Arrow Healthcare Limited

Alexandra Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 March and 10 April 2018 and was unannounced on the first day. At the last inspection in April 2017, the provider was in breach of three regulations. These related to consent in the key question effective, person-centred care in responsive and governance in well-led. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve these key questions to at least good. We checked to see that the action plan had been completed and found progress in some areas but further improvements were required in others.

Alexandra Court Care Centre is registered to provide care for up to 84 people who need nursing care and who may be living with dementia. The building is purpose built, over three floors accessed by passenger lift and stairs. All the bedrooms are for single occupancy and all of them have an en-suite shower, sink and toilet. Recent changes had taken place; the provider decided to close the top floor and use it for storage. People who required nursing care were now located on the first floor and those that required residential care were on the ground floor.

Alexandra Court Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the 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.

We had concerns with how some people's specific health conditions were managed so that they received timely oversight from professionals involved in their care.

Although improvements had been made in the quality monitoring system and more effective audits were carried out, there remained an issue with audit of records; some records were not up to date and had gaps which made it difficult to check if the care had been delivered. Management of the service was described as open and approachable. However, the move of people to different bedrooms to assist in the restructuring of the service was hurried and could have been managed more effectively.

We also had concerns about shortfalls in staff training, updated skills and supervision to ensure they were knowledgeable about how to manage people's specific health care needs.

These issues were breaches of Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take regarding these issues at the back of the full version of this report.

The provider had policies to guide staff in safeguarding people from the risk of harm and abuse. Staff knew how to raise safeguarding alerts if they had concerns. People had risk assessments and these were kept under review.

People received their medicines as prescribed. There had been some administration errors in the past, but when these occurred, staff acknowledged them, sought medical advice and informed the person and their relatives. Staff who administered medicines had received updated competency checks.

People were supported to make their own decisions and choices. The registered manager and staff had a much improved understanding of mental capacity legislation. People had assessments of capacity and best interest decisions made on their behalf if they lacked capacity; documentation regarding best interest decisions had been completed. Appropriate applications had been made to the local authority when people's liberty was deprived due to their lack of capacity and need for continual supervision.

People liked the meals provided to them. The menus gave people choices and alternatives and specialist meals were provided for people's diverse needs. We discussed with the regional manager how mealtimes could be held over two sittings to ensure people who required full support were assisted more effectively. They assured us this would be addressed.

There were mixed comments about the number of care staff deployed and whether this was sufficient. There had been a very recent staff rota change and the closure of six beds on one floor; staffing levels were to be monitored by the registered manager and regional manager to see if this impacted on the comments received from people.

People who used the service and their relatives we spoke with all had very positive comments about the caring approach of staff. They confirmed staff respected their privacy and dignity, delivered care which was person-centred and treated them as individuals.

People could remain in the service to receive end of life care. This had improved since a concern was raised last year. Staff attended meetings with other professionals to discuss people's needs at the end of their life and to make sure the right equipment and medicines were in place.

There were lots of activities for people to participate it within the service. There were also trips arranged to local venues and visits from entertainers and primary school children to help people feel part of the community.

The provider had a complaints procedure which was displayed in the service. People told us they felt able to raise concerns and these would be addressed.

The environment was safe and clean. Staff used personal, protective equipment to help prevent the spread of infection. Equipment used in the service was checked and maintained to ensure it was safe.

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 was safe.

Staff knew how to safeguard people from the risk of harm and abuse. They had policies to guide their practice. Staff completed risk assessments regarding people's needs and kept these under review.

People received their medicines as prescribed. Staff managed medicines safely and had their competency checked following any errors or concerns with their practice.

Staffing levels and rota arrangements had changed recently due to a restructuring of the service. There had been mixed comments about staffing numbers so this was to be monitored closely by senior management.

The environment was safe and clean.

Is the service effective?

Requires Improvement

The service was not effective.

Some people's health care needs had not been managed effectively and on occasions, referrals to health professionals could have been more timely.

There were gaps in training and supervision, which meant staff did not have all the skills required to care for people who used the service.

Staff supported people to make their own decisions. When people lacked capacity for decision-making, the provider used appropriate legislation and recorded best interest decisions made on their behalf.

People's nutritional needs were met through menus that provided choices and alternatives. Specialist diets were catered for, although the provision of mid-morning snacks could be improved.

Is the service caring?

Good

The service was caring.

Staff approach was kind and caring. People told us staff treated them well and respected their diverse needs, their privacy and their dignity.

Staff held people's personal data securely and ensured conversations about health and other issues were carried out in private.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans developed, which helped staff deliver care in an individual way.

End of life care for people had improved and staff consulted with professionals involved in care and treatment.

There was a complaints process on display and people felt able to raise concerns. They said the registered manager would deal with complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The restructuring of the service, which included people moving bedrooms onto different floors, could have been managed more effectively. This had left some people anxious and not informed properly.

Not every person had up-to-date and accurate records about their care. This made it difficult to check if care had been consistently provided to people.

There had been improvements in the quality monitoring system, although audit of records required improvement.

Alexandra Court 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.

This inspection site visit commenced on 27 March 2018 and was unannounced. Due to an unforeseen incident, the inspection was halted on the first day. The second day of the inspection took place on 10 April 2018. On the first day, the inspection team consisted of two adult social care inspectors, a new inspector under induction, a specialist professional adviser in end of life care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had expertise in caring for an older relative who lived with dementia.

The provider had completed a Provider Information Return (PIR) prior to the inspection. 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 checked the PIR and also our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at lunchtime. We spoke with eight people who used the service, 11 people who were visiting their relatives and a volunteer. We spoke with the registered manager, a nurse, three senior care workers and six care workers. We also spoke with an activity coordinator, a cook, a laundry assistant, an administrator and maintenance personnel. We received information from three health care professionals.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 22 people and monitoring charts for food, fluid intake, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005. This was to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included five staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

People told us they felt safe in the service and there were no issues regarding the management of their medicines. Comments included, "All the staff are very kind", "I like it; I like my room. I know the people here are looking after me", "It's very secure", "Absolutely [feel safe], even when hoisted. There is always a friendly face popping in and I never feel lonely", "My medicines are always given on time" and "They [medicines] are well-managed."

Relatives said, "She likes it here; she thinks the staff are beautiful and can't do enough for her", "She can lock her own room door", "It's very safe", "They are never left in pain; they will always be given pain relief when requested" and "Mum is safe and looked after."

Health professionals said, "Yes, it is safe. There was previously some staffing issues but with the recent changes [closure of the top floor], this has been better", "Yes, in my opinion it is safe" and "It is safe, I have not found any issues in the past. If I have seen anything and reported it, [Name of registered manager] has dealt with it quickly."

Staff had received training in how to safeguard people from the risk of abuse, although a large percentage of staff required an update. In discussions, staff were clear about the different types of abuse, what the signs and symptoms could be and what to do if they witnessed abuse or poor practice. The provider had a policy and procedure to guide staff on the actions to take should abuse be disclosed to them.

Staff completed risk assessments on areas such as people's moving and handling needs, falls, nutrition, fragile skin, choking and inhaling food, the use of bedrails and leaving the building unattended. These were evaluated monthly to ensure they contained up to date information about any increases or decreases in risk.

The environment was safe and clean. There were some elements of risk identified on the day of inspection and rectified straight away. These included cluttering of stairwells and ensuring plastic gloves, which were accessible to people with dementia were stored safely. There were also some maintenance issues which were addressed during the inspection such as a broken lock on the sluice room door and a broken grab rail in one of the bathrooms. Maintenance personnel were attentive and repaired items as soon as they were informed by staff. The provider had a business continuity plan to ensure any disruptions were managed appropriately and equipment used was serviced.

Staff used personal, protective equipment to help them prevent and control the spread of infection. There was hand sanitiser gel sited in the entrance and other parts of the service. People were reminded of the need for good hand hygiene.

People received their medicines as prescribed. There had been some medication errors in previous months, although these had not caused any harm. Staff had owned up to their mistakes straight away and took appropriate action to contact the person's GP and to seek advice. A system of auditing had been introduced,

which was thorough and when shortfalls were identified, these were rectified. Since the errors in medicines management, staff had received competency checks and supervision sessions to reflect on their practice.

Medicines were stored securely and systems were in place to order medicines in a timely way and dispose of unused medicines safely.

There were mixed comments from staff, relatives and visiting professionals about the number of staff deployed in the service. Five out of 11 visitors felt there could be more staff especially at peak times such as helping people to get up and ready for the day, whilst others stated there was always plenty of staff around. Two visiting professionals felt there were sufficient staff, whilst another stated it sometimes took them time to find staff when they needed them. People who used the service told us call bells were answered quite quickly. They said, "There are enough staff and they are very helpful", "The call bell is okay at night, usually answered in five minutes" and "The call bell is answered immediately."

The lunchtime experience for people, observed on the first day of inspection, was not as calm and relaxed as expected. There were too many people who required full support to eat their meal and insufficient staff available to afford them one to one support. We discussed with the regional manager the need to address the lunchtime experience and it was suggested two settings would ensure people received the correct support. The regional manager told us they would address this.

Staff were recruited safely and full employment checks were carried out before they started work at the service. These included an application form to assess gaps in employment, two references, an interview and a disclosure and barring service (DBS) check. DBS checks included police cautions and convictions and to see if potential candidates were excluded from working in care settings. There was a system in place to check qualified nurses were registered with the Nursing and Midwifery Council and that there were no restrictions on their practice.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in April 2017, we had concerns that staff did not have a clear understanding of the implications of the Mental Capacity Act 2005 (MCA) and the need to record assessments of capacity and best interest decision-making. We found improvements had been made in this area.

The 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 MCA 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 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 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 registered manager had made 27 applications to the local authority for DoLS, one of which was authorised and the remainder were awaiting assessment/authorisation. This showed us the registered manager was more aware of the criteria for DoLS and had acted appropriately. People who were assessed as lacking capacity and who had restrictions for their safety such as bedrails, sensor mats or wheelchair lap straps had best interest meetings recorded in their care files. This ensured relevant people involved in their care were consulted about restrictive practices and discussions had taken place about why these were necessary.

Staff were clear about the need to gain consent before carrying out care tasks and supporting people to make their own decisions. People told us staff explained their actions whilst supporting them. Comments from people who used the service included, "I do get asked what I want to do." Relatives said, "I have seen them ask but they have no capacity" and "They choose bedtime and will stay in bed in a morning if they want to."

We had concerns at this inspection regarding the management of some people's health conditions and the timeliness of referrals to dieticians.

Some people, admitted for nursing care, had wound care treatment delivered by nurses. The documents for this did not consistently show wounds had been treated appropriately. For example, one person was non-compliant with treatment regimes and health professionals had been involved, however, the registered manager had not yet discussed the complex wound care treatment as a possible safeguarding concern; this was completed on the day of inspection. There were no robust wound evaluations including photographs, descriptions and reviews during the 18 days when the concern was first identified and the first day of inspection. One person's records stated their wound was to be reviewed on a specific date but when checked this was not reviewed until four days after that. Similarly, another person's record stated their dressing was to be changed on alternate days or more frequently if soiled. Records showed the change of dressings had intervals of three, four, six and eight days. On one occasion, the nurse had changed the

dressing and stated the next review was to be in three days but this was completed after six days. This was not to say the review had not occurred at the three day interval, but the records did not reflect it.

The outcome of a safeguarding incident, (which occurred prior to the last inspection in April 2017), into the management of wound care have been made available to the Care Quality Commission during the writing of this report. The outcome made recommendations about wound care planning and recording and these will be followed up by the safeguarding team. We will also monitor this recommendation at future inspections.

Information from a health professional, received just after the inspection, referred to the need for increased staff understanding of catheter management and the impact of leaking catheters on wound care dressings. During the inspection, we observed one person's catheter bag was incorrectly positioned for optimum flow. Their change of catheter was three weeks overdue. Although the person had not experienced any issues as a result of this, the care plan had not been followed.

When assessed as required, people had pressure relieving mattresses in place. Maintenance personnel initially set all the mattresses at 'medium' and care and nursing staff had to readjust the setting when the person's weight had been established. During the inspection, inspectors had to prompt staff to check and adjust mattress settings to the correct level for multiple mattresses. Incorrect mattress settings had the potential to cause skin damage or prevent correct pressure relief.

When people were at nutritional risk, their weight was monitored in line with their risk assessment and dietetic advice sought. However, on two occasions this could have been completed in a more timely way. For example, one person was placed on weekly weight monitoring, as staff had identified a concern but they were not referred to a dietician until two weeks later. The area manager told us this was being monitored closely and lessons had been learned.

The concern regarding management of some people's health care conditions was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have told the provider to take at the back of this report.

Community health professionals were involved with people's care and treatment and staff contacted them when required. During the inspection, one health professional told us they had spoken to staff about catheter management in the past and had noted improvements regarding the number of calls they received for blocked catheters. Others said, "If we request changes be made or things put in place to care for the patients, then this is usually met positively and in a timely way", "All care needs are met with support of the staff" and "I feel some staff are not fully aware of pressure damage and the causes; they do act quickly to liaise with us regarding these." In discussions with staff, they described how to prevent pressure damage and what signs to look for when people were deteriorating and becoming unwell.

Staff training records showed gaps in what was considered by the provider as 'core' training. This had been noted by the regional manager and a training analysis was to take place. It was unclear if the training deficits related to the need for initial training or updates of the original training. For example, records showed 49 staff required information governance training, 31- nutrition and hydration, 27- MCA/DoLS, 29 – person-centred care and 31 – health and safety. There were also low percentages recorded in the completion of service specific training such as dementia awareness, falls prevention and tissue viability. Some of the care staff we spoke with had not received training in how to support people with catheter care. Forty-six staff required safeguarding training, although the training plan showed this was arranged for the end of March and April 2018.

Records of staff supervision and appraisal also showed shortfalls in 2017 and 2018. Staff confirmed supervisions were quite a way behind schedule. One person had not had supervision for two years and other staff had gaps of over six months. There were 17 care staff, one senior care worker and two nurses that had not had a supervision meeting so far in 2018. The provider's policy on supervision stated care staff were to receive formal supervision at least four times a year.

Not ensuring staff had the right skills, experience and knowledge was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have told the provider to take at the back of this report.

People told us they enjoyed their meals and were offered a nutritious and well-balanced diet. The menus provided choice and alternatives for people including vegetarian options and textured meals. We observed people received alternative meals when they declined the main choices on offer. Some people were prescribed nutritional supplements, which were documented on their medication administration record (MAR) as given to them at set intervals during the day. However, when we checked food and fluid intake monitoring charts, the amounts taken did not always correspond with the MAR. Some people only had half the amount or declined to drink it, or the supplement was not recorded on the monitoring chart at all. We did not observe any fortified snacks or even biscuits given to people mid-morning with their hot drink, although cakes, biscuits and fresh fruit were made available for the mid-afternoon drink. The regional manager told us fortified snacks should be available in-between all meals and said they would discuss this with the catering staff.

The environment was suitable for people's needs. There was appropriate signage to help people living with dementia locate specific rooms; we also noted toilet seats and grab rails in communal toilets were of a contrasting colour to white to help make them more visible. People living with dementia were served their meals on red plates which studies have found helped them to see their food. There were grab rails in bathrooms/toilets and handrails in corridors, which were wide enough for people who used wheelchairs. There was a range of moving and handling equipment. There were specialist bath and shower rooms, communal lounges and dining areas, a hairdressing room and a quiet room.

Good

Is the service caring?

Our findings

There were lots of positive comments about the kindness and caring attitude of staff. People who used the service said, "They are very friendly; my daughter and I know everyone's name and they are always chatty", "They are very nice and ask me what I want to wear", "They ask me if I am happy and I tell the girls [staff] I love them" and "They are all very kind, even the laundry lady."

Relatives said staff had a kind and caring approach and kept them informed. They said, "The staff are very caring to our relative and to us", "I think staff are caring and compassionate to my relative", "Staff are very friendly and helpful", "They always ring me up if there are any changes" and "All the staff, even the cleaners, are absolutely fantastic; they really care about the residents and are like friends to [Name]." One relative described how staff had arranged for an entertainer to visit their family member's bedroom for a short concert. They also said an entertainer now visits their bedroom weekly to play a few songs on a guitar and they really enjoyed this.

Health professionals also noted a good staff approach. Comments included, "Yes, they do promote independence and try to get patients to do things independently if able and appropriate", "Staff communicate with the residents and put them at ease" and "I have observed staff asking residents what they would like and encouraging them to be independent within their limitations. They always close doors to maintain privacy."

Staff had a good understanding of the need to promote privacy and dignity and described the ways this was achieved. They said, "We shut doors and curtains, knock on doors and keep people covered up during personal care", "There are privacy locks on bedroom doors" and "We always call people by their preferred name." We observed throughout both inspection days that people were appropriately dressed with clean clothes and footwear on to preserve their dignity.

People's religious and spiritual needs were clearly documented, and how these were to be met. In discussions, staff evidenced they were aware of people's diverse needs. They said they read care plans and it was clear they knew people and their needs very well.

During the inspection, we observed positive interactions between staff and people who used the service. Care staff were friendly in their approach, and smiled and chatted to people, which presented a calm atmosphere. Staff were attentive during mealtimes and provided assistance appropriately; they asked people if they had finished before removing plates, provided alternatives and asked people if they would like to wipe their hands following the meal. We overheard staff compliment people on their hair following a trip to the hairdresser. They also checked to see if a person was warm enough and did they need their blanket; they fetched this for them and helped tuck it around their legs.

We observed staff sit with a person, hold their hand, chatted to them and supported them to have a drink. When the person became upset about their clothing, the care worker suggested they went back to their room so they could make the person comfortable; this was completed and it reassured the person. We also

observed staff support a person when their relatives left, offering kind words and reassurance.

There were notice boards providing information to people. In the entrance, the notice board displayed items such as menus, the complaints procedure, a monthly newsletter, advocacy service details and previous Care Quality Commission reports. There was also information on local dentists and whistle blowing procedures. On the ground and first floors there were notice boards displaying the activities arranged for the week, including entertainers, outings, religious services and the days when the hairdresser visited. The notice boards were bright and cheerful. There was also a 'service user guide' on display which provided information about the service provided to people and what would incur additional costs such as chiropody and the installation of personal telephones. There was large pictorial signage throughout to assist people in finding their way to bathrooms, toilets and lounges.

Staff had information in care plans regarding how people communicated their needs, which included the use of assisted technology for some people. One care plan we looked at indicated what the person's first language was and referred to sight and hearing including whether aids were used. It also described how staff should approach the person when beginning conversation with them and the need to observe body language and facial expressions.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office or the registered manager's office. People's reviews were held in their bedroom or a quiet room. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The provider was registered with the Information Commissioner's Office, a requirement when computerised records were held. Staff records were held securely.

Good

Is the service responsive?

Our findings

At the last inspection in April 2017, there were concerns about how care was assessed and delivered in a person-centred way. At this inspection, improvements were noted.

Staff had completed assessments of people's needs and developed care plans. These helped staff deliver support in a person-centred way. For example, one person had a special bed arranged at a low setting and an extra mattress on the floor at night as bedrails were assessed as unsuitable and the person may roll out onto the floor. One care plan we looked at described what staff should say to reassure the person when they were anxious. Records showed staff had been persistent in securing a GP visit for a person with complex needs and had worked hard to persuade the person to go to hospital to receive treatment. Another person's care plan reminded staff they did not like the taste of meat and to ensure the vegetarian option was offered. It also described how the person at times chose to eat their meals in their bedroom, and this was respected. In discussions with staff, it was clear they knew people's needs very well.

A recent change in staff shift patterns and handover times had impacted on one person's preferred time of getting up in the morning. This was discussed with the registered manager and addressed on the first day of inspection. On the second day of inspection, we spoke with the person and they confirmed staff now supported them with their preferred time of getting up and dressed.

A relative said, "The care is person-centred. They were at death's door two years ago on end of life care but they are much improved; the staff have nurtured them back to health" and "They have their make-up bag and look smart; staff match their outfits."

People told us staff were responsive to their needs. Comments included, "I would ask them; I can't think they could do anything better" and "They would get a doctor if I needed one; I've seen a dentist." People's bedrooms were very personalised.

Relatives were happy with the care received and they told us they attended reviews. Comments included, "The minute anything is wrong, they get the doctor in", "They have recently been visited by the dental team to have impressions and fitting for new dentures; I was aware and attended the appointments" and "They are never left in pain." Other comments included, "I am involved in my relatives care and always consulted if there is a problem", "Recently, dolls were bought for the residents and they greatly improved the mood on the unit" and "The staff are marvellous and treat them as an individual, always talking to them and not about themselves to each other."

Health professionals said staff were responsive to people's needs. Comments included, "I feel they have a good approach to being positive and stimulating residents. There is always planned entertainment on."

Since the last inspection, there had been a concern raised that one person should have received better end of life care in relation to pain management. We found lessons had been learned and improvements made in end of life care since then. A senior care worker described the signs they looked for when someone was

deteriorating and end of life approaching. They also described which professionals would be alerted and the system for contacting them. Staff gave a full description of the care that was provided to people and how the care plan was updated to reflect this; the description of care was relayed in a compassionate and respectful way. Staff were knowledgeable about the types of medicines which were prescribed and who administered these. The member of staff told us nurses and senior care workers were involved in end of life 'Virtual Community Meetings' with other professionals, where people's needs and treatment options were discussed.

Staff confirmed they had received end of life training. A senior care worker said, "That episode should never have happened. I'd say there has been a 110% improvement in how we now support people who are at the end of their lives. Because of the training, and the fact that we are directly involved in the 'Virtual Community Meetings', we get the best guidance and advice from the MacMillan team" and "Yes, staff are aware of the incident. It is a good thing to bring it into the open and learn from it. They were a lovely family and had been very happy with the care their relative received right up until the last few days."

A relative said, "One of the senior staff has spoken to mum and myself about end of life and the pathways have been documented." Where appropriate, care plans detailed where the person preferred to remain at the end of their life, which included the service, hospital or a hospice.

There were two activity coordinators who both worked Monday to Friday, 9am to 5pm and were able to organise events on these days. The activities included exercise classes, bingo, news updates, quizzes, board and ball games, cinema afternoons, monthly 'pub' afternoons with a pianist and 'afternoon tea' days. They organised monthly visits to the Street Life museum for quizzes and cups of tea and fortnightly trips to Wilberforce College to visit students on a health and Social Care course. They arranged for the Lord Mayor to visit in the week before the inspection and local primary school children visit monthly. They said, "We listen to the residents and do what we can." Monday mornings were reserved for visits to people who remained in their bedrooms to complete activities such as nail care or hand massages.

The activity coordinators held a separate record for each person who used the service, which detailed the activities they had participated in. There was a colourful, monthly newsletter, which described the activities on offer.

Relatives told us they were invited to planned entertainments and supported fundraising activities. They said, "They are in the choir and go to the church monthly", "They have memory afternoons, which they love", "They don't join in any by choice, but I visit every day", "The entertainment girls have arranged a birthday performance with a singer in their room – excellent! They have enjoyed Easter, Summer and Christmas Fayres", "There is a choir, which is very good; the activities are second to none", and "They go out on activities." We observed two visitors singing with their relative and they all really enjoyed themselves.

The provider had a complaints policy and procedure which gave timescales for acknowledging complaints and investigating them. Complaints were recorded and this showed they were investigated and addressed. People said that if they had any concerns they would be able to raise them. Comments from people who used the service included, "I would speak to the manager but I have no complaints."

Relatives said, "[Name of registered manager] is very approachable and all things have been dealt with", "They ask if we are happy with the care", "I have no need for concern" and "We have raised concerns and they have been addressed."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2017, there were concerns that the quality monitoring system was not effective in supporting staff to learn lessons and improve the service for people who lived there. Whilst there were improvements in audits and checks, there remained improvements to be made in recording and how this was audited, and how certain issues were managed.

There were some gaps in recording, which made it difficult to audit if specific levels of care had been given. For example, some monitoring charts had gaps regarding fluid intake and position changes, and the type and quantity of food people consumed. Some people's charts also lacked information about fortified snacks in between meals. Care plans had improved but some lacked important updates or there were discrepancies between what was written on the care plan and the instructions on monitoring charts. Evaluations of care plans took place but information was recorded on separate sheets and updates not always transferred to the care plan, which meant staff would have to search for the most up-to-date information. There were shortfalls in wound care records and we were unable to locate specific test results for one person. There were also shortfalls and discrepancies in accident and incident analysis reports.

Not ensuring up-to-date and accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have told the provider to take at the back of this report.

There was an annual quality monitoring system which consisted of audits, checks, meetings and surveys to ensure shortfalls were highlighted and people's views obtained and action taken. The audit of records required improvement and this was mentioned to the regional manager to address with senior staff.

Audits included medicines management, care plans, housekeeping, kitchen cleanliness and catering issues such as a check on the availability of allergy information. Health and safety checks of the environment were carried out and meetings were held to discuss safety issues. There were infection prevention and control audits, which included observations of staff practices. Action plans were produced when shortfalls were identified.

There was evidence senior management completed regular monitoring visits to the service and left records so the registered manager and deputy manager could follow up any issues they had found.

There had been several meetings for people who used the service and their relatives. These included discussions about activities, the garden, meals and also included information about local primary school children who were due to visit the service. Staff meetings took place and topics discussed were recorded. These included policies and procedures, record keeping and infection control reminders, changes in the service, cleaning procedures, supervision arrangements and training. Staff were able to raise issues at the meetings.

A survey had taken place regarding people's views of the service delivered to them. The results were positive

and any shortfalls were addressed.

The service was undergoing a restructure. The provider had decided to close the top floor of six bedrooms and reorganise bedrooms on the ground and first floor. Before the change, those people with nursing needs occupied bedrooms on both floors which meant the two nurses on duty had to be on separate floors. It also meant some people living with dementia had bedrooms on the first floor and no direct access to the garden area. The separation of people with specific nursing and residential needs better supported the staff skill mix on each floor. Additionally, the top floor was now used for storage, which helped remove clutter in the service.

Whilst the restructuring supported the needs of people who used the service and staff, the process of moving people could have been managed better. Not all relatives had been informed of the move prior to this happening, which had caused upset and complaint. One person who used the service told us they did not get chance to see their new room before the move was arranged. Staff told us the whole process was completed very quickly without giving people the opportunity to get used to the idea; staff rotas were changed at the same time. Maintenance personnel had to redecorate all the rooms involved in the changeover, which left little time for other jobs. Comments from staff included, "It had to be done in two weeks and there was no proper plan; it could have been better supported by senior managers." The registered manager told us there were timescales for the moves to be completed and the process had been difficult. They said they had tried to consult with relatives as much as possible. This was mentioned to the regional manager who agreed the change process could have been managed more effectively.

The registered manager spoke about the culture of the organisation as being open and they felt able to raise concerns with their line manager. They spoke about the values of the organisation and their own views on the residents, their relatives and staff being fundamental to the service. For example, the change in staffing rota had some exceptions for staff with child care responsibilities.

Staff spoken with told us the registered manager was approachable and supportive. Comments included, "They are firm but fair", "They have been there when I needed them", "Management support is good" and "If anything is needed it will be sorted." Staff told us they enjoyed working at the service and had developed good relationships with the people who lived there.

Relatives knew the registered manager's name and said, "There is good management; they are very approachable", "Yes, it comes from the top. There is a good manager who employs good staff" and "The manager is available and always helpful." A health professional said, "I feel Alexandra Court is well-led. The manager and their team know all the residents and can answer any questions I have when I contact them."

The registered manager and staff team had developed good links with other health and social care professionals involved in people's care and treatment. Staff attended 'Virtual Community Meetings' in order to discuss people's end of life needs or frailty. They had reviews of people's care with community nurses, social workers and specialist nurses.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured people's specific healthcare needs were consistently addressed in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not ensured all records regarding the care delivered to people were accurate and up-to-date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had not ensured staff had up to date skills and training, and that supervision was used to support their development.