Four Seasons (Bamford) Limited

Alexandra Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced.

Alexandra Care Home provides both residential and nursing care for up to 76 people, some of who may live with dementia. At the time of our inspection the home had a manager in post who was registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The staff team at Alexandra Care Home were not all aware of people's needs and able to respond to these in an individual manner. However, we also found that there had been an increased staff turnover and relatives told us this had impacted on the service. The registered manager

Summary of findings

was aware of these issues and had recently recruited a number of staff. However people we spoke with told us that there were still at times insufficient staffing numbers to meet their needs. This meant they had breached regulation 22 of the Health and Social Care Act 2008 because they had failed to ensure sufficient numbers of staff were available to support people. You can see what action we told the provider to take at the back of the full version of this report.

Care plans were being reviewed regularly and the home was in the process of implementing a new personalised system for care planning. Peoples care needs were recorded and staff we spoke with were aware of people's individual needs and wishes. We observed staff being kind and supportive. People and their relatives told us that staff were caring.

There was a quality assurance system in place. The manager carried out regular audits and developed action plans. This was reviewed by the regional manager and discussed with the provider. Complaints were responded to appropriately.

Staff we spoke with were aware of how to keep people who lived at Alexandra Care Home safe. People who lived there and their relatives told us they felt safe and cared for. There were policies in place that identified how staff were able to report their concerns about possible acts of abuse.

Staff we spoke with told us that they were aware of the signs of abuse and how this was to be reported. However we also spoke with one person who had received poor care and did not feel safe.

This meant they had breached regulation 11 of the Health and Social Care Act 2008 because they had failed to respond to an act of suspected abuse and had failed to report this. You can see what action we told the provider to take at the back of the full version of this report.

The service had regular meetings for staff, people and their relatives. There were annual surveys sent out to people and their relatives to gain their views.

The provider acted in accordance with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive.

Food was not maintained at a safe temperature and people received meals that were cold. This meant they had breached regulation 14 of the Health and Social Care Act 2008 because they had failed to ensure that people were protected from the risks of inadequate nutrition. You can see what action we told the provider to take at the back of the full version of this report.

People were not always treated in a manner which promoted their dignity and respect and respected their privacy when assisting them with eating their meals. This meant they had breached regulation 17 of the Health and Social Care Act 2008 because they had not ensure people were treated in a dignified manner when assistance was provided.

The manager completed regular audits from a planned schedule, and then where necessary they developed action plans and reported their findings to the regional manager.

The provider failed to send to the Commission, when requested to do so, a written report in relation to the management of home. This meant they had breached regulation 10 of the Health and Social Care Act 2008 because they had not sent to the commission when requested a report of how they provider felt they met the regulations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always providing safe care for people.

Staff had carried out poor moving and handling which had not been reported as required by the provider's policy.

There were insufficient numbers of staff available to support people's needs in a timely manner.

The provider acted in accordance with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service effective?

Requires Improvement

The service was not always providing effective care for people.

Pressure mattress settings were set correctly and appropriate pressure relieving equipment was provided to people.

Where people were at risk of malnutrition or dehydration staff had made the appropriate referrals to health professionals, however people were not always supported to eat sufficient amounts.

Food was not maintained at a safe temperature and people received meals that were cold.

We spoke with two members for who English was not their first language who had difficulty in understanding our requests. One person who used the service told us they chose to not speak to a particular staff group because of this difficulty.

Is the service caring?

Requires Improvement

The service was not always caring.

Through the inspection we saw that staff engaged and spoke with people who used the service and their relatives in a polite and courteous manner.

People were not always treated in a manner which promoted their dignity and respect and respected their privacy.

Is the service responsive?

Requires Improvement

The service was responsive.

Each person had an assessment of their needs carried out prior to their admission.

Care staff understood to distract people positively who were distressed in a manner that each person responded positively to.

Summary of findings

Some nursing staff were not aware of the clinical needs of people on their designated units.

People we spoke with were aware of how to make a complaint, and the home provided people with this information.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider failed to send to the Commission, when requested to do so, a written report in relation to the management of home.

The provider carried out an annual survey with people who used the service and their relatives. Feedback from the results was reviewed and used to drive improvements in the home.

The manager completed regular audits from a planned schedule, and then where necessary they developed action plans and reported their findings to the regional manager.

People's views were sought in relation to the management of the home.

Alexandra Care Home

Detailed findings

Background to this inspection

We carried out our inspection of Alexandra Care Home over two days on 9 July 2014 and 11 July 2014. The inspection team comprised of one inspector and an expert by experience for the inspection on 9 July 2014. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had experience with older people receiving residential care.

As part of planning our inspection we looked at the information we had available. We had asked the provider to submit a provider information return (PIR) to us prior to our inspection to assist with our planning however they had failed to do so. This is information we asked the provider to send to us to show how they were meeting the requirements of the five key questions

We looked at information we held which included information from notifications of injury, death, and safeguarding adults that were received by the us. We also reviewed the findings from our last inspection on 27 May 2014 where no breeches of the regulations or areas of concern were identified.

During our inspection we observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During our inspection we spoke with eight people who lived at the home, five members of staff and four people's relatives. We also spoke with a health professional and a social care assessor who were visiting the service.

We looked at records relating to the management of the home such as audits, quality assurance and health and safety and seven people's care records.

Requires Improvement

Is the service safe?

Our findings

People could not be confident that they would be protected from suspected abuse as not all incidents and accidents had been reported and investigated. Not all staff were able to describe what constitutes abuse and what actions they would take.

We asked people if they felt safe living at Alexandra Care Home and if they knew how to report any concerns. Some people we spoke with told us they felt safe and that they approached staff if they were concerned about anything. One person we spoke with told us, "I do feel safe enough, I've got no fears like that."

We spoke with one person who used the service who told us that they had been injured recently after two members of staff used a hoist to move them from their chair. They said they told the staff they had just hurt them but, "Could not believe it when they did again ". They told us the member of staff said, "It was nothing and they didn't even say sorry." We then looked at the person's care records and found no entry had been made in the daily notes, skin viability care plan, bruising care plans, and also that no record had been made in the body map. We spoke with the registered manager who was also unaware of the incident. They immediately spoke with the person and confirmed the sequence of events with them. They told us that they would investigate the matter and where appropriate disciplinary procedures would be implemented. However the manager was unaware of the incident and had not instigated an investigation or made a safeguarding referral to the local authority.

We looked at records of incidents or accidents that had occurred within the home during June and July 2014. In the vast majority of reported incidents or accidents the matter had been entered onto the reporting system by staff, and then reviewed and investigated. However, not all incidents had been investigated. One person had an unexplained bruise and whilst some action had been taken a full investigation had not been completed.

We looked at the provider's 'Safeguarding Adults Policy' which provided guidance for staff to follow should they suspect abuse. Four out of the five staff member's we spoke with were able to demonstrate awareness of issues relating to abuse and who they were to report this to.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we spoke with told us there were insufficient numbers of staff. People we spoke with told us that they had to wait sometimes for up to 30 minutes to be seen when they needed support. One person we spoke with told us that they had been unwell which led to them soiling themselves. They told us they did not call for assistance and said, "I push my buzzer but because it takes them a long time to come I try to cope on my own." We saw that this person required assistance with their personal care due to their mobility needs. Where this person had felt their call for assistance may not be responded to, they had been placed at risk of injury through slipping or falling A second resident told us," I only press my button twice a week but even then get forgotten. There is not enough carers, I'd put this place in order with just one extra carer per floor."

A third resident we spoke with told us, "They are just so busy in the mornings that when they answer our bells, which is usually really quick, they then forget to come back." One member of staff we spoke with told us, "We answer nine out of ten of the bells in good time, but sometimes we need to prioritise, an extra carer would help us do the little bits."

We spoke with the registered manager about the lack of staff available to meet the needs of people. They were in the process of recruiting further staff, however told us that staff members who were recruited and started to work at the home soon left after commencing. In many cases this was because the type of work people were carrying out was not what they expected it to be. Gaps in staffing were managed within the homes existing staffing levels, and the use of agency staff to fill the shortfall had not been used. People were at risk of harm or neglect because there were not enough members of staff to respond to people's needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection, we observed staff positively assisting people to transfer from their wheelchair to an arm chair. When assisting people staff were patient, attentive, kind and took the time to reassure people who were agitated or unsettled. However, on one occasion staff had not ensured that the wheelchair was available before hoisting the person. Whilst the person was suspended in

Requires Improvement

Is the service safe?

mid-air by the hoist, staff moved away to get the wheelchair. During this time staff were not in control of the hoist whilst the person was suspended, so there was a risk that the person may be injured by the hoist tipping over.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to residential care homes. Where applications had needed to be submitted, proper policies and procedures had been followed for most people who required this. Staff had been trained to understand when an application should be made, and how to submit one. We saw throughout our inspection that key pads were fitted to all external doors in the home. One person had asked on numerous occasions to be taken out to the local town. They told us that they had never seen the town and would like to go for a coffee. We asked to view records to demonstrate that the appropriate procedures were followed; however staff told us they had not been completed for any of the people in the home. We spoke with the manager about the recent ruling by the Supreme Court in relation to locked doors. The manager was aware of the changes as a result of this ruling but had not started assessing people who have their liberty deprived. This meant that the requirements of the Mental Capacity Act 2005 have not been followed and people may unlawfully have had their liberty deprived.

We looked at people's care records and saw that each contained a comprehensive assessment of the person's needs and most were regularly reviewed when there was a risk to a person's health. For example we saw regular reviews had been undertaken to monitor those people at risk of developing a pressure sore.

We spoke with three members of staff who had recently been employed to work at the home. Staff told us that their recruitment had been robust and comprehensive. They confirmed that references had been taken up, and they were not allowed to start until all the appropriate checks, including criminal records checks had been reviewed as satisfactory.

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives told us that the food provided was not always appealing. One person "The food here is better, but there is room for improvement still and I hope it improves because some days I just don't fancy it." One told us the food was cold so we asked a nurse to check if the food was hot enough.

People who used the service told us that if they did not like the choices for a particular day then the cook was able to make them an alternative. One person who used the service told us, "The food is much better than how it used to be, and now if I don't like something the cook rustles me up something." We spoke with the cook who told us that for those people who were underweight and required encouragement standard practice was to enrich and fortify their meals. For example, dairy products were added to mashed potato and cream was added to porridge.

We observed breakfast and lunchtime during the two days of our inspection. We noted that each mealtime was calm and sociable with people sitting eating their meals with people they looked comfortable with. We saw that staff displayed the days menu using pictorial images however when we asked two people what they had for lunch on one particular day they did not know.

One person told us the food was cold. We checked the meal the person was eating in their room and confirmed it was cool. We then checked the server trolley in the dining room and found that all the food was below the recommended temperature. We noted that staff had checked the temperature of the food when it was delivered to the unit, however it had cooled rapidly. This indicated the trolley was faulty and the manager requested an engineer to visit. However people told us food had been cool for a number of weeks. Where people were at risk of malnutrition and chose to not eat their meal because it was cold this meant they were at risk of not having their nutritional needs met. This meant that food had not been are handled and delivered in a way that meets the requirements of the Food Safety Act 1990.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's care records and saw that each contained a comprehensive assessment of the person's needs and most were regularly reviewed when there was a risk to a person's health. For example, we saw that where people's dietary needs changed following a review by the dietician, the appropriate care plan had been amended to reflect this. For example, food and nutritional needs and frequency of repositioning and turning if they were at risk of developing pressure sores.

People who use the service told us that if they needed a doctor, chiropodist, physiotherapist or any other health professional then this was provided swiftly. We saw from care records we looked at that where people's health needs deteriorated staff referred people to their GP and followed their advice. When the matter was an emergency then staff called the emergency services to access rapid care and support. The home provided people with routine chiropody appointments, dentistry and provided access to physiotherapists. This was all provided to people within the home which made accessing the health care easier for people. We spoke with one person's relative who told us, "[Person] has seen the physio and I came along as well. They left us a set of exercises that I can help [person] with which is nice." A clinic is also held regularly throughout the week for the GP to review people's health. Where GP services are required outside of normal hours, we saw that arrangements were in place for out of hours cover

We looked at the pressure mattress settings for 12 people who were at risk of developing a pressure sore and noted that each had been set correctly to take account of a person's weight. We looked at the records for two of these people and spoke to staff about their care needs. Staff were aware of each person's care plan in relation to their skin integrity, and each staff member explained each person's repositioning frequency. We saw that an assessment of people's skin integrity was carried out and the appropriate care plan and equipment was implemented.

We noted from records of meetings that staff had indicated they felt that supervision meetings with their line manager were for 'telling offs' rather than development. We saw that in response to this the home manager had contacted the provider to review and introduce new supervision methods.

Training was used effectively to support staff with their caring roles. The registered manager told us there were plans to also introduce a counselling element to staff members supervisions in an effort to ensure that staff members did not view supervision as a reprisal but as supportive meeting.

Requires Improvement

Is the service effective?

Staff had received training in areas such as dementia care, safeguarding vulnerable adults, moving and handling and management of medicines. Staff we spoke with told us that the training they attended was helpful and supported them in their roles. At the time of inspection the provider was implementing a computer based system of learning. One staff member told us that they found it difficult to use computers. They told us that the manager had taken the time to support them with learning basic computing skills to support them with the new training approach.

Requires Improvement

Is the service caring?

Our findings

People were generally treated in a manner which promoted their dignity and respected their privacy. We observed that staff closed people's bedroom doors when providing personal care, and spoke to people discreetly when needed. We spoke with one person's relative who told us, "I have never felt awkward because of how the staff speak to [relative] or support them. Naturally there are differences in how staff speak to us, some treat us almost like a friend or family member, others are just respectful because it's the norm, but there are no staff here who are rude or abrupt at all." A second relative we spoke with told us, "The staff on this floor are brilliant, they treat us all in a personal and professional manner."

However, during one lunch observation we noted that staff did not always treat people in a dignified manner. We observed one staff member supporting people to eat their lunch in the dining room. At the time of our observation they were supporting four people to eat their lunch. We noted that they stood over each person and placed food onto a spoon without acknowledging or talking to the person. They moved from person to person with minimal interaction. When each person had stopped eating, the staff member removed their plate with little discussion or prompting. We also observed that whilst this staff member was assisting people with their lunch, they were also taking lunches to people in their bedrooms. Whilst being absent from the dining room one person poured their beaker of juice into their lunch. Throughout out lunch observation staff had not supported people's independence or maintained their dignity. We could not be confident that people who were assisted with their meals would always be supported to eat in a dignified manner.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Through discussion with the manager and carers we found that each had a fundamental understanding of the particular needs of each person. However not all staff were able to recall people or their needs as we have reported elsewhere in this report. We spoke with nursing staff on one unit who were unable to recall people's needs and required prompting from care staff. Where people on that particular unit had nursing needs it meant they were at risk of not receiving nursing care from staff who knew them well.

Through the inspection we saw that staff engaged and spoke with people who used the service and their relatives in a polite and courteous manner. Where staff spoke with people they did so in a manner which showed that they knew the people they were speaking with well.

Each care plan had been written with input from either the person themselves, or where they lacked capacity had sought the views of family members. Care needs were recorded in a way that expressed the individual's wishes and demonstrated their involvement.

Requires Improvement

Is the service responsive?

Our findings

People told us that their care needs were met by staff. People told us that their social needs were not always met in the same manner. One person told us, "I would like the staff to sometimes just pop in and see if I am okay, maybe pass me a book or magazine. That TV has been like that since I went to sleep last night."

We spoke with three staff members who were able to clearly describe to us people's care needs. For example, food and nutritional needs and frequency of repositioning and turning if they were at risk of developing pressure sores. Where the staff explained a person's care needs to us, this matched the current care plan. However, on the first floor we asked one of the nurse's about people's needs and they were not able to answer sufficiently. For example, we asked them about the length of time a number of people had been resident in the home, their room location and basic needs. They were unable to answer and asked a second member of staff who knew about the resident's length of stay and history. Where the nurse was unaware of people's needs and had oversight of the delivery of their care plan, this meant people were at risk of not receiving appropriate care, from staff.

We saw from people's care records that each person had an assessment of their needs carried out prior to their admission. Information obtained either from the person, their relatives or professionals was used to formulate the care plans and risk assessments. We saw that the assessment of needs covered areas such as mobility, mental health, physical health, medication, diagnosis, allergies and any equipment necessary for the person's care needs. This meant that the home was able to provide a continuity of care for people on admission.

Care plans we looked at had been developed to address the particular needs of each person. We saw that these were written clearly and concisely and detailed sufficient information for staff to know how to support a person's needs. For example, one newly recruited staff member was able to tell us about the particular mobility needs of one person and how these had improved. They told us how they supported this person with their changing mobility needs, and knew what was important to them. We saw that the care plan contained information that had been sought from the person which demonstrated people were actively involved in developing their care plan.

One person's relative we spoke with told us, "Each time there is any sort of change the nurse talks to me about [relative] and we agree what is the best approach. I am able to request a review of [relative's] care when I feel it is needed and the staff respond."

Staff provided a range of activities to people in Alexandra Care Home. These ranged from music and reminiscence to movies in a bespoke designed cinema area. Some people who used the service told us that the activities were enjoyable and sociable, however other people told us that the activities were, "The standard fare in these places, uninspiring and dull so I stay in my room. If they changed them around and mixed things up then maybe I would want to attend a bit more." We also observed that there was very little stimulation for people who were confined to their bed. We noted that for three people on one unit their television remained on a channel that was not broadcasting and displayed a blank screen. One of these people told us, "I would like the staff to sometimes just pop in and see if I am okay, maybe pass me a book or magazine. That TV has been like that since I went to sleep last night." We observed that in a second person's room their relative had left clear instructions on what television channels and programs to put on for their relative. We observed that the channel was incorrectly set to a channel that was not appropriate and the person was not watching their preferred program.

On two occasions during our inspection we observed staff supporting people who had become distressed and anxious. On both occasions each person had become frustrated and was attempting to hit a resident next to them. We saw that each staff member managed this behaviour in a calm and caring manner, using soft reassuring tones and then spend time with the person to understand what was upsetting them. Staff knew how to distract each person appropriately in a manner that each person responded positively to. Staff were aware of how to respond to people so they were not unnecessarily distressed or alarmed.

Staff and the manager told us that the home was implementing the "Pearl model" of care planning and delivery. This was a method of developing and providing personalised care to people that aimed to meet their specific needs. We were shown various documents relating to this being implemented and staff we spoke with were very positive about this change. At the time of our

Requires Improvement

Is the service responsive?

inspection the home was piloting the scheme for the provider, and had begun by meeting with staff and providing training. Staff told us that the purpose of the scheme was to place the carer in the shoes of the resident so that they were better placed to not only understand their needs, but to respond in a personalised manner.

We saw the home had a comprehensive complaints concerns and compliments policy in place. We looked at recent complaints that had been received by the home and noted that each had been investigated thoroughly. This usually involved the home manager carrying out a full investigation of the concerns with the support of the deputy manager. We noted that a full explanation was provided to the complainant on completion. In some circumstances complaints that were not resolved to the person's satisfaction were referred to the provider for a further investigation by senior management. People we spoke with were aware of how to make a complaint, and the home provided people with this information.

We spoke with two members of staff who had difficulty in understanding our questions or requests as English was not their first language. We observed one nurse speaking to one person who lived at the home and saw that it was frustrating and difficult for the person to convey their needs. We spoke with another person who used the service who told us that overall the staff understanding of English was good. However there were a small number of staff they chose not to speak with because when they asked for something they sometimes did not receive it, or that explaining their needs or preferences was too difficult. This meant there was a risk that people may not be able to explain to staff how they wish to be cared for, or when they are in need of assistance. We noted that the registered manager had requested support from the provider to address this however no support had been put into place at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection we asked the provider to supply us with information setting out how they are meeting the requirements of assessing and monitoring their care delivery and how they have identified and managed any risks in the carrying on of their regulated activities. We set the provider a deadline and also a reminder by email to complete the documentation prior to our inspection. The provider had failed to submit their information to us by the required time. They were in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) because they failed to send to the Commission, when requested to do so, a written report in relation to the management of the regulated activity.

One person's relative we spoke with told us, "The management here have made things a lot better, particularly the food. There are still things to do, but this whole home is so much happier now because they have listened to us." One person who used the service told us, "The cogs turn slowly here sometimes but they turn none the less. The management do listen, they do respond, but not always what we want to hear, but we can't have everything and they do the important things." The provider carried out an annual survey with people who used the service and their relatives in August 2013. This survey covered areas such as meals, care provision and communication. We noted that 100 percent of people who responded indicated they felt at ease talking to staff. However, 33 percent felt staff did not always use a language they could understand. The manager had developed an action plan to address this, which demonstrated how they were about to provide support to staff. However at the time of our inspection this language support had not commenced.

On the day of our inspection the home was being managed by a registered manager who was supported by a recently recruited deputy manager. Each of the three floors had a unit manager who over saw the day to day management of the care. Overseeing the home was an area manager who provided support to the home manager.

We spoke with staff who told us they felt the registered manager was approachable and supportive. One staff member told us, "[Manager] is busy, but approachable if I need any support or advice, I know all I need to do is go to their office for anything I need." A second staff member we spoke with told us, "The management are firm but fair, I know where I stand with them and what is expected of me every day. If there is ever anything that gets in the way of me doing my job then they are there for me to speak with." Staff also told us that they felt they were able to contribute to developments in the home. One staff member told us, "We are going through the Pearl program and that is all about the manager asking us to support them with getting it up and running. I feel very involved and my voice is heard in these meetings."

There were systems in place to ensure that the provider was able to monitor the quality of the service. The manager completed regular audits from a planned schedule, and then where necessary they developed action plans and reported their findings to the regional manager. The regional manager then carried out regular monitoring visits where they reviewed the manager's audits and actions plans to ensure they were accurate and on target for completion.

We saw a range of meetings were held in the home with residents, and people's relatives to seek their views. These ranged from a formal meeting held with people's relatives to informal coffee mornings and afternoons held with the residents. One person said they were happier now that staff introduced themselves when entering the room and a second person was happy to now have a longer call bell lead in their room. We saw that ideas were also taken for summer activities and feedback was sought around areas such as care, staffing and food. This meant that the manager had sought the views of people in how the home was managed and responded to issues appropriately. We saw that the relatives meetings were conducted in the same manner and the management had responded appropriately to concerns highlighted and sought feedback.

The views of staff were captured through peer review meetings with HR. The HR officer provided feedback to the registered manager any issues or concerns that had arisen. They told us that this was done in a confidential manner. Staff we spoke with told us this was overall a beneficial initiative. One staff member said, "If I have a particularly sensitive issue to mention about the manager of problems in the home, I can raise it anonymously and with the support of my colleagues."

Alexandra Care Home had a continual action plan in place to address issues identified both internally and by the local

Requires Improvement

Is the service well-led?

authority's monitoring visit and previous Care Quality Commission inspections. There was a clear plan in place and the manager was working through the actions with the support of the regional manager. This plan was constantly reviewed and audited by both the home manager and regional manager. We noted that issues that were identified were picked up through this monitoring and implemented. For example we noted that not all staff had completed training in relation to palliative care. We saw from meeting minutes that the home manager had taken strong action to ensure that staff completed this.

We felt that the leadership of the manager was adequately projected through the staff they supervised . Staff we spoke with told us that as the home had a strong management team in place and the home manager was able to spend time on the floor. Staff told us that the manager was available to offer support and guidance when they were present. They told us that this was positive as they learnt from their presence. As many of the staff were new members of the team it was seen as a positive for the manager to lead from the front in such circumstances.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Potential abuse had not been reported and responded to by the manager to ensure the safety of the person was protected. Not all incidents and accidents had been followed up to ensure people were safe, and not all had been reported as required. Regulation 11 (1) (a) (b).**

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The dignity, privacy and independence of service users had not been maintained when supporting people at mealtimes. Regulation 17 (1) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider failed to send to the Commission, when requested to do so, a written report in relation to the management of the regulated activity. Regulation (10) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected from the risks of inadequate nutrition as food was not stored at recommended temperatures in a way that meets the requirements of the food Safety Act 1990.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of staff employed for the purposes of carrying on the regulated activity.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.