HC-One Limited

# Alexander Court (Sheffield)

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 5 and 6 November 2014. The first day of the inspection was unannounced. We informed the registered manager that we would be returning on the following day to complete the inspection.

The last scheduled inspection took place on 11 October 2013 where we found the service to be in breach of Regulation 18 of the Care Quality Commission (Registration) Regulation 2009. This was because the provider did not notify the Commission about incidents that affected the health, safety and welfare of people who used the service. The provider notified us of the action they took and when we returned to the service on 29 November 2013 we found the service was no longer in breach of this regulation.

Alexander Court (Sheffield) is a care home providing nursing and personal care for up to 60 adults. The home is divided into three floors. The lower ground floor is used by staff only. This area houses the laundry, staff rooms, handyman's office and stock rooms. On the ground floor and the first floor there are bedrooms and communal areas accessed by people who used the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care

# Summary of findings

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.

We found the provider had not made the necessary arrangements to ensure people's medical and nursing records were securely stored at the service. The nurses' stations on both floors were left open and unattended for long periods. People's care records and sensitive documents were kept on the shelves and were accessible to anyone at the service

We observed that nurses were not always following the correct procedure when handling medicines. We received information through our website 'Share your experience' about relatives finding tablets on the bedroom floor and in the chairs where people were seated. They had raised their concerns with the staff and the manager. During our inspection two relatives raised further, similar concerns.

Staff had received training on safeguarding people. They were able to describe how they would recognise any signs of abuse and protect people.

We received a mixed response when we looked into the effectiveness of the service. Although some comments were positive, some relatives raised concerns about the skill and ability of staff. .

We saw that staff gave choices and did not rush people when they needed to make decisions. Staff understood the principles of the Mental Capacity Act 2005 (MCA). We found that people were cared for in an environment which took into account people's mental capacity, their human rights and their right to liberty.

People were not always supported to eat and drink enough to meet their nutrition and hydration needs. Two people said they did not mind as they knew staff would come to help as soon as they could. However, the present arrangement did not make sure all the people received their meals at the correct temperature and that some people had to wait with their meals placed in front of them for staff to become available to assist them with eating.

We observed staff making efforts to engage with people and gain their response. A person was sitting quietly in the lounge and looked lonely; a staff member went up to them and knelt next to them held their hand and chatted. The person smiled and stroked the care staff's face. This showed a positive interaction between the person and the staff member.

We received comments from some family members that they did not feel they were involved when changes were made about the care. But most people we spoke with and some other relatives told us that they were kept informed by the nurses and they were involved. However the documentation did not always support that relatives had been involved. Therefore the present arrangement did not demonstrate that all the people who lived at the service and/or their representatives have been involved.

Staff had a good understanding of confidentiality. People told us that they trusted staff not to divulge any personal information to others.

The registered manager told us that they had appointed an activities co-ordinator and in the interim they were organising social activities for people. During our inspection we found there was a lack of meaningful activities for people.

As part of this inspection we contacted the commissioners of the service, the local CCG team and the community professionals such as the tissue viability staff member and requested their view of the service. The comments we received were encouraging and informed us that the service had made improvements during the last year and that the registered manger and the nurses did not hesitate to seek help when they needed.

Staff told us that they had regular staff meetings. We saw a copy of the minutes with action points with time scales.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

# 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 safe as action was required by the provider.

The nurses did not always follow the correct procedure when handling medicines.

There was a lack of facilities for securely storing people's personal records.

Staff had a good understanding of how they would recognise and report abuse and they told us they had received training on protecting vulnerable people from abuse and harm.

**Is the service effective?**

Requires Improvement

This service needed improvements to be effective.

Some staff skills, competence and knowledge were questioned by relatives when performing certain tasks.

The present arrangement for meal times did not make sure all the people received their meals at the correct temperature and some people had to wait with their meals placed in front of them for staff to become available.

Staff understood the principles of Mental Capacity Act 2005 (MCA). People were cared for in an environment which took into account people's mental capacity, their human rights and their right to liberty. People had been referred to the supervisory body.

**Is the service caring?**

Good

The service was caring.

We observed staff treating people with dignity and respect and promoting people's independence by encouraging people to walk with aids and those who were unable to walk people were supported to move around using wheelchairs so that people were able to access other areas of the service.

We observed staff interacting with people and having a good insight into people's family histories and their preferences.

People who wanted to spend their day in their rooms were made comfortable by staff. They made sure people were able to access the call bell so that they were able to summon for help.

**Is the service responsive?**

Requires Improvement

The service needs improvements to be responsive

We received comments from relatives that the service was not always responsive to their family members' needs and staff were reluctant to call the GP especially in the evenings and at the weekends.

# Summary of findings

People did not receive meaningful stimulation to promote their wellbeing.

We saw the complaint policy displayed on each floor so that visitors to the home were able to have access to it.

**Is the service well-led?**

The service needs improvement to be well-led.

Not all the relatives who spoke with us and those who contacted us through our website shared a positive experience about the culture at the service. They said they found the culture to be defensive and felt they were not always believed when they raised concerns. However the provider surveys had not highlighted this.

The minutes from the latest staff meeting underlined improvements by different staff groups. This highlighted the monitoring of the registered manager of the service.

Learning from complaints, safeguarding referrals, incidents and accident were shared with the staff by the registered manager to reduce the risk of them happening again.

**Requires Improvement**

# Alexander Court (Sheffield)

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 and 6 November 2014. Day one of the inspection was unannounced. We informed the registered manager that we would be returning on the following day to complete the inspection.

The inspection team consisted of two adult social care inspectors.

Prior to our inspection, we reviewed the notifications submitted by the provider and other relevant information we held about the service. We asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also asked for information from the local authority contracting and commissioning team, safeguarding team, the local health watch team, community professionals such as district nurses and the local Clinical Commissioning Group (CCG) team. CCGs are the commissioners of local health services; a **CCG** is responsible for planning the right services to meet the needs of local people.

We used various methods to gain information during our inspection which included talking with ten people using the service. We used the Short Observational Framework for Inspection (SOFI) to observe five people who were unable to speak with us and share their experience. SOFI is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. We spoke with eight relatives and two visitors to the service. We formally interviewed five staff including a registered nurse and the registered manager. We also spoke with the cook, kitchen assistant, deputy manager and the administrators.

We checked the care records of six people, six staff recruitment files and training records. We also looked at other information such as complaints and compliments, incident and accident reporting, monthly provider visit reports, outcome of surveys by the provider and quality audits of the service.

Requires Improvement

# Is the service safe?

## Our findings

We asked five people and two relatives if they felt Alexander Court (Sheffield) was a safe place. These were some of their comments. A relative said, "My [spouse] used to be in another place and I felt very worried when leaving after visiting, wondering what was going to happen. I totally trust these staff and I know I have no worries about my (spouse)'s safety." A person who lived at the service said, "I always feel very safe when (names of staff) were on duty. But I have never felt unsafe even when others were on. Staff are very nice."

With the permission of people we checked five bedrooms and found they were clean and smelt fresh. However we found several bedside tables sticky and dirty. We spoke with domestic staff who told us that they stopped cleaning at 2.30pm and took clean laundry around to people's bedrooms. This meant there were no domestic support between 2.30pm and 7am the following morning. The domestic supervisor told us that they had recruited an additional staff member to increase the hours and to help with evening cleaning.

Staff and people who used the service said there was sufficient equipment to support people. We noted that the handyman continued to check all the equipment to ensure they had been maintained and in good working order. We saw staff using the equipment appropriately. However there was insufficient storage to keep the equipment when not in use. Often they were left in people's own rooms or in the bathroom. The registered manager told us that they were looking into better storage for equipment.

We found staff had received training on safeguarding vulnerable people and they were able to describe how they would recognise signs of abuse and report according to their safeguarding policy. We checked the safeguarding referrals for the last 12 months and the outcome of the local authority investigations. We observed that the registered manager had followed the local authority safeguarding policy to report and investigate the incidents. This meant the registered manager and staff handled the safeguarding referrals correctly to ensure people were protected and their safety was maintained.

We checked the care plans and ascertained that through person centred approach to care the staff had carried out risk assessment and recorded the plans to minimise the risk to individuals without restricting their freedom. For example people or their representatives had been consulted before bedrails were used to protect people from rolling out of bed.

Staff working at the home had a good understanding of the whistleblowing policy. Whistleblowing is when a worker reports suspected wrongdoing of others at work to the employer. We noted staff had raised concerns through whistleblowing and the provider had taken appropriate action.

We checked the incident and accident reporting process at the home. Staff described the process they followed when reporting incidents such as falls, skin tears and bruising. The registered manager said that they checked all reports and submitted the information to the head office where they were analysed and outcomes were shared with the service. Care workers said that they were encouraged to report all the incidents and accidents to the nurses so that immediate action could be taken. Therefore reporting incidents and accidents were seen as positive by staff to implement changes and make the environment safe.

During our inspection we saw sufficient number of care staff on both floors. We looked at staff rotas and found safe staffing levels had been maintained. The registered manager said bank or agency staff were used to cover short term sickness.

We asked four staff members how they were employed by the service. They described the process which followed their company policy and the records showed us that robust checks had been carried out before employing staff. We looked at six staff recruitment records. They had the necessary information such as satisfactory references, no unexplained gaps in their previous employment and a current satisfactory Disclosure and Barring Service check.to ensure staff were fit to work at the service. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

We saw the registered manager had followed the company policy when carrying out disciplinary procedures. Two staff members we spoke with were clear when and why disciplinary procedures would be used.

Requires Improvement

# Is the service safe?

During the morning medication round, we observed a nurse taking a pot of liquid medicine from the medicines' room without the person's medication administration record. We questioned this practice; the nurse admitted it was incorrect and went back to collect the medication administration records (MAR). We received information through our website 'Share your experience' from two relatives of people who lived at the service about them finding tablets on a bedroom floor, and in chairs and had raised their concerns with the staff and the manager with no improvement. During our inspection a relative told us that they found a tablet in their family member's mouth when they arrived at mid-morning and they had given plenty of water to help them swallow it. Another family member said when staff noticed them visiting, staff tended to leave the container of tablets on the bedside table expecting the family member present to give the tablets.

We asked the nurses about the arrangements for administering and managing medicines at the service. The process explained was in line with the company policy. We looked at six medication administration records (MARs), three records from each floor. We found there were no gaps on MARs and when people did not take their medicines the reasons were stated. Where the dosage of a medication had been changed by a GP, this was re-entered on the MAR as a new entry and the changed dose was recorded. This was to avoid any confusion of the dosage. A photograph of each person was kept in the front of their MARs to prevent medicines being given to the wrong person. However out of the six people's MARs two did not have their photos. Nurses told us that this had been identified at their monthly audit and was being addressed. This was confirmed when we saw audit records.

The above information highlighted that nurses did not always follow the correct procedure when handling and administering medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We saw the latest medication audit by the supplying pharmacist with suggestions for improvement. For example, when people refused medication there was no clear procedure for staff to follow and no guidance about when to seek medical advice. Nurses and the registered manager had taken action to address all the recommendations and provided us with documents to support these improvements.

Requires Improvement

# Is the service effective?

## Our findings

We found the comments received from people who used the service and their representatives were mixed with regards to the effectiveness of the service. Four relatives informed us that some staff were complacent and did not deliver care that was appropriate. They said on occasions they felt staff were not competent to perform certain tasks. For example staff understanding of positioning people in bed when they were given food. And staff hesitance to calling the GP when people's medical condition changed. Relatives questioned staff skills, competence and knowledge.

We informed the registered manager of the above comments. They said that they were aware of the concerns and had investigated and responded to the people who raised the concerns. They said that staff involved with the positioning of the person had received training and was supervised by senior staff. The registered manager also showed us evidence that all staff had received updates on positioning people ready for meals. In response to the concern regarding contact with the GP, the registered manager and the deputy manager said that the GP visited the service each week, confirmed that they knew people and had contacted the GP. The registered manager and deputy manager informed us that the concern was due to the lack of understanding of the relative of what had happened and that they had explained the situation to the complainant. We checked the file of the person where staff had clearly documented what had happened and it supported what the registered manager told us.

We observed people who were able to make decisions were given opportunity by staff to take their time and respond. However, there were a number of people who had varying degrees of memory loss and needed help with understanding what was said to them. We observed staff taking time to explain to people and helping them to decide what they wanted. We observed a member of staff asking a person which TV station they wanted to watch. They did this effectively by showing them the different channels so that the person was able to see and decide. On another occasion we saw staff offering fruit juice to people in the communal area and one of the people refused to have a drink. The member of staff went back after a while, explained that they had not drunk anything since lunch and suggested that they try a sip. We saw the person finishing the drink straight away and had another tumbler of juice. This meant staff gave choices and did not rush when people needed to make decisions.

Five people and two relatives praised the staff for their effective handling of the care. They said staff knew people and took into account people's likes and preferences when delivering care. One person said, "Care staff show me the clothes and ask me what I want to wear. I usually leave it up to them." Another person said, "I like to have my breakfast at 8.15am and staff make sure I get it on time." A relative said, "I have been to other homes but staff here know how to care for people. I know they get a lot of training and support from the manager."

We spoke with staff and viewed six staff training records and checked the frequency of staff supervisions and appraisal. The records stated that staff were in receipt of suitable training to be able to support and care for people at the service. There was documentary evidence that staff received supervision and appraisals as outlined in their organisational policy. Four staff and a nurse told us that they received sufficient training at the appropriate times and they could ask for additional training if they felt they wanted it. The registered manager and the two nurses on duty explained that they had recently attended a refresher course in supporting people with Percutaneous Endoscopic Gastroscopy (PEG) feeds. They told us that they found the update sessions very useful since they had people who were in receipt of this service. A PEG feed is a way of introducing food and fluids through a feeding tube into a person's stomach. This method is used where people were unable to have oral food or for those who cannot maintain adequate nutrition just with their oral intake. This was one of the examples where staff training was tailored to meet the needs of the people.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005 (MCA) legislation which is in place for people who are unable to make decisions for themselves. DoLS aim to make sure people who are in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Restricting a person's liberty is only done when it is in the best interests of the person and there is no other way to look after them.

Requires Improvement

# Is the service effective?

Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA), and understood that there was a procedure for assessing people's capacity and this was decision specific. We were informed by the registered manager that they had gained approval through the supervisory body for deprivation of liberty safeguards (DoLS) to give medication covertly to a person since this was in their best interest and promoted the person's wellbeing. We saw the form which had been completed by the best interest assessor (BIA). BIA is an independent professional who is appointed through the local authority. This meant nurses ensured when administering medication covertly people's human rights were not breached. This meant people were cared for in an environment which took into account people's mental capacity, their human rights and their right to liberty.

We saw people finishing off their breakfast around 10am and they were well supported by the care staff. We observed people were invited into the dining rooms to have their dinner at midday. People sat where they preferred. Those who were friends sat at tables together. Food looked appetising and was presented well. People were asked if they needed a second helping by care workers. Staff made sure the meal time was sociable and enjoyable. People were not rushed and staff went around checking people who had their meals in their rooms.

On the first day of our inspection there were more people who needed help with eating than there were staff available to help at mealtime. All the people were served their meals at the same time by staff. This meant some people had to wait for staff to become available before they had their food. We shared our findings with the manager who told us they had protected meal times and all staff including the nurses were expected to help as this would ensure people received their meals without delay. On the second day of our inspection we found there were still not sufficient numbers of staff to help people at one sitting. We informed the registered manager who said that they would look at two sitting at meal times.

We saw in care records, people's likes and dislikes about their food and drinks were documented. We saw risk assessments and plans to monitor people who were at risk of malnutrition and weight loss. We saw staff completing food and fluid charts during the day to ensure people were in receipt of sufficient food and fluids and to monitor this.

We interviewed the cook and found out that they had information about people's individualised diet needs. During our visit we were informed by a member of the speech and language therapy team (SALT) that they found the staff did not always follow their instructions and gave an example that they had requested pre-mashed food and staff were giving the person fork mashed food. The speech and language therapist told us this was about the suitable texture of food for the person. They also said that they had arranged a time with staff to assess a person during lunchtime and when they arrived the person was not ready. We asked the professional if they had given clear indications as to the consistency. They told us that they expected the staff to know. We informed the registered manager of the concern and suggested that they took swift action to make sure staff understood the different consistencies and received the appropriate training so that they were competent in following instructions from the speech and language therapist team.

Good

# Is the service caring?

## Our findings

We were informed by people who used the service and their representatives that staff were considerate, kind and compassionate. They told us staff treated people with respect and did not discriminate against people in relation to their age, disability, race or religion. We observed that the staff group was diverse and people who used the service and staff had a good rapport. We heard people talking about the wars and English history with staff and explaining what they did during the world wars and what impact the wars had on their lives. One person told us that most staff showed interest in their life history and attempted to understand how they felt about getting old and having to rely on others to help them. They said, "It shows staff care about us and want to understand us."

We observed staff interacting with people and having a good insight into people's family histories and their preferences. They told us about some people getting distressed from certain triggers and how they distracted them. We observed staff actively listening to people, reassuring people when they became anxious and responding to their wishes in a considerate way. Staff reminded people about who was coming to visit them and when their birthday was and talked about what they would like to do We observed several examples such as these which confirmed that staff had a good understanding of the people they were caring for.

We saw staff members laughing and joking with people and encouraging people to get involved. We observed staff making efforts to engage with people who were not interacting with others to gain their response. A person was sitting quietly in the lounge and looked lonely; a staff member went up to them and knelt next to them held their hand and chatted. The person smiled and stroked the care staff's face. This showed a positive interaction between the person and the staff member.

We asked a domestic staff member if they would find someone to help a person who wanted to get out of their chair. The staff member went up to inform the care team, then returned to the person and explained that a member of the care team would be with them in a few minutes. This meant when people asked for help they were informed when the help would be available so that they knew that they had been listened to.

During our inspection we saw a chiropodist attending to people's feet and the hairdresser who seemed very popular with the people. People told us having their hair done made them look better and therefore they felt better. We observed staff getting people ready so that they could have their hair dressed. One person was reluctant to have their feet looked at by the chiropodist. However we saw a care worker spending time with the person and encouraging them. Later in the day we saw the same care worker chatting and distracting the person whilst the chiropodist attended to their feet. This meant staff got involved in promoting people's wellbeing.

People who used the service and their representatives were given information about the service during admission to the service. Staff told us that further information was displayed to visitors on the notice board on each floor. We saw notices displayed on both floors.

We were informed by the registered manager that all the people who lived at the service had representatives who helped them with decisions. This was either their family members or legal representatives. But they said in the case of people needing an advocate they would make arrangements for an advocacy service to meet with them. This was confirmed by nurses who were on duty and the administrator who told us that they had the contact details if they were needed. Advocacy service supports and enables people to express their views and concerns, access information and services, helps to defend and promote people's rights and responsibilities.

During the day we observed staff treating people with dignity and respect and promoting people's independence. People were encouraged to walk with aids to the communal areas by staff. We observed staff transporting people who were unable to walk using wheelchairs to different areas such as the lounge and dining room to ensure people has the opportunity to mix with others and socialise. People who wanted to spend their day in their rooms were made comfortable by staff. They made sure people were able to access the call bell and told them where it was so that people were able to summon for help. We observed staff checking on those who were in their rooms from time to time during the day.

Staff had a good understanding of confidentiality. They gave us some examples such as "When I speak about their personal care needs I make sure I do it discreetly so that others don't get to hear about it". "Some relatives know

Good

# Is the service caring?

most of the people here. They inquire if a person was missing from the lounge. I am careful what I tell them. If not sure I ask the nurse to speak with the person". People told us they were confident that staff would not divulge confidential information to others. This was supported by three relatives who spoke with us.

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Requires Improvement

# Is the service responsive?

## Our findings

We looked at six people's care records during our inspection. The records showed that the registered manager or a nurse from the home had carried out a pre-admission assessment before a person was accepted to be cared for at the service. This was to ensure staff at the home had the skills and knowledge to meet the needs of the person.

We saw that following admission people had 'a seven day' care plan which was an interim care plan used whilst the person had time to settle into the home and the staff had the opportunity to get to know the person and their relatives/representatives. Following the interim period staff developed a care plan with identified needs, relevant risk assessments and instructions to ensure the care and support planned minimised the risks to people and met their needs. The care plans gave detailed instruction as to how the staff planned to meet people's needs. The outcome from the care delivered was recorded in the daily records and the supplementary records. The care records were person centred and highlighted people's interests, life histories and their preferences.

Staff informed us that people who lived at the service and/ or their representatives were always involved in making decisions when planning care and when changes were needed. Staff told us that involving people and their relatives helped them ensure people's views and their relatives opinions were taken into account. This was supported by the comments from four relatives and two people who lived at the service. However we received comments from family members that they did not feel that they were listened to when they had made comments to the staff and the registered manager about the care and they were not always kept informed of the changes. We checked the care records of the people who were referred to by the families and the care records indicated that the families were fully involved. However, this was not evidenced by the signature of the family member or the person who lived at the home. This meant the present arrangement did not ensure that all the people who lived at the service and/ or their representatives have been involved when making decisions about the care and when changes were made to the care plans.

We observed people's day to day health care needs were met by nurses and care workers. We received comments from relatives that the service was not always responsive to their family members' needs and staff were reluctant to call the GP especially in the evenings and at the weekends. We shared this information with the registered manager. We saw the records which showed that the GPs visited the home weekly to check on people's wellbeing and reviewed people's treatment plans and medication when needed. On the day of our inspection we saw a nurse contacting a GP with regards to a person's deterioration in their condition and getting advice. Care records stated when health professionals had been contacted and what the outcome or their advice was. This included the GP, tissue viability nurse, speech and language therapist, physiotherapist, optician and dentist. The nurses in charge of the units showed us evidence from their daily diaries when they had contacted the GPs and we saw the times included weekend and evening.

We were informed by four people and three relatives that they were happy with the way staff responded and offered help. One person said, if they were in pain "I know the nurse will be here soon with my pain killer. They do their best to keep me comfortable." A relative said, "I know the manager will be on the phone to me if there was any change to my (relative's) condition and I know they would be letting the GP know as well. I cannot complain. They are marvellous." This meant people received help in a timely manner.

The registered manager told us that they had appointed an activities co-ordinator and in the interim they were organising social activities for people. On the first day of our inspection we saw a lack of involvement between the activities person and people. We did not see people being stimulated by the music played. When the organist was playing music staff tried to engage people to dance but they were not interested. When we asked people whether they enjoyed listening to music, one person said, "It's alright. Same all the time." Another two people just smiled and did not comment. A fourth person said they did not like the music played. One of the people who were in their bedroom said they were not aware of the organist being around and that they would have liked to have joined in to listen. This meant not all the people were made aware of the activities.

We asked the people who used the service what they did all day and how they would like to spend the days. These were some of the comments we received. "I would love to go out into the garden/grounds for a few minutes every day just

Requires Improvement

# Is the service responsive?

for a bit of fresh air. Staff did not have the time to do this. That is what I really like." "I like my own company but I also like going out." "I don't like going into the communal areas. But when they have activities I like to join in. Often staff tended to forget to let me know. They are too busy. I don't blame them." On the ground floor we noticed staff were in constant contact with people in the communal areas. However there were long periods on the first floor where people were left unattended did not have access to stimulation or activities. We found people did not receive sufficient stimulation during each day and there was more emphasis on organising trips out and organising parties for people. There was a lack of spontaneous activities for people to make the most of their positive mood. People and some relatives suggested staff using the company mini bus to take small groups of people out for a drive, a trip to a local garden centre, depending on the weather have a picnic and get people involved in the local community activities.

We found the present arrangements did not promote people's welfare and take into account their social and day time activity needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

During our inspection we spent time in the communal areas observing people. We wanted to ensure people were treated with respect by staff. We observed people were relaxed and comfortable when staff interacted with them.

We saw staff being sensitive to people's body language when people were unable to give verbal feedback. Staff knew the people well and we saw them using various ways to communicate with people.

We saw the complaint policy of the company displayed on each floor so that visitors to the home were able to have access to it. We asked people if they knew how to make a complaint and if they had made any. One person said, "I tell the care workers or nurses. Sometimes they make mistakes and I am sure it was not intentional. I have been satisfied with the response. Another person said, "I don't make complaints. If I am not happy I get it sorted out." A relative told us, "What is the point of complaining. Just need to work with them and get things done. Staff have a lot to do and they need help to sort things out for my (relative)."

We saw the records of complaints and the outcome of investigations and how the manager had responded to the complainant. The manager had used the company policy and all complaints had been reported to the regional manager who was involved in addressing and resolving the issues.

We spoke with staff who had a good knowledge of the process for reporting complaints. However staff told us that they try to resolve complaints when they were raised. They said often complaints were due to misunderstanding and miscommunication. Staff told us that they appreciated families wanted the best for their relatives and they addressed all complaints and responded appropriately by using their company policies.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager who was responsible for the day to day running of the service. We asked people who used the service and their relatives for their views and experiences on the culture and the atmosphere at Alexander Court (Sheffield).

We spoke with people who used the service, visiting relatives and used the information from those who contacted us through our website to share their comments and experience about the culture at the service. The comments were mixed in their nature. Four relatives out of six found the culture to be defensive and said sometimes they found the manager did not believe what was raised as concerns and gave excuses. For example when one relative had asked the manager why their family member looked unkempt, they were told that they had refused to have a wash. The relative said that the staff were not consulted and they felt they were just given an excuse. Three relatives said there was a lack of transparency and reluctance in accepting mistakes.

However, three people told us that they had met the registered manager and most days she visited them and had a chat with them. Two people said they could let the registered manager know if they were unsure about discussing personal matters with other staff. People said the registered manager was approachable and responded to their issues promptly. Two relatives were very positive about the manager and told us that when they had raised any issues with the registered manager they had been dealt with to their satisfaction. They made positive comments about the leadership at the service.

As part of this inspection we contacted the commissioners of the service, the local CCG team and the community professionals such as the tissue viability staff member and requested their view of the service. The comments we received were encouraging and informed us that the service had made improvements in the last year and that the registered manager and the nurses did not hesitate to seek help when they needed. This meant there was recognition from the outside organisations that the service had made improvements.

We asked the registered manager how they gained and monitored the views of the people who used the service and their representatives' comments. The manager said they had an open door policy where anyone could speak to her anytime. This was to encourage an informal chat with people who may wish to raise positive or negative comments with them. We were informed through the PIR that they used annual surveys, through the Mori Poll survey. (Mori Poll is a survey company which conduct surveys for a wide range of organisations. They carry out surveys independent to the organisation and report the findings to the provider.) This enabled people who lived, worked or had any dealing with the service to voice their opinions. The last two surveys in February 2014 and September 2014 were analysed and the home was informed of the results. They were encouraging and did not highlight any concerns.

We saw records of incidents, accidents and complaints investigations and the response by the registered manager. The records identified learning points and staff who spoke with us said they had received feedback from the registered manager when incidents or complaints had been investigated so that they were made aware of the issues so that they could avoid it happening again. Information was submitted to the head office for monitoring and analysis. The registered manager told us during the regional manager visits the outcomes of the analysis were discussed and addressed.

We obtained a copy of the minutes of the staff meeting which was last held on 30 September 2014. This underlined the improvements required by different staff groups. The items discussed were the need for staff reading care plans and not simply relying on handover information, accurate recording of delivered care, the staff responsibility for completing essential and the need for nurses completing competency in managing medicine. We saw action plans which indicated how and when these should be achieved by staff.

Staff told us that they had regular meetings and they were able to raise any issues relating to their work. They said the manager was receptive to their comments and helped them manage situations. For example they said they had discussed the need for the hair dressing room to be relocated and additional store rooms to keep equipment. They said that this was being addressed by the registered manager.

We viewed the home's quality assurance systems. This included audit reports by the registered manager and specific staff, monthly regional manager visit and a report

Requires Improvement

# Is the service well-led?

with an action plan if improvements were required and the report from the monitoring visits by the local authority commissioners. The registered manager shared with us the findings of their audits and the actions completed to address the issues highlighted. The regional manager informed us when they visited the service each month they spoke with people who lived at the service, visitors and staff and asked for their views. They said that comments were favourable and did not highlight any issues or problems. The reports produced by them supported their comments.

Although the provider had a QA system in place this had not identified some of the issues identified at our inspection in relation to dignity, medicines and care and welfare. This showed the quality monitoring process was not effective in identifying and addressing areas where improvements were required.

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

The registered manager and the nurses ensured that they informed CQC of all the notifiable events. Our records showed that the service had informed us of the safeguarding referrals. The registered manager said that they were to inform us of the latest DoLS approval, which arrived on the day before our inspection.

We saw the nurses' stations on both floors left open and unattended for long periods during our inspection. People's care records and sensitive documents about people were kept on the shelves and anyone could help themselves to the folders. This meant the provider did not make the necessary arrangement to ensure personal records belonging to people who lived at the home were kept securely.

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

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**The provider did not make the necessary arrangement to ensure personal records belonging to people who lived at the home were kept securely.**<br>**The audit systems used by the provider were not effective.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The provider did not protect all the service users against the risks associated with the unsafe use and management of medicines.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**The provider had not made sufficient arrangements to meet the social and daytime activity needs of the people who live at the service.** |