

Lifestyle Care Management Ltd

Alexander Court Care Centre

Inspection report

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Dagenham
Essex
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Website: www.lifestylecare.co.uk

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Alexander Court Care Centre provides accommodation with personal care and nursing care for up to 82 adults who may be living with dementia or have physical needs. The premises consist of a large purpose built property arranged across five units over three levels. There are three units for people living with dementia and one unit for young people with physical disabilities, all providing nursing care. There is also a residential unit for older people. At the time of this inspection there were 60 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 28 and 29 November and 5 December 2016 we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was placed in Special Measures. We found the provider did not ensure risks to people were minimised when receiving care. The service did not have suitable arrangements to manage medicines safely. People's preferences and choice of activity were not consistently accounted for when planning care. The provider was not providing care in line with the principles of the Mental Capacity Act (2005). People's dignity was not consistently respected. The provider did not always ensure people received treatment in a timely manner. People using the service and their relatives told us they did not think there were enough staff to meet their needs and they waited for unacceptable periods of time for assistance. Staff were not always given appropriate support through training opportunities to enable them to fulfil their role. Quality monitoring systems had not identified the issues identified in our inspection.

This inspection took place on 5, 6, and 8 June 2017 and was unannounced. We found improvements had been made. Although the service is no longer in special measures we found there continued to be three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However since the inspection a new provider has taken over the registration of this service and conditions have been attached to their registration to ensure the breaches are rectified.

Risk assessments did not always correspond to the care plans or how care was delivered. Some care plans were missing information or contained contradictory information. Although medicines management had improved we found a few issues of concern. People's choices and dignity were not consistently respected. The provider's quality and audit systems did not identify the issues picked up on at inspection.

The building was safe in accordance with building safety regulations. Domestic staff worked hard to maintain cleanliness of the environment. Staff appropriately followed infection control procedures.

The provider and staff were knowledgeable about what was required of them to work within the legal framework of the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and when they needed to

obtain people's consent. People had access to healthcare as they required it. The service offered nutritious meals and there were choices of food and drink for people.

We observed staff were caring and were knowledgeable about how to develop positive relationships with people who used the service. Staff were knowledgeable about maintaining people's independence.

Staff had awareness of giving personalised care and care plans were personalised. The service had a variety of activities to offer people. The provider dealt with complaints in accordance with its policy.

Staff received support through supervision, meetings and training. Relatives and staff spoke positively of the service and management. The provider had a system in place to obtain feedback from people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. Risk assessments did not always correspond to information contained in care plan. Staff were not consistently aware of how pressure mattress settings were calculated. The management of medicines had improved but there were still a few discrepancies.

People and relatives felt the service was safe. Staff were knowledgeable about safeguarding and whistleblowing. Staff were aware of how to respond in emergency situations. The building was maintained in line with building regulations. The service had infection control systems in place.

Requires Improvement ●

Is the service effective?

The service was effective. Improvements had been made since the last inspection in respect to supporting staff with training, with working within the legal framework of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People were provided with access to healthcare when required.

People were offered a varied and nutritious diet and the chef was knowledgeable about people's dietary requirements. Most people had a pleasurable experience at mealtimes.

Good ●

Is the service caring?

The service was not consistently caring.

Staff had awareness of developing positive relationships with people but did not always know people's histories. People were not always given choices or their choices were not always respected. Staff had awareness of respecting people's privacy and dignity but this was not always put into practise.

People were encouraged to maintain their independence.

Requires Improvement ●

Is the service responsive?

The service was not consistently responsive. Staff had awareness of providing personalised care. Most people's care plans were personalised, contained people's preferences and their life histories.

There was a variety of activities on offer. The provider dealt with complaints in accordance with their policy.

Requires Improvement ●

Is the service well-led?

The service was not always well led. The quality audit systems used by the service did not identify the issues picked up on during the inspection.

Staff and relatives gave positive feedback about the registered manager. The provider had a system in place to obtain feedback from people who used the service and acted on feedback received.

The provider held regular meetings with staff to obtain and give updates on people's welfare and the service.

Requires Improvement ●

Alexander 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.

We carried out this unannounced inspection on 5, 6 and 8 June 2017. Three inspectors, a specialist nurse advisor and an expert-by-experience carried out the inspection on day one. A specialist advisor is a person who has professional experience in caring for people who use this type of service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors visited the service on the second inspection day and one inspector visited the service on the third inspection day.

Before the inspection, we looked at the evidence we already held about the service. This included the last inspection report and notifications the provider had sent us. We also contacted the local authority to obtain their views about the service.

During the inspection, we spoke with 15 people and two relatives of people who used the service. We spoke with 20 members of staff. This included the regional manager, registered manager, the deputy manager, two activity coordinator, two domestic staff members, maintenance person, the chef, three nurses and eight care staff.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed nine care records relating to people who used the service, twelve staff files and records relating to the management of the service including menus, medicines, staff

training, quality assurance, complaints and policies.

Is the service safe?

Our findings

At the last inspection in November and December 2016, the provider did not ensure risks to people were minimised when receiving care because risk assessments were not always fully completed and did not always include guidelines for a medical condition or for managing a specific risk where required. At this inspection we found some improvements had been made but further work was needed.

Records showed individual risk assessments and management plans were completed and were reviewed once a month. For example, two people had risk assessments in place for diabetes with guidance for staff to check blood sugar levels and action to take when levels changed. Another person had a risk assessment in place for choking that stated, "Risk of choking and aspiration pneumonia. To have stage 1 thickened fluids. Staff to ensure she is in upright position during meals. Advise her how to eat her meals ensuring her to take her time. Foods need to be cut into small pieces. Thickened fluids stage 1 (2 level scoops)." This person's care plan also contained information from a recent review from the speech and language therapist.

However, risk assessments did not always correspond to the care plans or how care was delivered. For example, one person's risk assessment for self-neglect stated, "Unable to use call bell when he needs help." However the bed rails care plan stated, "Call bell to be at easy reach to allow him to call if he can." Another example was one person's risk assessment for smoking stated, "Not to smoke in his room or go out on his own to smoke. He can only go out when accompanied by staff." On the first inspection day a staff member told us, "We don't need to go with him. He's capable of going on his own." This meant that people could not be assured they were receiving safe care.

We observed one person sitting in their wheelchair who was not using a safety belt. The deputy manager told us this was because of the risk of this person sliding through and choking. However, this person did not have a risk assessment in place to this effect. This meant the person's safety could not be assured. The deputy manager told us referrals had been made for the person to assess if there was an alternative wheelchair or lap belt that could be used to keep them safe.

One person's care plan stated their pressure mattress setting should be checked twice a day. Records showed this had only been checked once a day between 1st and 5th June 2017. We also noted this person's pressure mattress setting had changed from soft to medium and back to soft over a three month period even though their weight had remained quite stable. However staff were unable to give an explanation as to why the setting had changed and there were no instructions on bedroom walls about settings for each mattress. This meant staff did not have the information they needed to manage people's risk of developing pressure wounds. We raised this with the deputy manager who gave a satisfactory explanation for the setting changes and showed us documentation which supported this.

The above findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November and December 2016, we found medicines were not safely managed and

administered by the service. At this inspection we found improvements had been made.

One care worker told us if someone was to refuse their medicines, "We try, we don't just let it go. We'll try later on. [Person] may not be in the right mood. We'll monitor them and alert the GP."

Medicines were stored appropriately in locked trolleys and cabinets in locked clinical rooms on each floor. Care records contained a medicines care plan which gave a list of medicines with possible side effects the person was on. Medicine fridge temperatures were monitored and recorded daily and these were up to date and within the accepted range.

The provider had a medicines policy which gave clear guidance to staff about the management of medicines including controlled drugs and monitoring people who self-administer their medicines. There were guidelines in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. We saw PRN medicines had been administered and signed for as prescribed.

Records showed that for people who needed medicines administered covertly, appropriate assessments for capacity were completed and there was guidance and authorisations in place from the GP and pharmacist. Medicines that are administered covertly means they are disguised in food or drink without the knowledge or consent of the person receiving them. However, we found for one person on one unit, their covert medicine guidance was not up to date because the GP had changed the format of their medicines from tablet to liquid form which did not need to be disguised.

Medicine administration record (MAR) charts were completed correctly and reasons for not administering were recorded. However, we found on one unit for two people the MAR charts for topical medicines needed to be more specific as to where on the body they should be applied. There was also a bottle of eye drops with no opening date which must be discarded after four weeks of opening. We raised this with the deputy manager who told us as staff had not recorded the opening date, this would be discarded four weeks after the date of delivery to ensure the medicine was not passed its effective lifespan.

On another unit we found a bottle of prescribed supplement in the medicines fridge without a label or opening date. We noted this medicine should be discarded after fourteen days of opening. The deputy manager explained this was a problem with the prescription label as it had fallen off. The deputy manager took immediate action, wrote on the bottle who it was for and the opening date and contacted the pharmacy to have supplies of this medicine re-labelled. We recommend the provider follows good practise and guidance on managing medicines in a care home.

People and relatives told us they thought the service was safe. For example one relative told us, "It's the level of monitoring and the good communication. It's been like a weight off my shoulders."

There was a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, we found staff had produced proof of identification, had produced confirmation of their legal entitlement to work in the UK and had been given written references. We also saw staff had criminal record checks carried out to confirm they were suitable to work with people. We saw records of letters sent to staff during the inspection reminding them they were due to update their criminal record check.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and

midwifery professions in the UK who ensure nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards. This meant a safe recruitment procedure was in place.

Relatives told us they thought there were enough staff. For example, one relative told us, "I've never had to look for staff." Staff also told us they felt there were enough staff on duty. For example, one staff member told us, "There are enough staff. At the level of [people who used the service] at the moment the staffing level is ok. If someone is off sick we have bank staff that can cover shifts. The management team are very helpful; they'll roll up their sleeves and do the work themselves. We don't really like to use agency staff."

We observed call bells were responded to promptly and people did not have to wait long for attention. However, we also observed that staff did not have the time to sit with people and spend time with them as they were constantly on the move. This meant people would not necessarily feel encouraged to ask for assistance if they thought staff were too busy to attend to them or to listen to them.

Staff were knowledgeable about how to report incidents of abuse. One staff member told us, "If I see something wrong going on, I have to tell the manager, head office, social services, CQC or the police." Another staff member said, "If I see anything that is not right, I'd report to the [registered] manager and if the manager did not do anything about it, I would let the social worker or CQC know about it." One staff member told us, "I would definitely report it or use the whistleblowing line." Another staff member told us, ""I would report it to my manager and if she didn't act I'd go to the social worker, police or CQC."

Staff were also knowledgeable about how to deal with emergency situations. One staff member described the process of evacuating people from the building, how they would use the chutes that were on the stairs if need be and where the fire meeting point was outside for people. Another staff member described the actions they took if somebody had an accident. This staff member told us, "We check the [person], make sure they're ok. We inform the doctor. We'll document it, observe the [person]. Call the ambulance."

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, testing of portable electrical appliances was done during March 2016, a gas safety check was carried out on 14 December 2016 and fire equipment was serviced on 20 October 2016. The provider had a system of regular unannounced fire drills with the most recent one being done on 11 May 2017 and weekly fire alarm testing which was up to date. This meant the provider had systems in place to ensure the safety of people in the premises.

The service had a comprehensive infection control policy which gave guidance to staff on minimising the risks of infection. There were hand sanitizers on every floor. People who used the service were given a wet wipe and helped to wipe their hands before meals were served. Staff were observed to use protective equipment such as aprons and gloves and to change these before starting a new task. The housekeeper told us the domestic staff understood how important it was for the service to be properly cleaned. The housekeeper said, "I explain to them, if it was your mum or gran, how would you like it if it was dirty and smelly?"

Domestic staff were observed to be working hard to keep the home clean. There were pedal bins in use in toilets to prevent the risk of spread of infection. However we noted although bathrooms, showers and en-suite facilities were kept clean, there were areas of wear and tear on various sinks, bathrooms and toilets which if left unattended could become an infection control risk. One staff member told us that there was a halt on major maintenance work because the home was in the process of being taken over by a new service provider. Each unit had a repair and maintenance book so the maintenance person could co-ordinate any work that needed to be done. During the course of the inspection, there was a maintenance team on the

premises carrying out minor repair works in individual bedrooms and en-suites.

The service had a large laundry room with three industrial washing machines and tumble driers. Staff knew the temperatures and settings to use when washing laundry that may pose a risk to infection control. The laundry area was organised into clean and dirty areas, with signage informing staff which doors to use. The service used a system of disposable laundry bags to manage the risks associated with soiled laundry. Laundry was sorted into individual containers for people who lived in the home before being returned to their bedrooms.

Is the service effective?

Our findings

At the last inspection we found staff were not always supported to receive training to enable them to fulfil the requirements of their role. At this inspection we found improvements had been made in this area.

Relatives told us they thought staff had the skills needed to provide care effectively. Staff confirmed they had regular opportunities for training and found this useful. One staff member told us, "We are doing e-learning and face to face [training]. We recently did one that was very interesting on asthma and COPD." Another staff member told us, "I've been here four months. I had an induction; we went through how to support residents, for example, with feeding and personal care. For my first three days I shadowed, I did the training as well, for example, moving and handling. I worked across all of the different units." A third staff member said, "[Training] updates me and makes me enjoy my work."

The provider's training matrix showed nurses were 96% up to date with achieving competencies, the topics of which included continence care, communication, medicines and pressure care. All staff received training in topics including dementia awareness, fire safety, food safety and health and safety and most were up to date in these areas.

Staff confirmed and records showed staff were supported with regular supervisions. One staff member told us, "Supervision is bi-monthly." Another care worker told us, "I have supervision. I feel supported." A third staff member told us, "[Supervision is] every three weeks. It's very useful."

At the last inspection we found the service was not working within the principles of the Mental Capacity Act 2005 (MCA). 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 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. During this inspection, we found improvements had been made in this area.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of this inspection 34 people had DoLS authorisations in place and 10 people were waiting for the outcome of applications made. These applications had been made because the individuals needed a level of supervision that may amount to their deprivation of liberty. Mental capacity assessments had been completed and best interests decisions discussions were documented to support the applications for DoLS.

Staff demonstrated an understanding of the Mental Capacity Act (2005). One staff member told us, "It's about people who don't have capacity and it's about an agreement to act in their best interests. Most of

them [people who used the service] do come under DoLS." Another staff member said, "Mental capacity is for people who have dementia who don't know what they are doing." A third staff member told us, "We try and communicate with people to see how much they understand about certain things. If we have concerns we get the GP or family involved for a best interest meeting." Another staff member told us, "The MCA is for those who can't make a decision for themselves. Decisions have to be made by their family and next of kin in their best interests."

Staff were knowledgeable about how to obtain consent before delivering care. For example, one staff member told us, "I need to get consent from the person themselves. I have to look for expression or touch if they don't speak. I need to ask before I do everything or before an activity or before I enter their room." Another staff member said, "You must get their consent first."

At the last inspection we found the service was not always proactive in ensuring people had access to healthcare services. At this inspection we found improvements had been made in this area. A relative told us, "They are really good with her seeing the GP and they call me." Records showed the GP visited weekly and there were regular visits from the multi-disciplinary team consisting of an occupational therapist, physiotherapist and speech and language therapist. Care records also showed people were seen by the optician, dentist and chiropodist.

Care plans contained information about people's needs in relation to eating and drinking. For example one person's care plan stated, "Able to eat independently, she uses melamine mugs and plates and sometimes will throw them on the floor. Stage 1 thickened fluid. During mealtimes [person] should be sitting upright and closely supervised not to be left alone due to the risk of choking." Another care plan documented the person was intolerant of dairy products. Staff monitored people's weight if there was a concern around weight loss or gain.

During our inspection we observed people having their meals and saw food was generous in portion size. One person who used the service told us, "[The food] is lovely. I've got shepherd's pie." Another person told us, "It's tasty. It's lovely." A relative said, "They (staff) couldn't try harder with her meals. They are encouraging her all the time and give her time to eat."

People who used the service were given choices and menus were printed and displayed on tables. We observed on one of the units, the menu on the table did not match the pictorial menu display board outside the dining room. This meant people could not be sure what food was being offered on the day. The menus were varied and nutritious and included a snack menu of fruit, biscuits and cake. There were condiments and flowers on the tables. People were offered hot and cold drinks to accompany their meal.

The chef at the service told us, "Carers ask residents what they want and they come back and tell me. There's always an option. There's a ham sandwich every day for one person and fish for another person every day because that's what they want." The chef was knowledgeable about the specific dietary requirements of people who used the service. For example, they told us, "There are five people [on pureed diet] and they have what's on the menu. It's not all mashed together. It's separated on a serving plate. Today they had cottage pie. I save some of the mix for the puree and do the mash separate. I wouldn't eat it if it was all mashed, why should they? We try all the food and we make fresh soup every day." The chef also told us, "I'm arranging to have a meeting on Thursday with the residents. I'm going to show them a pictorial menu so they can choose their menu to reflect the summer."

Staff gave wet wipes to people to clean their hands before eating and assisted those people who could not do it themselves. We saw examples of staff interacting with people to give them a good mealtime experience

and assisting people to eat at their own pace. One example, a nurse sat down with one person to help them to eat and the nurse kept checking the person was okay and whether they wished to drink. This nurse was observed to also chat with the person. However, on the first inspection day, we observed two staff members in two separate units standing while assisting people to eat their lunch. On the third inspection, we observed a staff member assisting a person to eat at quite a fast pace without checking in between mouthfuls if they were ready for the next one. When this person started coughing about halfway through the meal, the staff member did not check they were okay to continue eating. This meant people did not always have a positive experience at mealtimes.

We recommend the service follows good practice and guidance on assisting people with nutritional intake.

Is the service caring?

Our findings

At the last inspection in November and December 2016 we found service users were not always treated with dignity and respect. We found further improvements were needed in this area.

Some people who used the service did not think the service was caring. Comments included, "You must be joking, what with the staff here, they just don't care", "nobody cares, we just chat to each other here not the staff. They don't listen" and "I tell you they don't care." However, we observed one person telling a staff member, "Thank you for always looking after me." Relatives told us the service was caring. One relative told us, "We have both been really pleased. There is a good rapport with the staff and her room is clean. They (staff) are always very respectful and they always know what is going on with her."

Staff were smiling, friendly and engaged with residents. We observed there was laughter and joking between staff and residents. Residents appeared comfortable with staff. Most staff were attentive even when they were multi-tasking. For example, if a person asked for a cup of tea, staff brought it to them promptly.

Staff described how they got to know people who used the service and how they developed caring relationships with people. One staff member said, "Welcome the person and get to know them by looking at their care plan. Communicating with them [person who used the service] and communicate with the family." Another staff member told us, "By clear communication, trust, taking consent from people, positive attitude and being compassionate." A third staff member told us, "Sometimes I go through the care plans. It's really helpful, helps you know much about the residents you're supporting." However, one staff member was unable to tell us the background of one person whose history was documented on their care file.

People's choices were not always respected. We observed staff offering people choices of drinks. However, one staff member was offering drinks to one person, "Do you want juice, tea or chocolate? Pick one and I'll bring it to you." When the person did not immediately respond the staff member left the room without waiting for an answer. We also observed mid-morning; a staff member came in and switched the television over to another channel without consulting anyone in the lounge area.

A staff member was observed in one of the units at teatime to announce to people in the room, "It's time for dinner, we're moving to the dining room." We observed one person in a wheelchair was moved into the dining room without being given a choice. Another person in a wheelchair was asked by three different staff members several times to go to the dining room. This person refused each time clearly indicating they did not want to go to the dining room but her wishes were not listened to and staff had not kept each other informed about her wishes. The inspector raised this with the third staff member and asked if there was any reason why the person could not stay in the lounge. The staff member replied, "She can stay."

We observed one person sliding down in their wheelchair seat. Staff used a sliding sheet to support the person into an upright position and a privacy screen was used. However, one staff member on one of the units was observed to call out to another staff member who was not in the room, "Can you come here? Can you take [person] to the toilet?" This meant people's dignity was not consistently respected.

The above findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had awareness of respecting people's privacy and dignity. One staff member told us, "Before I go into a room, I knock and I say their name how they like to be called. I cover the places [private areas on the body] I am not working on at the moment." Another staff member said, "By closing the door, shutting the windows and curtains. We put a sign on the door when giving personal care to let others know not to come in." A third staff member told us, "It depends on people's preferences. People may only want a female care worker. We try to give them as much privacy as possible. With personal care we keep the door closed and curtains as well."

A relative told us that their family member was bedbound but the service had ordered a special chair which would enable them to sit in the communal areas to socialise with other people. Staff had awareness of encouraging people to maintain their independence. One staff member told us, "If I give them [person who used the service] personal care there are things I leave them to do themselves if they can." Another staff member told us, "By listening to them and letting them do the task themselves if they are able."

Is the service responsive?

Our findings

At the last inspection November and December 2016 we found the provider did not always ensure that people who used the service received person centred care and treatment that is appropriate. We found some improvements had been made in this area.

Staff had awareness of delivering personalised care. One staff member told us, "Be there for [people who used the service]. Don't do things that make it easier for staff. If I do something else, I am not doing what they like." Another staff member said, "In our job we try one thing and if it's not working we try something else." This staff member gave an example of one person who recently moved into the care home who liked animals so staff introduced the person to the resident cat which helped her to settle into the service.

Care plans were personalised and contained people's life history. For example, one person's life history stated, "[Person] loved reading and writing, she said she loved writing poems and she had written six books. She enjoys watching River Cottage and X Factor and old Western movies."

Care plans contained details about people's likes and dislikes, for example for one person it stated, "[Person] likes to have a drink between sleeping," In addition, care plans contained information about how people's needs would be met, for example, "[Person] needs assistance from two members of staff with all personal care." Care records contained a snapshot care plan which was a high level summary of the individual's needs and was kept at the front of the file for easy access to key information.

However, we found four care plans were missing or contained contradictory information. One person's care plan lacked information on care preferences. For example, the care plan stated, "Needs assistance for bath, shower and wash" and "[Person] needs a full body wash daily, bath or shower once a week." There was no information about how staff should assist this person or about their preferences. We asked a staff member who told us, "Bathing, once a week, the night staff support it. It's not that straightforward though. It depends on the weather and her condition. She uses the one with the chair. She's not keen on having the water on her body. She needs two people. She screams. Normally the night carers do it." This meant the staff member knew the person well but if the the information was included in the care plan it would have been beneficial to all staff.

Another person's eating and drinking care plan stated they ate independently but did not mention they were diabetic until later in the care record. The snapshot care plan at the start of the file also did not mention the diabetes. A relative had written a life history for this person which included information on their interests. However, this information was not transferred to the section about interests and social hobbies. We recommend the service follows good practise and guidance in recording personalised care for people.

The service had a "resident of the day" system. This meant that each person had a day each month where they were made to feel special. The housekeeping team deep cleaned the person's room and activity staff would ask the person if there was a special activity they wished to do. The chef told us, "Every day I go and see a designated resident of the day, sit and have a chat with them regarding the food. If a service user can't

communicate I talk to their family or the nurse in charge. Records showed that care plans were audited on a monthly basis and updated as required. For example one person's care plan had been audited in May 2017 and actions were documented, for example, for referrals to be made.

Some people thought there were enough activities offered. For example, one person told us, "I love my music, I love every day the music, yes it is very good here." Another person said, "I love the singing, I could sing all day long. Yes they all love singing here." A third person told us, "I love painting. I can do painting here." However, one person told us, "Only Bingo, Bingo, Bingo, so I just sit here and watch the telly. They do some stuff down there [activities room] but I couldn't tell you what it is, no good I just watch the telly" This person and one other person told us they would be voting in the forthcoming election accompanied by the activity co-ordinator. A staff member told us, "We take [people] to the garden, they play bowls and dance and entertainers come in."

The provider employed two activity co-ordinators. One of the activity co-ordinators told us they delivered newspapers to people if they wished first thing in the morning. They also told us 29 people received one to one sessions in their rooms which included reading and hand care. A relative told us, "[Person] gets one to one time from staff."

We observed there was a range of activities on offer including arts and crafts, garden picnics, life stories, round the world discussions and visiting entertainers, The activity co-ordinator showed us the vegetable and herb patch which people interested in gardening helped to plant and look after. The service had one main group activity in the morning and one in the afternoon. We observed one of the afternoon activity sessions, which consisted of people throwing hoops over sticks. The atmosphere was positive and staff were skilled in ensuring everybody in the room including a relative took part. People and staff were laughing and engaging with each other.

There was an activity board outside the activity room which showed what activities were available in June. These included exercises and visitors from places of worship for prayer sessions. The activity co-ordinator told us people could go on trips to the supermarket, café or local shopping area. We observed people went out on these trips during our inspection. The hairdresser visited one morning a week and we observed people made use of this service.

People told us they would not make a complaint. One person told us they would not tell anyone if they were not happy with the service they were receiving. This person said, "Not one member of staff listens, they are all rotten from the management down." Another person told us, "I would not bother telling the staff, there is one who I go out to the shops with; I might tell her." A relative told us they had never made a complaint but would tell staff if they were not happy.

The provider had a clear complaints policy. We reviewed the complaints records and saw one person had made a complaint since the last inspection about food quality, activities and the care the person received. Appropriate action was taken promptly within the provider's policy timescales and documented.

Records showed the provider had documented a recent compliment made by a visiting healthcare professional who was impressed with the home being clean and preparing freshly cooked meals.

Is the service well-led?

Our findings

At the last inspection November and December 2016, the provider did not have effective systems in place to assess, monitor and mitigate the risks relating to health, safety and welfare of people using the service. We also found the provider did not maintain complete and contemporaneous records in respect of each person using the service.

During this inspection, although we found improvements had been made, further improvements were required because the various audit systems had not picked up on the issues we identified. The various quality checks included checks on bedding in people's rooms, people's weights and accidents or incidents. We saw when issues were identified, actions to be taken were recorded and dated when completed. However the audit systems did not identify that contradictory information was contained in some care plans, and risk assessments. Additionally, issues around medicines were not identified, for example, pharmacy labels on refrigerated medicines. This meant the provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This meant people could not be assured that they were receiving a safe and effective service

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager at the service. One relative said, "[Registered manager] is very co-operative. Takes [family member] to my home every month with a carer. Very helpful and very friendly" Another relative said, "We see [registered manager] around. She always gives us an update. I think she has started to develop the staff."

Staff told us they felt supported by management. One staff member told us, "Yes. Seniors, team leaders, the [registered] manager, deputy manager, nurse in charge all support us. I find the nurses very good." Another staff member told us the registered manager thanked them if they had done a good job and if they had not done a good job it was discussed and they were offered training. This staff member also told us, "I have never regretted joining them." A third staff member said, "I feel supported and valued by everyone. The staff really care."

The provider had a system of obtaining feedback from people who used the service. We reviewed eight responses to the survey conducted in January 2017. One person had commented on the form, "I'm happy." Another person had stated, "I think they [staff] do a good job." We noted that three people had indicated they would like regular exercise, movement and music sessions and that these were now included in the weekly activity programme.

People who used the service had regular meetings. We reviewed the minutes of the meetings held on 3 January 2017 and 24 April 2017 and saw the topics discussed included catering, laundry, housekeeping and activities. The registered manager told us relatives had meetings twice a year and there had not been a meeting since the last inspection.

The provider held regular meetings for nurses and for staff. One care worker told us, "We have team meetings every month. They're good. We get to communicate a lot." Another care worker told us, "I go to team meetings. They're good."

Daily flash meetings were held so the registered manager could be updated on the welfare of people using the service and issues arising within auxiliary teams. These meetings were documented and were up to date. We reviewed the minutes of the staff meetings held during March April and May 2017 and saw topics discussed included, communication, patient care, cleaning, medicines and completion of care charts. Records showed the minutes of the nurses meeting held on 1 June 2017 included discussions of incident reporting, confidentiality, new admissions and daily nurses' checks.