Adiemus Care Limited

Alexander Court

Inspection report

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Ratings

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

Overall summary

The inspection took place on 25 November 2015 and was unannounced.

Alexander Court provides accommodation and care for up to 47 older people. At the time of our inspection there were seven vacancies in rooms on the first floor for people who may be living with dementia. There were 40 people living in the home.

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

At the last inspection of this service in April 2015, we found that improvement was needed in all areas. The service was in breach of regulations for staffing, planning and delivering care to meet people's individual needs,

Summary of findings

and for notifying CQC about events taking place in the home. We found that action had been taken to ensure the regulations were met and for improving in other areas.

Staffing levels had improved so that people's needs could be attended to more promptly. The manager undertook to review arrangements on the first floor for the late afternoon and early evening to see if further improvements could be made. Staff deployment took into account the numbers of people using the service and their dependency. There was a designated staff member to support people with their interests and hobbies. This represented an improvement in the way that people's social and recreational needs were being met.

Improvements had also been made to staff training. Staff better understood how to protect the rights of people who may be unable to make informed decisions for themselves.

The manager had taken action to ensure that they told CQC about events and incidents happening within the service and to comply with that regulation.

However, there was a breach of one regulation where we found concerns about people's safety in relation to the management of risks associated with medicines administration. Medicines audits had not identified the issues we found at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Staff understood how to recognise and report concerns that anyone may be being abused or harmed.

Recruitment practices also contributed to protecting people from unsuitable staff being appointed. There were regular checks on the safety of the premises and equipment to help protect people from risks that these were unsafe.

People had enough to eat and drink to ensure their welfare. Staff took action to ensure concerns about people's physical or mental health were responded to promptly and to seek advice from relevant health professionals.

Staff responded to people in a kind, caring and respectful manner. They took prompt action to offer reassurance to people who were distressed or anxious. People's privacy was promoted and there were only isolated examples of this being compromised when staff walked into their rooms without knocking if their doors were open.

People, with support from their relatives if necessary, had opportunities to express their views about their care and about improvements they thought could be made to the service. They were confident that their complaints or concerns would be addressed if they had any.

Improvements had been made to the way that the quality of the service was checked and monitored. Action to improve the service in response to visitors and people's suggestions was taken more promptly than was the case at our last inspection. However, some staff still expressed frustration that suggestions they felt would make improvements easily were not always responded to promptly.

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?
The service was not consistently safe.

Medicines were not always managed in a safe way.

Staffing levels had improved to contribute to people's safety. Staff knew how to recognise and report abuse to help protect people.

Risks associated with people's health, mobility and the premises were assessed and managed.

Requires improvement

Is the service effective?
The service was effective.

Improvements had been made to ensure that people received support from staff who were competent and trained.

Staff had a better understanding of how to support people who found it difficult to make informed decisions. The manager understood what to do if they thought someone was being deprived of their liberty to ensure their safety.

People had enough to eat and drink. Staff took action to seek advice about people's physical and mental health.

Good

Is the service caring?
The service was caring.

There were improvements to the way that staff responded to people when they were anxious or distressed. People were supported by kind and compassionate staff.

People, with support from relatives if needed, were involved in decisions about their care.

Good

Is the service responsive?
The service was responsive.

Improvements had been made to the way that care was planned to meet people's needs and staff understood what support people required. This included support to meet people's recreational needs, hobbies and interests.

People were confident their complaints would be responded to.

Good

Is the service well-led?
The service was well-led.

The manager had taken action to improve what they told us about events happening within the service.

Good

Summary of findings

There were also improvements in the way that people's suggestions were acted upon and the way that the quality of the service was monitored.

Alexander Court

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. It was also carried out in order to check whether the improvements identified as necessary at inspection on 9 April 2015 had been made.

The inspection took place on 25 November 2015 and was unannounced. It was carried out by three inspectors 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.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the home and which the provider is required to tell us about by law. We also reviewed the action plan that had been developed after the last inspection to see what improvements we should expect to see.

During our inspection we spoke with the manager and deputy manager. We spoke with two senior care assistants, three care staff and the activities coordinator. We also spoke with the maintenance person and administrator. We spoke with six people using the service and five of their visitors.

We observed how people were being supported. 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 with us. We also observed the hand over to two staff members coming on duty for the afternoon shift.

We reviewed care records for six people and records associated with the quality, safety and management of the service. We reviewed recruitment records for two staff and training records for the staff team. We also reviewed medication administration records for people on both floors of the home and audited medicines for four people.

Requires improvement

Is the service safe?

Our findings

We identified concerns during this inspection about the safety of systems for managing medicines. We saw that the medicines trolley was routinely left unlocked when it was unattended. The deputy manager told us staff had been instructed that the trolley should be within line of sight, facing across the doorway when they were in people's rooms. We observed that this was not consistently the case. For example, we noted that a staff member took medicines to a person in their room but their position meant that the trolley doors could not be seen at all times. On another occasion on the ground floor we observed that the staff member responsible for administering medicines left the trolley open and unattended in the hallway. This presented a risk to people's safety and to their medicines which were not protected from unauthorised access.

We noted that there were checks for monitoring the safety and effectiveness of medicines. Two of these had taken place for the management of medicines on the ground floor in September and October and were clear in what was checked. However, we were not able to see that medicines on the first floor were thoroughly audited at the same time and this was where we found most concerns. Although staff said their competence to administer medicines was assessed, the system was not as robust as it should be in promoting best practice.

We discussed with the management team that there were some potential issues for infection control when administering medicines. This was associated with people being given water with which to take their tablets when there was not a clear and distinct system for managing used and clean drinking cups. We also discussed that, during the morning, one person's medicine administration record had already been signed to show that their lunch time medicine had been administered. Staff told us this was because they had taken the medicine with them when they had gone out. However, their record was not coded appropriately to show the person was away from the home. Staff should not have signed the record to show that the person had actually had their medicine.

For two people, prescribed a medicine for occasional use, their medicine administration record (MAR) charts showed the medicines were out of stock during the period leading up to our inspection. For one person their medicine had been unavailable for more than three weeks. We asked the deputy manager about these, who said that they thought the medicines were no longer required although they were still shown as prescribed on their MAR charts. The deputy manager undertook to check this with the doctor.

There were some medicines being prescribed for administration in variable doses and when required (PRN). We noted that, for some of these, the amounts given were not clearly indicated on MAR charts. For example, one person prescribed one or two sachets of a medicine had been given this on two days during November. On neither occasion was the actual amount given recorded. For two people, prescribed medicine for pain relief, their MAR charts did not clearly indicate the amount of medicine they were given. This presented a risk to people that they might not receive adequate medicines to control their condition, if staff could not be sure whether or not they had already received the maximum dose. It also presented a risk that they could be given more of the medicines than intended if staff were unsure how much had already been administered.

One person was prescribed half or one tablet of a medicine for agitation, to be given when it was needed. Their records showed the amount given and recorded that they had been given two during the course of November. We found that the medicine records showed there were 18 tablets in stock at the beginning of the month and so there should have been 16 tablets remaining. We found that there was an anomaly of half a tablet which was missing and unaccounted for or may have been given and not recorded.

We checked the person's daily records to determine whether the use of the medicine had been justified on the occasions when it was recorded as given. On neither occasion when the medicine had been given did their daily notes show that they were agitated. The person's daily notes showed that on one of the days it was given they were weepy but on the other day that they had been settled throughout the day. The management team could not therefore be confident that the person was given this medicine for the purpose intended by the prescriber to promote their well-being.

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

People spoken with said that their medication was administered on time. People told us about the way staff

Requires improvement

Is the service safe?

administered their medicines and whether they stayed to make sure the person had taken them. One person said "Sometimes they do and sometimes they don't because they know I'll take them." Another told us, "They always ensure that I take my tablets."

At the last inspection of this service in April 2015, we found that there were not enough staff to meet people's needs safely. The provider told us what improvements they were going to make to staffing levels and we found that this action had been taken.

We raised with the registered manager a remaining 'pinch point' for staff, particularly on the first floor where they were supporting people who lived with dementia and had significant support needs. This was after ancillary staff left for the day at 4pm. At that time, staff were trying to serve tea, address personal care and laundry issues and were very busy. The manager undertook to review arrangements at this time to see whether any additional support with domestic tasks would be of benefit. He had already addressed the time of peak demand in the morning, using a short shift of three hours so that people could be assisted to get up and to receive personal care promptly.

The manager had introduced a tool for assessing people's dependency and calculating the number of care staff that were needed to support them. We checked the duty rosters and confirmed that staffing levels had increased from those we had seen at our last inspection. Dedicated staff time was available for activities where previously an activities coordinator had been taken off those duties to work on care when shifts were short.

People told us that their calls for assistance were responded to promptly. One person said, "They respond to the call bell definitely straight away. If you want them they're there immediately." Another told us, "Yes there is quick response to the call bell."

Throughout this visit we saw that, although staff were busy, they were able to respond to requests for assistance promptly. Call bells were responded to quickly and we saw that staff were available to intervene to support people who became distressed or agitated. We noted one period of 15 minutes when staff were not available in the lounge area on the first floor but this had no adverse impact on the people using the area. The majority of the time, staff maintained either a regular presence in communal areas or made regular checks to ensure people's welfare and safety.

We concluded that there had been improvements to ensure there were enough staff to support people safely and that this was being kept under review.

We reviewed the recruitment records for two staff who had recently been appointed. We noted that the application form did not prompt prospective staff members to provide a full employment history. However, the administrator told us that, when they issued application forms they did ask for prospective staff to provide a 'CV' showing their employment history. We saw that this was in place. We also noted references were taken up and enhanced checks made to ensure prospective staff were not barred from working in care. We concluded that recruitment practices contributed to promoting people's safety.

People told us that they felt safe in the home. One person said, "Yes, I feel safe but if didn't I would talk to a social worker." Another said, "Definitely, I've never been safer." A visitor to the home told us, "I'm quite satisfied with [person's] safety." Another visitor told us that they had never had any concerns about the way staff responded to their relative or the way they had seen and heard staff dealing with other people. Staff spoken with confirmed that they had training to help them recognise and respond to abuse. They were clear about their obligations to report it and what might lead them to be concerned for someone's welfare. The manager provided information confirming that a further training 'workshop' in safeguarding vulnerable adults had been arranged for early December.

Other risks to which people were exposed were assessed and recorded within the individual plans of care that we reviewed. Improvements were continuing in this area, focussing first on those people who were considered as at high risk. For example, we found that people's risks of not drinking enough were recorded. The management team showed us information about how the service was working with the local GP practice to identify a 'target intake' for each person and to increase monitoring and recording of fluid intake. People's risk of falls and of developing pressure ulcers were also assessed and recorded with guidance about the way staff should support people to minimise the risk.

The safety of the premises and equipment was checked and monitored regularly. This included checks on hoists and lifting equipment, gas appliances and electrical equipment. We also found that there were regular checks

Requires improvement

Is the service safe?

and servicing to ensure that equipment needed for the detection and control of fires would work properly in an emergency. Records showed that staff had access to training in fire safety and health and safety.

We concluded that there were systems in place to assess and manage risks associated with people using the service and the premises, to promote people's safety.

Good

Is the service effective?

Our findings

When we inspected this service in April 2015, we found that, although regulations were not breached, the service people received was not as effective as it should be. The provider told us what they were going to do to address this and we found that improvements had been made.

People spoken with all felt that staff knew them well and understood their needs. A visitor to the service told us that they felt staff were competent to meet people's needs and understood how to work with people. Staff told us that they felt opportunities for training had improved. They said they were offered opportunities to complete additional training which would allow them to obtain a qualification in care work.

Information from the manager showed that the percentage of staff having completed the provider's required training, such as health and safety, moving and handling, and first aid, had increased. We also noted that training records showed most staff had completed training in dementia awareness and training in 'customer awareness and dignity in care' since our last inspection. The manager was aware of those staff who needed further encouragement to complete the required training and was monitoring this.

Staff expressed mixed views about the way they were supported but most felt that the support they received was good. They said that they had opportunities for supervision to discuss their work and development needs. They also attended staff meetings to discuss issues affecting the home and team work. The manager was aware of some gaps in supervision and appraisal for staff and showed us that they had a schedule in place to address this to ensure that staff received more consistent support.

We reviewed how the service supported people in line with 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.

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.

The manager and staff team had reviewed the way that people were supported to make informed decisions about their care and how this was recorded. We saw that care records included specific decisions about people's care and welfare and whether they were able to understand and make that decision. Where they were not able to do so, a record was made of what was in their best interests. A relative told us how the person they visited may not understand their care and care plans but that staff had discussed with them the support they needed.

Care staff spoken with demonstrated an improved understanding of the MCA and how they supported people with decision making and choices. For example, a staff member told us of how they needed to know people so that they understood what the person was communicating about their choices. This included where people may not give consent verbally but would be accepting of care that was essential to ensure their welfare. Training records showed that the provider had prepared care staff to understand their responsibilities under the MCA and DoLS with all but one member of the care team having completed training.

People were able to move around the home and in the enclosed garden and were supported by staff to do so if this was needed. People were free to come and go as they wished but all had mobility problems to varying degrees and some would have to be accompanied. One person said, "I could do [go out on my own] and I'd like to but I don't think I'd manage." Another told us, "I do go out into the town but there is always someone with me." They said that they were worried about falls and so were supported. Some people went out with their family members.

The manager was aware of when an application to deprive someone of their liberty in the interests of their safety may be necessary. At the time of our inspection, no such applications had been made as no one was considered to be subject to constraints that infringed their rights.

Staff commented to us that the meals were sometimes close together, particularly lunch and tea. There were sandwiches on offer again during the evening for people so

that they could have something to eat between tea at approximately 4pm and breakfast the next morning. Although staff commented on this as a potential issue affecting people living in the home, people themselves were satisfied with arrangements.

For example, people told us about what they had to eat and drink and were complimentary about it. One person said, "The food is fantastic, you can't fault it." A visitor told us, "I haven't tried the food myself but [person} is quite satisfied with it." All of the people we spoke with said that there was enough to eat. Another visitor told us how, when their relative had first moved to the home, they had refused to eat and drink well. They told us that staff had persevered and offered encouragement so that the person was now eating and drinking well. One person said, "If there's something you don't like they'll find you something else." People told us they could choose to eat in the dining room or in their own rooms.

We saw that a drinks trolley was taken round the home on a regular basis and people told us that they had plenty to drink. One person said, "They come round with the drinks trolley every two to three hours." We observed that there was a choice of main course and of dessert and people were asked to make their choice during the morning. On the first floor, where people were living with dementia, they were shown sample plates of food at lunch time and tea time to assist them with making choices. We noted that one person wanted a cup of tea with their lunch rather than the choice of squash and a tea was made straight away.

Tables were set with cloths, place mats and napkins to help provide a pleasant environment for people to eat their meals. We saw that people were offered drinks with their meals. Those who required assistance were supported appropriately. One person who kept falling asleep was gently wakened and encouraged by staff. They eventually managed most of their meal. We noted that another person refused their meal and that this was returned to the hot trolley so that staff could try again later to see if they would accept it. We saw that another person was asked if they wanted assistance to cut up their food. One person was late to the table as they had been for a haircut. They told staff their food was cold and we saw that a fresh meal was presented straight away from the hot trolley.

We noted that records indicated one person had lost a significant amount of weight over the course of one month but that this was being monitored and they had regained part of the weight they had lost. We concluded that people were supported to have enough to eat and drink to meet their needs.

People who were able to tell us said that staff called the doctor if they were unwell. We noted from people's care records that this happened. For example, one person had been referred to a speech and language therapist for advice about their swallowing. The advice had been incorporated into the person's care records and we saw that staff followed it during the lunch time period. A visitor told us that, "When my [relative] was unwell and in bed they checked [person] every 15 minutes and recorded how much drink [person] was taking. I cannot fault them." Another visitor commented, "They let me know straight away if anything is wrong."

One person's care records showed that there had been concerns about their eyesight and that staff responded quickly to contact the optician. Other records indicated people saw health professionals such as the district nurse and continence advisor. On the day of this inspection we noted that two people received support from community psychiatric nursing services so that staff had access to appropriate advice. A visitor to the service told us that their relative had not been well when they first moved to the service, "…but they soon arranged for a doctor to see [person]."

We concluded that people were supported with their health and advice from health care professionals was sought promptly when it was needed.

Good

Is the service caring?

Our findings

When we inspected this service in April 2015, we found that, although regulations were not breached, the service people received was not as caring as it should be. The provider told us what they were going to do to address this. This included additional training and monitoring the approach of staff. We found that improvements had been made.

People spoken with were complimentary about the caring approach of staff and the way they were supported. One person said, "The staff are very good and they look after you very well." Another person told us, "If the staff see you're down or a bit depressed they come and have a chat with you." A visitor commented to us about the approach of staff. They said, "I have no issues about care. Staff are always polite. They always seem friendly and cheerful."

We noted that there were isolated occasions when people had their room doors open and staff did not knock before entering their rooms. However, for the most part we saw that staff did knock, and announce themselves before entering. One person said "Staff always knock on the door before they come in." Another person told us, "They know me as a person and I'm treated with respect," and also, "The staff never get impatient with me." A visitor described staff as very respectful.

We noted that, where people needed assistance with their personal care, this was given behind closed doors so that their privacy was promoted. Unlike our previous inspection, we noted that inappropriate discussions about personal matters affecting people, did not take place in front of others. We concluded that improvements had been made to the way people's privacy and dignity was promoted. However, we did note that there were short periods during lunch time, where staff engaged more in conversation with one another than encouraging social interaction with people using the service.

We observed that staff responded promptly and kindly to people who needed reassurance or assistance. For example, a member of staff in the first floor lounge intervened promptly when someone was ill at ease. The person had been looking anxious and repeatedly saying, "Oh dear, oh dear." The staff member got down in front of the person's chair so that they could make eye contact and took time to establish what it was the person wanted. Their mood changed and they became calmer, smiling at the staff concerned before accepting assistance to go to their room.

Another person was anxious and became agitated when staff offered to assist with their personal care. Although this was a difficult situation, staff responded calmly and offered to return to help them later. We saw that eventually the person accepted the care that was offered and smiled as they went with staff to receive assistance and change their clothes.

Since our previous inspection, considerable work had gone into developing more detailed personal histories and family background within people's care records. This meant that staff had more information about people's needs and preferences and could engage more meaningfully with people who may be living with dementia. We observed that a staff member used this with one person who had become anxious. They were reassured when the staff member talked about the area where the person was born and brought up. We saw that they became less anxious, smiled at the staff member and started to talk to them.

Some people living in the home said that they felt the care they received met their needs but they did not expect to be involved in discussions about it. However, they told us that they felt their relatives could be involved if they wanted them to be and one person said they had not had to raise issues about their care but, "I'm sure they'd talk to me if I wished." A visitor to someone who found it difficult to engage and express their views told us that they had been involved in discussions about the person's needs, developing the care plan and providing information about the person's history. They said that they had also been involved in discussions about their relative's care with the medical practice and were kept informed.

People told us that they were supported to stay in touch with their family and friends. Those who did not have their own telephone lines said staff in the reception area were very helpful on contacting their relatives for them. One said, "I would have to go to the desk and ask them to phone my daughter - they seem to keep her informed how I am." Another person told us, "The desk will contact my son if I ask them." Throughout the course of our inspection we saw that people's visitors came and went and that there was no restriction on visiting hours.

Good

Is the service responsive?

Our findings

At our inspection on 9 April 2015, we found that the service was not as responsive as it should be. People's needs and preferences, particularly in relation to their preferences for meaningful activity, were not consistently identified and their care was not designed to meet these needs. The provider told us what they were going to do to improve to ensure people's wishes and preferences were taken into account in the way that care was provided. We found that action had been taken.

We did note that during lunch, the television was on throughout the meal in one dining room and turned off as soon as the news started. Music was then put on but we did not see that people present were consulted for their preferences. Staff did recognise that the volume of this was intrusive and later turned it down.

People spoken with told us that they could get up and go to bed when they wished. One said, "I choose what time I get up and what time I go to bed although I do need help to go to bed." We noted that one person's records showed that they had not slept well the night before our inspection so staff respected that they wished to have a lie-in. Another person said, "I can have a bath twice a week and more if I want." They said they could also choose whether to have their room door open or closed.

We saw that staff were flexible in their response to people. For example, one person refused the offers of staff to provide them with the personal care they needed. However, staff returned to the person at various times, reflecting that when they were less anxious, they would be more willing and able to accept the essential support that was offered. Another staff member had identified that a person responded more positively to accepting their medicine from a colleague who wore a polo shirt rather than a tunic. They said that they felt tunics raised anxiety for the person about being in hospital. They told us they had raised this with the manager as a way of encouraging the person to understand and accept their medicine and were awaiting a response. We concluded that staff were aware of the individual needs and issues affecting each person.

A programme of updating people's care plans and care records had been implemented, prioritising those with the most complex needs. We saw that these took into account people's past interests and hobbies. Care staff were able to tell us about the needs of people they supported. The information was consistent with what we identified in people's support plans and these were reviewed and updated on a more regular basis than previously so that they reflected people's current needs.

We noted that there were monitoring records in place where people's needs warranted this, for example where a person experienced difficulties with agitation or distress. There was no specific care plan for these issues but we noted additional professional advice was being sought to support staff in responding to the person's needs appropriately.

People were aware that there were activities available to them and that they could choose to attend if they wanted to. One person said, "I spend most of my time in my room but I don't have any hobbies. There are occasional activities if you want to go but I choose not to". Another person told us, "There's Bingo, flower making and cake making."

A staff member was specifically allocated to supporting people with activities in a more planned way rather than this being 'ad hoc' when staffing levels allowed. The staff member had been appointed as activities coordinator in May 2015, after our last inspection. They told us how they were hoping to increase people's participation in activities in the future to include activities outside the home and involvement of the local community. They were enthusiastic about their role, were able to tell us about people's needs and preferences and knew what activities might be suitable for individuals.

During the course of our inspection we saw that people were engaged in making large snow men decorations in preparation for Christmas. We saw evidence of some craft work in the form of mittens with tactile surfaces that people could pick up and feel, and photographs of what had taken place. The staff member was able to describe how one person had been supported with a foot spa, which they had enjoyed after being reassured about the equipment. There were plans for future events including trips out, cake making, coffee mornings and planned parties. Another staff member commented to us that they felt the home had changed a lot since the activities coordinator had been employed and that people were more involved and supported with activities they enjoyed.

Good

Is the service responsive?

We received information at our last inspection that most people felt their complaints were addressed satisfactorily within the home by the manager. However, we subsequently received two complaints from people's relatives who were concerned that the response to their complaints had not been robust. We raised two of these with the operations manager overseeing this and other services for the provider, and received comprehensive responses.

We reviewed the records of meetings involving people who lived at the home and their relatives. These showed that, where issues arose which affected the quality of life for groups of people using the service, in most cases the notes showed that action had been taken to follow them up. This contrasted with our previous inspection where the same issues were raised repeatedly over a period of time and not resolved to people's satisfaction.

At this inspection we found that people and their visitors were confident that they could speak to the manager if they had any concerns or complaints about their care. People spoken with told us that they did not have any complaints. A visitor told us that they were confident the manager would address any concerns they had. The procedure for making complaints was available in the reception area.

From the changes made within the service, we concluded that arrangements for listening and responding to people's experiences and complaints had improved and now needed to be sustained.

Good

Is the service well-led?

Our findings

At our last inspection of this service on 9 April 2015, we found that the manager had failed to notify us of events taking place within the service as required by regulations. The provider told us how they would review the notifications they needed to make and ensure these were made promptly. Since that inspection we have received regular information about events the provider or manager needs to tell us about. This included the failure of the lift, the action taken during the failure and confirmation of repairs. We concluded that the relevant regulation had been met.

Although further regulations were not breached at inspection in April 2015, we had concerns that the systems for auditing the service were not sufficiently robust and had not identified the failings that we found during that inspection. The manager had taken action to improve the way the quality of the service was monitored.

We noted that the twice daily 'walk around' checks the provider told us the management team would be doing and recording, were not recorded consistently. This meant that the records did not demonstrate the action the provider had told us they would take, had been implemented. We spoke with the manager about this. They explained to us that they considered that provider's form was overly focused on the nature of the environment. They said that they had found it did not take sufficient account of the quality of care. Although they assured us that they did make checks throughout the home twice daily, they had not recorded the checks they had made since 4 November 2015 to show their findings. They had not adapted the record or added a supplement as a prompt to the issues they felt should be included. We addressed this with the manager who immediately reintroduced a 'freestyle' record that they had been using in October.

At our last inspection people told us that they did not see much of the manager around the home. At this inspection, we identified an improvement in the way that the manager was 'visible' and accessible around the home. They confirmed to us that there were regular meetings they could attend to express their views, although several people spoken with had chosen not to. People spoken with said they could not suggest any way in which things could be improved. One person said, "Generally I'm happy and I think yes, I would recommend it [the home] to someone else." Another person told us, "Yes I would recommend it. I've done so for several people."

At our last inspection, visitors and people using the service expressed concerns that, although there were meetings for them to express their views, action was not always taken to improve. They felt that they were told something would be done but it took a long while to happen. People expressed no such concerns at this inspection.

We reviewed the minutes of 'residents and relatives meetings' that had taken place since our last inspection and found that these showed clearly that suggestions had been responded to and the action taken between meetings. This had included upgrading a television and providing a small freezer as someone suggested it would be nice to be able to have ice cream for supper. A relative told us another meeting was planned for December and they had already been sent an agenda. We concluded that people were empowered to express their views and make suggestions so that the service could develop.

We noted that there had been a survey of people's visitors and of professionals connected with the service. These expressed a good level of satisfaction with the quality of the service, but we noted they were undated when they were returned to ensure the information was current.

We found that there were regular checks on people's experiences of mealtimes. These showed that people were satisfied with the way that meals were timed, prepared, served and the options available to them. We found that the results were more positive than we had found at our last inspection. We concluded that the provider had taken action to improve where this was needed.

However, staff had mixed views about how they could express their opinions. Some felt able to make suggestions to improve the service and to express their views. Others were less confident that their views would be listened to. They said that it sometimes took a long time for action to be taken in response to their suggestions or for them to receive feedback on their ideas and views. Our discussions with staff and review of staff meeting minutes indicated that there were some issues for team work and morale which we raised with the management team.

Following our last inspection, the management team had implemented a programme for increasing staff training and

Good

Is the service well-led?

awareness of customer care and dignity and reviewed how this was being applied. We recognised that improvements had been made in the way that staff responded to people, including those who were living with dementia. Improvements had also been made in the way that training was monitored to see when it needed to be reviewed, renewed and updated. The significant gaps we identified at the last inspection had been addressed and there were plans to ensure that further shortfalls were also addressed.

The manager confirmed in writing to us that further practical training had been arranged for December to ensure gaps in first aid, safeguarding, moving and positioning and dignity in care were addressed.

We concluded that there had been significant improvements in the range of checks on the quality and safety of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Action had not been taken to robustly assess risks associated with the way that medicines were administered, recorded and handled. Action had not been taken to mitigate risks and to ensure that people always received medicines as intended by the prescriber. Regulation 12(1)(2)(a),(b),(f) and (g)