.com

Date of inspection visit:
24 May 2016
25 May 2016

Date of publication:
07 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 24 and 25 May 2016. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.
The previous inspection took place in August 2014 when we found a breach of one regulation. This was because the hot water system was not working properly. We received an action plan in September 2014 which stated that new taps had been installed and a new water pump was being obtained. At this inspection we checked that the hot water was working properly, which it was.
Alexandra Lodge Care Centre is a care home which provides residential and nursing care. It is registered to provide accommodation for up to 37 people. At the date of this inspection there were 34 people living in the home. Of these 14 were receiving nursing care and 20 were receiving 'residential' care.
There are seven bedrooms on the ground floor, six of which are en-suite. The remaining 28 bedrooms are on the first floor, 14 of them being en-suite. Two of those can be shared by two people. Downstairs there are two lounges and two dining rooms. There is an enclosed garden. There is a nurses' office next to the main lounge.
A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Alexandra Lodge Care Centre had a registered manager. They had been in post since May 2014 and had become registered in April 2015. At the date of the inspection they were taking extended leave of around two months, which the provider had notified us about. The clinical lead was the acting manager.

Most people told us they felt safe. Staff were trained in safeguarding. We found that an allegation about bruises had been made and not reported as a safeguarding incident to the local authority. This was a breach of the regulation about safeguarding. We also found two incidents had not been reported as safeguarding incidents to the CQC. This was a breach of the regulation requiring allegations of abuse to be reported to the CQC.

The arrangement for storing controlled drugs was not satisfactory. Medicines were administered in a safe manner, except that we saw they were recorded in a batch rather than individually, which risked errors. These two issues were a breach of the regulation relating to the safe administration of medicines.

There were sufficient numbers of staff on duty to meet people's needs, although fewer in the early evening. There had been a high turnover of staff which meant agency staff were used. Staff and relatives raised concerns about agency staff not knowing people as well as regular staff did. Because of staff availability some staff, including the acting manager, were working excessive hours per week. This was a breach of the regulation relating to having sufficient numbers of staff available.

At its last infection control inspection Alexandra Lodge had scored highly. Most areas of the building were clean. We noted some stains on the walls in one dining room, and some food debris on a radiator. This was cleaned during the inspection but there were still some stains.

Alexandra Lodge followed good practice in recruitment to ensure that all staff were suitable to work in the home. The home was well maintained and precautions were taken against fire.

People had access to healthcare services outside the home. However we found one example of someone who had been waiting three months for an appointment to be made for a new hearing aid. This was a breach of the regulation relating to providing appropriate care.

Alexandra Lodge was complying with the requirements of the Mental Capacity Act 2005, although staff did not always explicitly ask for consent when carrying out care tasks. Authorisation under the Deprivation of Liberty Safeguards was applied for when needed.

There was a good range of training. Staff were supported with regular supervision.

People said they enjoyed the food. The cook was able to cater for special dietary needs.

The building was comfortable and homely. We have made a recommendation about improving the environment for people living with dementia.

People living in the home and relatives were enthusiastic about the quality of care. However, district nurses told us that continence needs were not always met and people were not always kept clean and dry. This was a breach of the regulation relating to meeting people's needs.

We saw some other examples where staff were not putting first the needs of people living in the home. However, at other times staff were treating people respectfully.

The home had a good working relationship with a local GP practice. The home was experienced in caring for people who were nearing the end of life and enabled people to stay in the home till the end if they wished. Several relatives had commended the home for the quality of its end of life care provision.

Thorough assessments were completed before people moved into the home. Care plans were detailed and tailored to the needs of the individual. More personal history of each person would enhance the person-centred care. Care plans were updated regularly.

There was a newly-appointed activities organiser who was developing a range of activities. There were links with the community and people could go out shopping with the activities organiser. Residents' meetings took place.

There was a complaints policy and procedure, but no complaints had been received within the last 12 months.

Feedback from relatives about the quality of the management was mainly positive. However, the high turnover of staff had affected staff morale and contributed to some of the failings identified in this report.

The Statement of Purpose was out of date, but policies and procedures were up to date.
Staff meetings were held, and meetings for nurses. Some staff felt that the meetings did not make a lasting difference.

Audits were conducted to monitor and improve the quality of the service. The manager's office was untidy, which made finding documents difficult, but a new filing cabinet was on order which would help with

organising the office.

We found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one regulation of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of the report.

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 always safe.

Most people said they felt safe but in two cases allegations of rough handling had not been reported as safeguarding incidents. Medicines were managed safely except that the recording was not always done correctly. The storage space for controlled drugs was insufficient.

There were enough staff on duty but some staff were working too many hours and there was a high turnover of staff and use of agency staff. There were safe procedures for the recruitment of staff.

Some areas of the home needed to be cleaned better or more often. The building was maintained and had precautions against the risk of fire.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to healthcare.
Staff were trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and the legislation was being used appropriately.

Staff received sufficient training and supervision to equip them for their tasks. People told us they liked the food. The environment needed to be upgraded to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People living in the home and their relatives were on the whole satisfied with the standard of care, but we received critical feedback from district nurses that people's needs were not always met.

Staff respected people's privacy but did not always consider their

preferences.

The service was equipped to meet the needs of people nearing the end of life. It had a good working relationship with a local GP practice, and steps were taken to assist people to stay in Alexandra Lodge if that was their wish.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Thorough pre-admission assessments were done to ensure Alexandra Lodge could meet people's needs. Care plans and risk assessments were detailed, although there was scope for more personal information to be gathered.

In one case a person's need for a new hearing aid had not been addressed. Staff did not always ensure people were protected against the risk of pressure sores deteriorating.

There was a new activities organiser in post who was developing new activities. We saw some activities taking place. There had been no formal complaints within the last year, but the management had an open-door policy and preferred to deal with issues before they escalated.

Is the service well-led?

Requires Improvement

The service was not always well led.

Feedback from relatives about the quality of the management was mainly positive. At the date of the inspection the deputy manager was in charge.

The Statement of Purpose was out of date but policies were up to date.
Staff meetings were held. Staff told us the biggest problem was the high turnover of staff, which affected morale.

There was a system of audits to monitor the quality of the service. However, the issues identified in this report had not been picked up by the audit system.

Alexandra Lodge Care Centre

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 over two days on 24 and 25 May 2016. The first day was unannounced which means we gave no notice of when we were coming. The second day was by arrangement.

One adult social care Inspector and an expert by experience carried out this inspection. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert by experience had personal experience of supporting older people.

Before the inspection, the provider completed a 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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us under the regulations.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. They told us their last visit in October 2015 had not raised any significant concerns. We also saw a report of a visit by an officer of Manchester City Council in February 2016 assessing the home for the 'Bronze silver gold' award. This is a method of validation of quality by the Council.

During the inspection we looked around the building and observed mealtimes and interaction between staff and people living in the home. We carried out an observation known as a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who

cannot easily express their views to us.

We talked with 13 people using the service, five visiting relatives, seven members of staff, and two visiting professionals. We also spoke with the acting manager, the provider and other office staff.

We looked at three care records in detail, medicine administration records, five staff files, and staff rotas for the week of our inspection and the two previous weeks. The registered manager and provider sent us a number of documents at our request, including their business contingency plan, and training records and certificates.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Alexandra Lodge whether they felt safe. Not everyone was able to communicate with us verbally, but those who could all told us that they did feel safe, with one exception. People said "Yes I feel safe," and "We are well looked after."

The exception was a person who told us they were unhappy in the home and said that they had sustained a bruise on their left arm due to being gripped too tightly when being transferred in and out of their wheelchair. They said this had happened very recently but there were no bruises on their arms. We checked this person's care records and saw that their allegation was recorded on their risk assessment, along with a similar allegation from ten days earlier. The earlier allegation was about a bruise to their hand, but the risk assessment recorded that the person had subsequently said it was caused by banging the hand against a chair. There was therefore some uncertainty about the validity of their allegations, but the second allegation about the bruising ought to have been recognised as an allegation of abuse, and reported both to the local safeguarding authority and to the Care Quality Commission (CQC). We discussed this with the acting manager who accepted that such an allegation ought to be reported.

The failure to identify incidents of abuse and alleged abuse and to report them appropriately to the local safeguarding authority was a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found another incident which ought to have been reported to us at the time as a safeguarding incident. A district nurse had visited someone in the home and became concerned about their bruising, informed the home and decided to raise a safeguarding alert with Manchester City Council. This meant the home was required to report the issue to the CQC, but they did not do so. Subsequently the GP's opinion was that the bruising was unlikely to have originated from a blood test, as had been suggested, because the bruising was over the wrists. But there was no conclusion as to the origin of the bruises. Even though the investigation proved inconclusive, Alexandra Lodge should have recognised the referral as a safeguarding incident and an allegation of abuse.

All care staff except five recent recruits had received training in safeguarding. Five staff were overdue refresher training by two months, as their training had been in March 2015 and according to the provider's policy it should be renewed annually. The training was delivered by an outside company, and we saw from the certificate provided on completion that it covered the necessary topics. We asked staff about their understanding of safeguarding and they were able to explain the different types of abuse and what to do if they witnessed or suspected abuse had occurred. This indicated that they were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to accurately record and report potential incidents of concern.

We looked at the arrangements for ordering, storing, administering and disposing of medicines. There was a suitably secure room where medication was stored, and where the dispensing trolley was kept locked to the wall when not in use. There was a locked cupboard containing a small safe for storing controlled drugs.

These are drugs which by their nature need to be kept more securely than other medicines. There are strict rules in the Misuse of Drugs (Safe Custody) Regulations 1973 governing how they must be stored. The safe was adequate but it was not large enough to contain the number of controlled drugs that were being stored. There were some drugs, which were recorded in the controlled drugs register, which were being stored outside the safe, inside the locked cupboard. This did not comply with the requirements of the Misuse of Drugs (Safe Custody) Regulations.

We checked three of the controlled drugs that were in the safe and saw that the amount of the drugs corresponded with the amount in the register. We saw that all the entries in the register were countersigned by a second member of staff, as required by legislation. At the end of each shift the nurses checked the controlled drugs were correct, and we saw the record of those checks in the nurses' office.

The administration of medicines was done by two members of staff, one for people on the residential side and one for those receiving nursing care. This meant that the administration round did not take too long and everyone received their medicines in a timely way. We were told that one person needed to receive their medicines at a specific time, and the nurse on duty told us this was always done. We saw that people were given their medicines in a calm manner, and the member of staff explained what it was and observed that the medicine was taken.

Staff used a medicine administration record (MAR) to record when medicines were given. The MAR sheets included pictures of each person, which would assist new or agency staff to ensure that the correct person received the medicines. The pictures were however very small.

We saw that the nurse at the end of the administration was signing all the MAR sheets in one batch. They should be completed after each person has received their medicines. We asked why they were doing this and they said it was because they were busy. This was poor practice, as it risked the record not being accurate if for example one person had refused one medicine. It is important that MAR sheets are accurate as they are used by medical professionals to verify that medicines have been taken. The NICE Guideline on 'Managing medicines in care homes' states that providers should ensure that staff are "making a record of the administration as soon as possible".

The inadequate storage of controlled drugs and the poor practice around MAR sheets together amounted to a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there was an efficient relationship with a local pharmacy which supplied medicines to Alexandra Lodge, and there were no reports or evidence that medicines were ever not available when needed. A record was kept in the nurses' station of all the medicines in stock as a precaution to ensure that medicines would not run out. There was also a proper system to dispose of any unused medicines.

We checked staffing levels and saw they corresponded with the rotas. We looked at rotas for the current week and the two preceding weeks. During most of the day there was one nurse and six care workers, including the team leader, on duty. At 3pm each day (4pm on Mondays) the team leader finished their shift, which meant there was one fewer member of staff through the afternoon and early evening. This was a potentially busy time, with the evening meal and some people going to bed. At night there was one nurse and three care workers on duty.

There had been a high staff turnover in the few months leading up to our inspection. One member of staff told us that eight staff members had left since the start of 2016, out of a complement of 16. We had concerns

that agency staff were commonly being used, because there were not enough staff on the roster to fill in if staff were on leave or went off sick. One visitor said, "There are too many agency workers who don't understand what [my relative] needs," and another visitor said, "I have no confidence in the agency staff system."

One member of staff said there had been times when they had been the only regular member of staff on shift, the rest had been agency workers. A district nurse commented to us that there were a high number of both new staff and agency staff, which was potentially risky. Another district nurse told us there had been one occasion when they arrived during the day to find only agency staff on shift. We saw that some agency workers came repeatedly to Alexandra Lodge which meant they could get to know the people, but having that high number of agency workers together was far from ideal.

A related concern was that some staff were working long hours. We noted that the clinical lead, who was acting manager, was on the rota to work seven days in the week we were there, including two long days (i.e. 12 hour shifts) at the weekend. This added up to a 64 hour week which was excessive. On top of that they were scheduled to work three nights, on the Monday, Tuesday and Sunday. In the event they cancelled the night shift on the Tuesday and brought in an agency worker. There had been a similar pattern in the two preceding weeks, although with less working at weekends and one less night shift.

The acting manager explained that this was an unusual period because of the absence of the registered manager on extended leave, and things would be more manageable once he returned (which was expected in a month's time). Nevertheless the high use of agency staff and the excessive hours worked by some staff indicated a lack of staff availability. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Alexandra Lodge had recently installed a new nurse call system. When someone pressed their buzzer, the system showed the bedroom number, which floor it was on, and how long the buzzer had been pressed. This enabled staff to respond to calls in a timely fashion. It also produced records so that management could identify any times of the day when buzzers were rung more often or staff were taking longer to respond. When we talked with people no-one said it took a long time for staff to answer the buzzer.

We looked at how well the building was kept clean and how people were protected from the risk of infection. In the most recent inspection by Manchester City Council in November 2015 Alexandra Lodge had achieved a high score for infection control. It had then implemented an action plan. Infection control formed part of induction training, and all staff apart from recent recruits had received training in infection control, within the last 18 months.

We looked round the building immediately after our arrival. Corridors and most communal areas appeared clean, and we saw the cleaner going in and out of bedrooms. Bathrooms and toilets were clean and we did not detect any unpleasant smells. The carpets and flooring did not appear to have been thoroughly cleaned. In one of the dining rooms we saw splashes of food and liquid on the walls, and there was dried food inside the top of the radiator by the window. From its appearance this was not just food which had fallen inside the radiator that morning, but some of it had been there some time. Later in the morning the cleaner cleaned the top and accessible areas of the radiator but some stains were still visible inside.

One of the relatives we spoke with commented on the walls in the dining room, and implied the stains were a common occurrence: "The walls are dirty but the residents do it, it's how it is in the care system." We asked the cleaner about the walls and they replied, "I do the floors, the care staff do the tables." We asked the provider and acting manager about this. They acknowledged that there were food stains on the walls and

that the particular radiator we had seen was unacceptably dirty until it had been cleaned. They stated that one person always wanted to sit in the same place by the window, and tended to spread food around. We commented that this behaviour needed to be managed and the cleaner needed to take responsibility for cleaning all dirty areas. However, we considered that the food stains, while unsightly and unpleasant, did not in themselves represent a hazard of infection to the people living in the home.

We looked at the personnel files of three recently recruited staff and saw that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. Alexandra Lodge's standard application form requested job applicants to account for any gaps in their employment record, and to supply their home address for the last six years. There was evidence of a DBS check (the Disclosure and Barring Service checks for any convictions or cautions). In two cases there was the original certificate from the DBS on file, and we advised the acting manager that the correct procedure is to keep a record of the certificate number but return the certificate to the employee or destroy it. There were documents proving the job applicant's identity, and two references had been obtained. The acting manager kept records of the job interviews. In one case the referee stated that they had only known the job applicant for two weeks, which reduced the value of the reference. Despite this, we were satisfied that adequate checks were made to ensure the service used safe recruitment practices.

Accidents and incidents were reported but were kept on individual people's files rather than together. This would make analysis more difficult.

We saw evidence of safety and maintenance checks on the lift and hoists, gas appliances and electrical appliances. The fire alarm system, fire detection system, and fire extinguishers were routinely serviced. There was a fire risk assessment which had been updated in March 2016. A "resident evacuation" list with brief details of each person's mobility was kept in the office and had been updated the week before our inspection. The intention was to give this list to the emergency services in the event of a fire or other need to evacuate the building. It would be best to keep this list where staff can access it immediately in an emergency.

In our previous inspection we found problems with the hot water distribution system. New taps and a new water pump had been installed. We tested a tap in one of the en-suite bathrooms and found there was hot water at a safe temperature. There were risk assessments relating to the fabric of the building. Following our visit the provider sent us at our request a copy of their business contingency plan, which set out in sufficient detail their plans for dealing with emergencies which might affect the safety of people living in the home.

Requires Improvement

Is the service effective?

Our findings

We saw from care records that people had access to healthcare professionals outside the home, including GPs, dentists, chiropodists, and opticians. We met district nurses who came in daily to provide support for people receiving residential care in the home. We also met a GP from a nearby medical practice who told us they were a regular visitor to Alexandra Lodge. One person told us, "They get me a doctor if I need one." A visitor said they were kept well informed about health issues affecting their relative.

We looked at how well Alexandra Lodge was complying with the requirements of the Mental Capacity Act 2005. 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.

All of the care staff had undertaken training on the MCA within the previous 15 months. We saw from care records that a record was kept of when people had consented to decisions about their care, and what steps were taken if people were unable to consent. For example the wording of the bed rail risk assessment included the question "Has the resident been consulted regarding the use of bedrails?" It went on to record their consent, if they had the capacity to consent. If they did not, the form had space to record a best interests decision. One person had a DNACPR on file (Do not attempt cardiopulmonary resuscitation). We saw this had been discussed with the person concerned who had capacity to agree to it. We also saw there was a policy on covert medicines, which means medicines given without the person realising. Although there was no-one in the home currently receiving medicines covertly, the policy showed that the home took into account the principles of the MCA.

At lunchtime we observed that staff did not always ask for consent before a care intervention. For example, they put clothes protectors (i.e napkins) to keep the food off their clothes on people without asking. Then they placed food and drink in front of them without checking that they wanted it. Staff moved some people closer to the table without asking, but saying for example, "You need to be closer." It would be good practice for staff to seek consent or at the least tell people what they were doing.

People can only be deprived of their liberty so that they can 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 in terms of applying for DoLS authorisations when needed, and whether any conditions on authorisations to deprive a person of their liberty were being met.

All care staff had received training in understanding DoLS. We saw no evidence that people were being deprived of their liberty without authorisation. Applications for DoLS authorisations had been made and in some cases authorised (although others were still awaiting a decision). Those applications we saw had been completed correctly and set out the reasons for the application. The outcome of applications had been

notified to CQC, as required under the regulations. In one example there was a full explanation of why the DoLS authorisation had been applied for, demonstrating a good understanding of the criteria.

We looked at whether the staff received the training they needed to carry out their roles. We obtained a copy of staff training record. We found staff had undertaken mandatory training in safeguarding vulnerable adults, person-centred care, health and safety, food hygiene, first aid, moving and handling, fire awareness and infection control. All staff apart from the newest recruits had completed all the training described by the home as mandatory, although some staff were now due refresher training. In addition all staff had received training in the use of catheters, diabetes, epilepsy, HIV, pressure care, safety at work, challenging behaviour, dementia and Alzheimers, and end of life. This was a comprehensive set of training topics. All staff had certificates of attendance on their files.

All new staff had an orientation checklist which listed the training courses they were expected to attend and recorded their completion. Three new staff were having moving and handling training on the second day of our inspection. We noted that the five newest staff had not yet received any training, according to the training record, but they ought to receive the most vital training as early as possible after joining Alexandra Lodge.

All staff were receiving supervision roughly every eight weeks. Staff told us they had received supervision at these intervals. This was confirmed by the record of supervision for 2016 to date. We noted that the acting manager (clinical lead) had conducted all the supervisions in January 2016, but had delegated some of the supervisions to senior staff (team leader and deputy team leader) in March. This meant that staff would receive supervision and learn from a variety of people. We saw that some supervision records were identical, which indicated that the supervision had been used to communicate information to staff rather than as an opportunity for staff to express themselves. Annual appraisals had taken place for all staff in July 2015, although because of the high turnover rate only 10 staff remained in post since that date, and the other 10 staff had been recruited since then. The regular supervision of staff meant they were supported in their work and also enabled management to oversee performance.

We spoke with the cook, who informed us they were not involved in ordering or purchasing food. Nevertheless, they confirmed that the menu was varied, and we saw that portion sizes were adequate. The cook told us they had previously been a care worker in the home. They did not have formal qualifications in cookery, but had attended a food hygiene course in 2014, and the provider told us they were planning to send them on a "cooking for care homes" course. The cook had a list of special diets on the wall of the kitchen, and was able to cater for health, religious or cultural needs. We saw that some people were served different meals because of their requirements.

People waiting for lunch told us they had no idea what was going to be served, and there were no menus available. One person said, "I don't know what's for lunch, I think they should have a menu." Providing a menu would improve the mealtime experience. We also observed the tables were bare, with no tablecloths and no condiments, which made the dining room feel rather institutional. At lunch, the choice available for the standard meal was potato hash with corned beef and beetroot, or cheese and tomato sandwich. People appeared to enjoy it, and most people finished the meal. Minutes of residents' meetings also recorded that people liked the food. One critical comment came from someone who always ate in their bedroom, "The food is ok but with no choice. Sometimes it's a little cold." This meant that staff needed to ensure that food taken to people in their rooms stayed hot enough.

Anyone identified as being at increased risk of malnutrition, or dehydration, or who had significant weight loss, had their diet and fluid intake monitored and recorded through the completion of monitoring charts,

and fortified diets were provided where appropriate. Everyone was weighed monthly or more often when needed. A record of weights was kept both on individual care records and centrally, to enable easy access and so any trends could be identified.

The premises were homely but we observed there were few adaptations to make them more appropriate for people living with dementia. There was little signage to assist people who were independently mobile, or use of colour schemes to help people recognise their bedrooms. We did not see any specific items around the home which could help people living with dementia, no tactile objects, very few pictures or objects to encourage discussion between people or with staff. There were no items for triggering memories.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We asked people living in Alexandra Lodge whether they felt well cared for. The answers were positive: "We are well looked after", "Anything they can do for you they do. They keep me clean and tidy", "They are very friendly here, and it's a nice atmosphere." One visitor told us the staff were friendly, and that Alexandra Lodge was more homely and less clinical than the home their relative had been in previously. We saw that a professional visitor had written in a questionnaire, "Staff treat the residents very lovingly. Staff know the residents and their needs well."

However, we received some critical feedback from one of the district nurses who was visiting on the first day of our inspection. We also spoke by telephone with the district nursing team leader. The district nurse stated their opinion that continence issues were not well managed. Continence management was not listed on the staff training record as a topic that any staff had covered. The district nurse added that often when they came in one or two people needed cleaning or changing before they could attend to them. They said they could tell that people had been in this condition for several hours before their arrival. They mentioned one particular person this had happened with that morning. We looked at the care record for this person. It was recorded that they needed support to manage their continence and needed to wear a pad. The acting manager also told us that staff were aware of the issue and would change their pad or clothes as necessary. We pointed out that our information was that the person was not always changed ready for the visit of the district nurse. This meant that people's basic need for comfort and dignity were being ignored. There was also a risk of skin deterioration and moisture lesions developing. This was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We considered how well Alexandra Lodge respected the needs and wishes of people living in the home. In the morning after breakfast several people were sitting at the tables in one of the dining rooms. One of the nurses was checking the medicine trolley. Loud modern pop music was playing on the radio. We asked the nurse why the music was on so loud and they replied "It keeps me going." We then asked the four people whether they liked it and they all said they did not. One of them said there was a CD which they preferred, but it appeared the CD player was not working. The nurse had considered their own preferences rather than those of the people living in the home.

We also observed that a member of domestic staff came into the dining room and removed people's tea and coffee cups without saying anything or asking whether people had finished. Even if domestic staff were not part of the staff caring team, their attitude mattered as it made a difference to people's self-esteem. However, later on we saw the same domestic staff did engage with people as they were clearing the tables.

We saw that in other ways staff respected people's dignity and privacy and observed that bedroom and bathroom doors were closed when personal care was being provided. Staff knocked on bedroom doors and waited for a response before entering people's rooms. Care files were kept securely in the nurses' station which meant that people's personal information was kept confidentially.

We asked whether the service ever assisted people to have an advocate. We were told this had happened

and would be arranged again when needed. This was confirmed by someone living in the home who told us about a problem involving their finances. They said, "I told the manager and he contacted my social worker and arranged for me to have my own advocate." They added, "The staff show a lot of empathy if you have a problem and make sure you are safe."

During our visit we met a GP from a nearby medical centre, who explained that they were a regular visitor to Alexandra Lodge. Their practice not only responded to medical needs, but visited proactively to build up relationships with the people living in the home and their families. On this occasion they were meeting two separate families to discuss the future care needs of their family members.

The GP said they were involved by the home when someone was nearing the end of their life. They stated their view that the home was very capable at meeting people's needs at this stage and enabling people to stay in the home rather than go to hospital, if that was their preference. They added that the home provided, "Good palliative care." Staff at the home encouraged families to be involved in writing advanced care plans, which set out people's wishes. The provider told us that because Alexandra Lodge was able to provide care at the end of life people were often placed there who were nearing that stage, and they tried to ensure dignity and comfort for both the people using the service themselves and their families.

Nearly everyone in the home had a DNACPR in place. This is a form which instructs the staff and paramedics not to attempt cardiopulmonary resuscitation in the event of a cardiac arrest. When people were considered to be nearing death, staff at the home worked with the doctor. The service made sure special drugs were obtained to meet the medical needs of people nearing the end of life, and that the nurses were trained to use the appropriate equipment.

A family member wrote to us, "the whole family is grateful for all the care, kindness, compassion and medical care that was given to [name] in their final days." This sentiment was repeated in several more cards sent to the service by families after their loved ones had passed away.

We also saw a note that had been received from a GP, "Thank you and the rest of the team for providing such professional care, with kindness and humanity, to [name] in their last days."

Requires Improvement

Is the service responsive?

Our findings

We saw in the care records we looked at that a comprehensive pre-admission assessment had been carried out before people were offered a place at Alexandra Lodge. The provider told us they were often involved in pre-assessment, along with a nurse. Where appropriate a nursing needs assessment was completed. This was intended to ensure that the home was suitable and that staff were able to deliver effective and safe care that met the individual's needs and preferences. Once people had moved into the home a care file was compiled. We saw one pre-admission assessment was unsigned and undated, but the rest had all been completed fully.

Each care record contained multiple care plans. These included plans relating to moving and handling, nutrition and dietary needs, skin integrity, and a care plan entitled activities of daily living. These were accompanied by multiple risk assessments, specific to the individual. In one example the risk assessments included risks related to constipation, urinary tract infections, sleeping patterns and the use of bedrails, pressure sores and mobilising.

We noted that a great deal of information was gathered, but it would not be easy for a new member of staff to grasp, or in particular agency staff, since Alexandra Lodge was using quite a few agency staff. There was limited personal information about people's history, their family, interests, likes and dislikes. This kind of information is helpful and enables staff to engage with people in a person-centred way. When we spoke with senior care staff, they knew quite a lot about the past history of people living in the home. But it would be better if that information was stored in care records to make it accessible to other staff.

We saw the care records had been reviewed regularly each month to ensure the information reflected the person's current support needs. The reviews were kept on each person's file, showing which care plans and risk assessments had been reviewed and when. There were some entries which recorded simply "no change since last review", which may have been the case but was not very informative. Others carried information about what had been assessed and how.

We also saw examples where staff were not responsive to people's needs. The district nurse who talked with us raised concerns about pressure care, saying that they had found one person sitting on their pressure relieving cushion but it was not plugged in. (Such a cushion is designed to reduce the incidence or development of pressure sores but will not function if it is not plugged in.) There were other people with minor pressure sores, but the district nurse did not make any criticism of the home's care and treatment of these people.

While most people's health needs were met, one person told us that their hearing aid had been lost about three months earlier. They said a nurse had taken it home with them but had never brought it back. They added they had told everyone they could that this had happened, but no-one had done anything about it. We asked the clinical lead who confirmed that the details of this account were correct. They stated that the nurse had taken the hearing aid home to clean it, but for some reason had not returned it. The week before our visit one of the staff had contacted the audiology clinic to make an appointment. We checked the

relevant care file and found that the last audiology appointment had been in October 2015. There was no reference in the care file to the hearing aid having been lost or to any attempt to replace it.

We considered that the failure to address promptly the loss of the hearing aid had adversely affected this person's quality of life. Alongside the failure to ensure that the pressure cushion was plugged in, there was a breach of Regulation 9(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Alexandra Lodge had recently appointed an activities organiser who had been in post a month. On the first morning of our inspection they were escorting someone to a hospital appointment. It was explained to us their role was as a care worker in the mornings, and organising activities in the afternoons. They told us they sometimes took people shopping. One person confirmed this, saying "Once a week I go out to the shops with a staff member, we go in a taxi." Another person said, "I went shopping yesterday to Stockport." The activities organiser confirmed this trip had taken place, although it was in fact to Manchester. These shopping expeditions were clearly appreciated by those who were able to take part in them, but of course meant that only one person was taking part in that activity.

The activities organiser told us they had a limited budget to buy equipment but there was no storage space for them to keep it. They were keeping some items in their own car, which was only a temporary solution. They were enthusiastic about their new role and told us they had lots of ideas. There was a programme of activities on the wall in the entrance hallway but we understood these were left over from a previous activities organiser and did not represent what was currently on offer. We watched a cookery activity in the afternoon, which was engaging the interest of a dozen people. One visitor told her that her relative had done some colouring, despite a disabling illness which made it very difficult for them to hold the brush. The activities organiser told us they had helped them by holding the brush at the same time.

Other people told us that there were not many activities other than watching TV. Another person said they thought there were not many activities, "You get up in the morning and that's it." However, we took into account that the activities organiser was very recently in post and would need time to establish which activities worked well.

There was a large garden which could be accessed easily from the building. During our visit garden maintenance staff attended to tidy the garden and cut the grass. Staff told us that people could use the garden in the summer months. We saw evidence that people could attend a church or other place of worship when they wished to, and some people had access to the local library. Visits were arranged to and from a local high school.

We saw minutes of residents' meetings which had been held roughly every two months during 2016. Although not everyone had been able to take part, those that had done so had contributed. They were consulted on the decoration of their rooms and communal areas, on activities and menus. On occasion some people were invited to meet prospective new care workers on the day of their interview and to comment on their suitability. This was a good example of involving people in their own care and the running of the home.

There was an up to date complaints policy. The complaints procedure was hanging on the back of bedroom doors. This informed people living in the home and their families about how to make a complaint. The provider and acting manager told us that no formal complaints had been received in the previous 12 months. The acting manager told us that they and the registered manager were always available and they preferred to deal with issues at an early stage rather than let them escalate. One relative said to us, "The management have been very responsive when I have raised care issues with [the acting manager]." One

person told us that the TV was not working in their bedroom. They said they had mentioned this to the acting manager, but when we raised the matter the acting manager said she would get the maintenance man to sort it out right away. These were examples of the approach of dealing with issues immediately in order to meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was on extended leave at the time of this inspection. We saw that the clinical lead, who was the deputy manager, was filling that role effectively, and they told us they were closely involved in the management of the home at all times. During the registered manager's absence they had appointed new staff, and conducted disciplinary procedures. The provider was also present in the home at most times. Although they did not take an active part in the leadership of staff and in care provision, they offered advice and assistance on many aspects of running the home.

We received positive feedback from a relative who wrote, "Alexandra Lodge is extremely well run with both [registered manager] and [clinical lead] at the forefront at all times coupled with dedicated and caring staff. The cleanliness, meals and even the entertainment is second to none and if I could award 5 stars I would." We noted that these positive comments did not coincide with all our findings at this inspection. Another relative was less complimentary, saying "The home lacks leadership, carers just do their own thing." But another relative told us "I have complete faith in the management."

Another relative had sent a card at Christmas to the clinical lead saying, "With appreciation for the wonderful care and all your brilliant management skills. Things at Alexandra Lodge have improved immeasurably since you [both] took over."

We requested to see the Statement of Purpose, which the provider sent us immediately after the inspection. This is a document setting out the aims of the service and what it can offer, and it should be made available to people using the service and their families. Although this version carried the date December 2015 the document was very out of date, as it referred to the Health and Social Care Act 2001 instead of the Health and Social Care Act 2008, and in some places to the Commission of Social Care Inspection which was superseded by the Care Quality Commission in 2009. It was clear it had not been fully updated. It did contain ample information about the care home and the terms and conditions for people living there.

We also received the service's business contingency plan which set out the service's plans for dealing with an emergency, such as fire or flood. This showed that the provider had plans in place to minimise disruption to people living in the home in the event of a major emergency. We saw a renovation/improvement plan detailing works on the fabric of the building. This plan finished in July 2015, but the provider told us there was a more recent version, which was not shown to us.

The home had a set of policies which had been revised in August 2015 and which referred, correctly, to the regulations introduced in April 2015. These included policies on whistleblowing, safeguarding and the Deprivation of Liberty Safeguards. Although these were kept in the manager's office staff told us they knew where they were, and could refer to them if they needed to.

Staff meetings were held every two or three months. However no minutes of the last meeting in March 2016 were available. The acting manager told us these were still being typed up. Ideally minutes should be available for the benefit of all staff including those who could not attend the meeting. On the minutes of the

previous meeting in December 2015 there was a list of five care staff who had attended, none of whom were still working at Alexandra Lodge. This was indicative of the problem of unusually high turnover of staff.

There were also meetings for "qualified" staff, which meant the nurses. The minutes of these suggested they were a vehicle for the registered manager to inform nurses about matters, rather than a forum for nurses to raise issues themselves. We saw that these meetings did have some effect. At a meeting at the start of April 2016 the registered manager had informed the nurses that photographs of residents were missing from some care records. By the time of our inspection photographs were present on every care record.

One member of staff told us "We can raise issues at staff meetings, and then things improve for a while, but then they slip back." This staff member also raised the issue of staff turnover. They said they noticed more and more agency staff. We raised this issue with the provider and acting manager. They talked about the difficulty of retaining staff, including nurses. They also pointed out they had recently recruited five staff. They stated it was their intention to reduce the number of agency staff. However, the high turnover affected staff morale and in our view contributed to some of the issues with the quality of care identified earlier in this report.

We looked at what audits were done within the home to monitor the quality of the service. An accident audit was done monthly to analyse falls or other accidents within the previous month. These audits were in the same file but were not kept together, which would make it more difficult to identify any trends over time. Care plans were audited although we did not see an audit in the past two months. There were also monthly medication audits, infection control audits, mattress audits and room checks. The registered manager usually (when present) conducted health and safety checks on a weekly walk through the building. We also saw a medicines audit conducted by the pharmacy that supplied medicines to the home.

Although we were satisfied that the provider conducted a range of audits to monitor the quality of the service, these audits had not identified many of the issues identified during this inspection, or if they had, action had not been taken. We noted that although there had been no formal complaints, a number of people including people living in the home had raised issues but nothing had been done. We concluded there was a failure of governance to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17(1) and 2(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Alexandra Lodge like other services is required under regulations to submit notifications of significant events to the CQC. We knew from our records that notifications of deaths had been submitted, although we mentioned that sometimes there was very similar wording in different notifications.

However, we mentioned earlier that there were two safeguarding incidents which should have been reported to the Care Quality Commission. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009. Any further failure to notify such incidents will result in enforcement action.

We noticed that the filing in the manager's office was rather chaotic, with files on the floor. On several occasions the acting manager struggled to find a particular file or document. However, the provider told us they had already ordered a new filing cabinet which would help keep documents in order.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify to the CQC abuse or allegations of abuse Regulation 18(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate Regulation 9(1)(a) People's comfort and dignity were not always respected Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring the proper and safe management of medicines Regulation 12(1) and 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to notify the local safeguarding authority of incidents of abuse or alleged abuse towards a service user

Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems to assess monitor and improve the quality and safety of the service. Regulation 17(1) and 2(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of suitably qualified staff were available to meet the needs of people living in the home Regulation 18(1)