Life Style Care (2011) plc

Alexander Court Care Home

Inspection Report

320 Rainham Road South,
Dagenham,
Essex,
RM10 7UU
Tel: 02087090080
Website:www.lifestylecare.co.uk

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Overall summary

Alexander Court Care Centre is registered to provide 24 hour care, including personal care, for up to 82 people and is comprised of five units. This includes nursing care for people with dementia and those with physical needs. There is a registered manager for the service.

We found that the service was not always safe for people. People were not protected against identifiable risks of acquiring an infection. Electrical equipment in the main fire escape route presented a fire safety hazard. However, most people and their visitors told us people felt safe.

There were some aspects of care that were not effective. People were not protected from the risks of inadequate nutrition and dehydration. Some people's care records were not stored securely. However, people's capacity, needs, preferences and choices for care, treatment and support were assessed.

Most people and their visitors told us that staff were caring and kind. However, we were told that some people were not listened to. We were told of and observed some poor interactions between staff and people.

The care provided was not always responsive to people's needs or delivered in a timely manner. A complaints system was in place. However, it was not in a format to meet some people's needs and some people were not provided with support to make a complaint. People, those significant to them and professionals were consulted and involved in decisions about people's care. An activities programme met some people's needs.

Staff and relatives told us that the registered manager was approachable. Regular audits were made of the service and accidents, incidents and complaints were monitored. Effective staff recruitment, training and support for staff was in place. Most people's views of the service were sought.

The provider was not fully meeting the requirements of the Deprivation of Liberty Safeguards as some restrictions were being placed on people's movements without obtaining the necessary approvals. People's human rights were therefore not being properly recognised, respected and promoted.

We found six breaches of The Health and Social Care Act Regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staff knew how to recognise and respond appropriately to incidents or allegations of bullying, harassment and abuse. However, some staff were not aware of the provider's whistleblowing policy.

People were not protected against identifiable risks of acquiring an infection. We observed some staff not washing their hands, a lack of gel dispensers throughout the building, and less evidence of personal protective equipment being used by staff during breakfast. We saw that most areas of the home were in a clean condition. However, there were some areas of the home that were in poor decorative condition and difficult to clean. The provider informed us of their commitment to refurbish Alexander Court over the next 12 -18 months. Infection control audits were being carried out.

Electrical equipment in the main fire escape route presented a fire safety hazard as a source of ignition and an obstruction. Records showed that maintenance was being undertaken to the premises and equipment.

Most people and their visitors we spoke with told us that people felt safe. Individual risk assessments were made for people.

Effective staff recruitment, selection and employment processes were in place.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found that Alexander Court Care Centre had DoLS applications in place for some people and were in the process of making further applications. However the impact of door keypads on people's freedom of movement had not been risk assessed. People's human rights were therefore not being properly recognised, respected and promoted.

Are services effective?

People were not protected from the risks of inadequate nutrition and dehydration. People were offered choices of food and drink and made menu suggestions. However, some people told us of some dissatisfaction with the food. Some staff were not aware of peoples allergies or if people were diabetic. There were some gaps in people's nutrition records.

People's needs, preferences and choices for care, treatment and support were assessed. Staff were mostly aware of people's

Summary of findings

individual needs. We saw there was continuity of care between shifts. People and those significant to them were consulted about their care and capacity assessments were made. Some people's records were not stored securely.

People's end of life care needs were mostly being met. Records showed that some staff had received end of life care training and further training was planned.

Are services caring?

We saw some good interactions between staff and people who used the service. Staff were kind and respectful and most staff had a good rapport with people. However, some people were not treated with consideration and respect or involved in decisions relating to their care or treatment.

We saw that some staff were rushed and task focused. Some staff told us they had little time for social interaction with people.

Are services responsive to people's needs?

People were not always protected against the risks of receiving inappropriate or unsafe care. Most people were in their rooms or in bed during our visit. We saw that some people's call bells were not responded to in a timely manner. A system was not in place to regularly monitor call bell response times. Staff told us that people received one to one time from staff several times per week for emotional and social support. However, records showed this was between 20 minutes to one hour per week. Most staff were aware of people's needs, however, care from staff was mainly task focused.

We saw people participating in activities which included "Play your cards right" which 15 people were engaged in and were enjoying. The activities programme also included board games, shopping and church services.

People, those significant to them and advocates were involved in making decisions about peoples care. Professionals including GPs, speech and language therapists and palliative care specialists were also involved.

The provider had a complaints policy and procedure in place and individual complaints had been investigated and responded to and acted upon appropriately. However the complaints system was not in a suitable format to meet some people's needs or provide some people with support to make a complaint.

Summary of findings

Are services well-led?

Staff told us that they had a good relationship with the registered manager and were encouraged to raise any concerns or issues and these would be addressed.

The provider sought the views of people who use the service, staff and relatives. However, views were not sought from people who were less able to communicate.

The provider had a system in place to manage accidents and incidents reports and complaints. They were reviewed and monitored monthly by the registered manager to establish any themes. Staff were told of any learning from these reviews. Improvements were put in place.

Most staff had received regular supervisions and appraisals. Staffing levels were calculated by establishing the dependency levels of people. However, we were told of some concerns regarding sufficient numbers of staff to meet peoples care needs.

The provider was regularly monitoring and auditing the quality of the service. We were told of improvements that were planned for the service which included refurbishment and end of life care training for staff.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 16 people using the service and five relatives.

Most people and their visitors told us people felt safe.

Most people and their visitors told us that staff were caring and kind. However, we were told that people missed interaction with others, and were grateful for the chance to chat with us. Some people expressed concerns. For example, one person told us that some care workers were inconsiderate when being repeatedly requested for support with their personal care, and the care staff were not attentive enough. Another person told us their mail was being opened rather than being given directly to them. Two people told us they thought the care staff were sometimes rude.

One person told us, "Just getting out into the fresh air makes me feel a bit more alive again, to see other people, traffic etc. I've only been and bought a Mars bar, but it's made me feel so much better." The person pointed to a member of staff saying, "This girl is absolutely fantastic, she speaks to me like I have a brain, and we've had a real laugh together." Another person told us, "Staff are friendly."

We were told that some people were not listened to or given choices. Some people told us they often felt deprived of choice in their daily lives including wanting to go into the lounge or out more. Three people told us they would like to go into the lounge, or eat in the dining room, but they were never given this opportunity and they never left their room. Two people told us they would like to go out more and get a paper from the local shop. Some people told us they did not like to make a fuss or complain. One person told us, "I don't like to cause a fuss". Another person said, "I just accept whatever they do, they don't have time for a discussion about things, they come in and go out." One person told us they were concerned about making comments that may get a resident or staff into trouble. Another person told us they rarely queried anything as they "did not like to be a nuisance".

Some people told us of some dissatisfaction with the food. One person told us, "It is not my type". Another person told us, "My relatives bring me in fish and chips which are much better."

One relative told us, "My only concern about this home is that mum is left on her own a lot. I wish she had more interaction with members of staff. I feel it would help her so much." Another relative told us, "They need to renovate the building."

One person who was new to the home told us they had been well looked after as they settled in. They were grateful that staff had understood it was not an easy process and were pleased to have their own possessions. One relative told us "I don't think the care could be any better. In general I am satisfied."

When we tested one call bell one person told us "not to bother to call anyone as nobody ever came". Some people told us that they had to shout for staff who did not always respond. One person told us "I have no bell, I just have to keep shouting, and then they come and tell me off!" Three people told us there was sometimes a long wait to receive care.

Relatives told us that the registered manager was approachable and they could approach them with any concerns. However, one relative told us that the home does ask for feedback occasionally, but they had not noticed much change.

Alexander Court Care Home

Detailed findings

Background to this inspection

The inspection team was made up of four people - an inspector, a specialist advisor who was a qualified nurse with a specialism in dementia care and two experts by experience. These are people who have personal experience of using or caring for someone who use this type of care service.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We reviewed all the information we held about the home before our visit.

There were 71 people using the service on the day of our visit. We spoke with 16 people using the service and five relatives. We looked at care or treatment records of 14 people currently using the service and four staff records. We spoke with 13 staff, the manager and regional director of the service.

We observed people throughout the day and also used the Short Observational Framework for Inspection (SOFI) during lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We toured the premises, looked at records and reviewed information given to us by the provider and manager. We looked at people's records, audits and incidents logs, meeting and staff records during the visit, and the provider's policies and procedures of the service following the visit.

Are services safe?

Our findings

People were not protected from avoidable harm. This was a breach of the relevant legal requirement (Regulation 11). The action we have told the provider to take can be found at the back of this report.

Staff we spoke with mostly knew how to recognise and respond appropriately to incidents or allegations of bullying, harassment, avoidable harm, abuse or breaches of people's human rights. Staff were aware of the provider's safeguarding policies and procedures. Staff told us they would report concerns initially to their manager.

Most staff we spoke with had received training in the Mental Capacity Act 2005 (MCA). However, some staff were not clear about the requirements of the MCA and the requirements of the Deprivation of Liberty Safeguards (DoLS). Most people were in bed during our visits. Three people told us they were not given the opportunity to go into the lounge or outside. Our records showed that three DoLS short term applications had been approved by the local authority and notified to CQC. People's records included risk assessments of why each person's movements had been restricted. However, there were key pads throughout the premises restricting the movements of all people using the service. The provider was not meeting the requirements of the DoLS as some restrictions were being placed on people's movements without obtaining the necessary approvals. People's human rights were therefore not being properly recognised, respected and promoted. Risk assessments and best interest meetings were not being held to consider why people's movements needed to be restricted within the premises.

People were not protected against identifiable risks of acquiring an infection. This was a breach of the relevant legal requirement (Regulation 12). The action we have told the provider to take can be found at the back of this report.

Most staff were wearing appropriate personal protective clothing throughout our visit, however, there was less evidence of it being used during breakfast. We saw that some staff were not washing their hands between giving people care. Although there were hand washing facilities in peoples rooms there was a lack of hand washing facilities or gel dispensers to clean care staffs hands in some areas of the home. This presented a risk of infection to both people and staff.

Staff told us how they would recognise and deal with urinary tract infections. Records showed that monitoring arrangements were in place to identify infections. Most staff had received infection control training recently.

Some systems were in place to assess the risk of and prevent, detect and control the spread of an infection. The staff infection control lead told us that infection control spot checks of staff and procedures were undertaken. Records of these checks were not kept. We saw that infection control was a regular item discussed at staff meetings. Records showed regular infection control audits had been completed and issues identified had been dealt with or improvements were programmed. The April audit was in progress. A legionella audit had been completed.

We saw that food temperature was being monitored and recorded to ensure that it was being served at the correct temperature to prevent the spread of food borne infections.

Appropriate arrangements were mostly made for the storage and collection of waste. We saw that clinical waste was stored externally in appropriate containers. However, these containers were not locked. Therefore there was a risk that access could be gained to infectious materials.

We saw that most areas of the home were in a clean condition. Cleaning schedules showed and people and staff told us that regular cleaning was carried out. This included a deep clean of rooms every two weeks. Staff were aware of the cleaning materials to be used in specific circumstances.

Some areas of the home were in poor decorative condition, in particular the laundry. This made it difficult to effectively clean. One relative told us, "They need to renovate the building." The manager and staff told us a programme of refurbishment of each room was underway. During our visit we received written confirmation from the provider that a full refurbishment programme would take place over the next 12 to18 months and was to include redecoration throughout the premises and replacement of carpets and furniture.

People were not protected against the risks of unsafe or unsuitable premises by means of the proper operation of the premises. This was a breach of the relevant legal requirement (Regulation 15). The action we have told the provider to take can be found at the back of this report.

Are services safe?

We saw that a photocopier was within the fire escape route and it was connected to the electric supply with a lead that ran into an adjacent office where the door was closing onto the lead. The presence of electrical equipment presented a risk of fire within the escape route and an obstruction. There was also a risk of damage to the electrical lead which presented a risk of electrocution and was also a tripping hazard. We raised this issue with the regional manager who told us the photocopier would remain in the fire escape route and a socket outlet would be provided within the fire escape. This would not alleviate the risk of a fire and risk to the health and safety of people, staff and others.

Records showed that maintenance was being undertaken to the premises and equipment. This included water temperature and gas safety checks, servicing of hoists, bed rails and wheel chairs.

Most people and their visitors told us that people felt safe. Records showed that individual risk assessments were completed for people and included moving and handling, falls, and nutrition. Some people were assessed for their risk of developing pressure ulcers. Most pressure relieving mattresses were being regularly checked and people were turned in accordance with their care plans. However, we saw some gaps in one person's records. We saw that appropriate procedures had been followed and consent had been obtained from relatives who had power of attorney for the use of bedrails. One person's records showed that staff were reminded to use sliding sheets and not to lift people by their arms to avoid bruising. We saw that the sliding sheet was available in the person's room. These measures demonstrated that appropriate action was being taken to reduce risks to people.

Appropriate checks were undertaken before staff began work and effective recruitment, selection and employment processes were in place. Staff records showed staff had Disclosure and Barring Service criminal record checks, two written references, the right to work in the UK, proof of identity, a full employment history and were physically and mentally fit for work. Records showed that staff had certificates showing qualifications and additional training and staff had the skills and experience necessary to carry out their role. We did not see any records of numeracy and literacy tests. The regional manager told us that people's English and numeracy skills were assessed as part of the application and interview process. We had received some concerns from relatives and people we spoke with that some staff whose first language was not English were difficult to understand.

Are services effective?

(for example, treatment is effective)

Our findings

People were not protected from the risks of inadequate nutrition and dehydration. This was a breach of the relevant legal requirement (Regulation 14). The action we have told the provider to take can be found at the back of this report.

Records showed that people were offered a choice of food for each meal. During lunch we heard people being offered a choice between chicken and bean casserole, however, the menu stated pork casserole. We asked care staff which kind of meat it was but they were not able to tell us. Daily menu records identified which people required soft or pureed food. Records did not identify which people had food allergies or were diabetic and we spoke with some kitchen and care staff who were not able to identify these people. The chef told us which people were diabetic. There was a risk that some staff's unawareness of food ingredients and people's dietary needs could impact adversely on people's religious, cultural or health needs.

We saw that one person was given a beaker to drink from but the spout had been incorrectly positioned and therefore the person was unable to use it to drink. This person's fluid balance chart on the day of our visit had a fluid output of 500ml recorded at 6am but nothing further recorded when we viewed the record at 12.30 pm. The risk of dehydration was therefore increased for this person.

Records showed that people discussed menu suggestions at residents' meetings and this would be incorporated into the menu. People were also asked for their preferences each day. We spoke with three people who told us the food was not very good. One person told us, "It is not my type." Another person told us, "My relatives bring me in fish and chips which are much better." The chef told us that people can choose an alternative to the menu choices if the ingredients were available. We were shown records of surveys of people's likes and dislikes and told this informed the purchasing of ingredients to provide alternative meals.

There were some gaps in people's records. For example, one person's records showed that a nutrition assessment had been made, however, the Malnutrition Universal Screening Tool (MUST) record was not completed whereby a person is assessed for the risk of malnutrition and we found the person had been weighted intermittently over recent months. A speech and language review had taken place in September 2013 and normal fluids and a soft diet advised. Records showed that a food chart recorded a soft diet eaten, but the amount was not recorded on two out of four occasions. The risk of malnutrition was therefore increased for this person.

Most people's records were stored securely. However, we saw some people's records on "Jasmine" were left in in a communal lounge area unattended and were not stored securely. There was a risk that people's personal information could be accessed by those that were not authorised.

People's needs, preferences and choices for care, treatment and support were assessed. Records showed that this involved people and their representatives or relatives. Most staff knew people's individual needs. One person who was eating lunch in their room told us they preferred to have their meals in their room. However, some people told us they would like to get out of their room. Staff told us there were no restrictions on visiting times. One person's assessment included a section on "expressing sexuality" and it stated that they "did not mind a male or female carer". This did not describe how the person wished to express their sexuality and therefore this person's needs and preferences with regard to their sexuality may not be met.

Records showed most staff had received training to ensure they had the skills to meet the needs of people. This included moving and handling, health and safety and dementia awareness.

We saw that one person who was being cared for in bed had a physiotherapy plan displayed on the wall. Staff told us and records showed that other people who were being cared for in bed had limited input from physiotherapy or passive limb exercises. The manager told us that people were referred for physiotherapy if they were able to do it and they were reviewing people's access to physiotherapy services to improve people's health and wellbeing.

There was continuity of care for people using the service. We saw the handover of care between staff when shifts changed. Staff we spoke with were aware of people's needs that had arisen during the previous shift. Key written information was provided when people were transferred between services including people's medical and communication needs and how to maintain a safe environment for the person.

Are services effective?

(for example, treatment is effective)

People's end of life care needs were mostly being met. Staff told us and records showed that most people or their representatives had discussed their wishes with staff and had Do Not Attempt Resuscitation forms (DNAR) in place. These records were readily available. Staff told us an End of Life Care facilitator from the local hospice provided support to people, their relatives and staff. However, one care worker was not aware of a person's end of life care needs to whom they provided care. Records showed that some staff had been trained in end of life care and further training was planned.

Are services caring?

Our findings

Some people were not treated with consideration and respect. This was a breach of the relevant legal requirement (Regulation 17). The action we have told the provider to take can be found at the back of this report.

We saw during our visit that some people were not being listened to. Some people told us they often felt they did not have choice in their daily lives. For example, one person was given porridge for breakfast each day. We asked if they liked porridge and they told us and the care worker they did not and were asked if they would like toast. The care worker returned with a sandwich and the person's facial expression indicated their disappointment. We queried this with the care worker who said, "Oh yes, it was toast wasn't it? Shall I take this back?" The person received the toast and told us they rarely queried anything as they "did not like to be a nuisance."

We saw one care worker sitting in the lounge with five people. We did not observe this care worker interacting with people in any way. There was no conversation or eye contact. Music was playing at such a high volume that we could not make ourselves understood to anybody sitting in the room. There was no attempt by the care worker to use the music as a stimulus for a sing-a-long, or to enter into conversation with anyone. However, we saw two care workers in another lounge singing and dancing with a person.

Most challenging behaviour we saw was being ignored, rather than addressed or diversionary tactics used. One person walking the corridors was left to do this but was not engaged in conversation, or asked or encouraged by staff to take part in any meaningful activities. Another person who was being nursed in bed spent a lot of time shouting loudly. A lot of the time this was ignored, but occasionally staff would go in and placate the person, but not spend any quality time with them. When we talked to the person, they gradually calmed down telling us, "I have no bell, I just have to keep shouting, and then they come and tell me off." We saw that the person did not have a call bell and did not observe staff talking to this person disrespectfully. The person's relatives told us the person was often demanding and that they were bored and angry about their quality of life.

We saw some good interactions between staff and people such as the kind and respectful way that staff spoke with people and saw most staff had a good rapport with people. For example, we saw one care worker who comforted a person that was distressed by talking to her kindly and giving her a cuddle. The person told us, "I was very lonely at home, and though I miss my home, I am treated very well here. I love them all." We saw another care worker gently helping a disoriented person back to the lounge, helping them into a chair and then asking whether they would like a drink. We saw another person walk out of the dining room at lunchtime, shouting. Staff spoke calmly and walked with the resident until they were calmer and encouraged them back into the dining room for lunch. People who were not able to communicate verbally used hand signs and facial expressions, to show us that they were well cared for.

Some staff told us they knew peoples likes and dislikes. One care worker told us one person liked doing her buttons up on her cardigan and liked music. Records showed that one person's cultural food preference had been met. Useful phrases had been provided by the family of one person in their language and staff told us they used these to communicate with the person. However, we did see communication between staff and people break down due to people and staff not hearing or understanding each other. On a couple of occasions, we intervened to explain requests, or aid people to hear or understand staff.

We were told of some people's concerns. For example one person told us that younger carers did not "treat them very well" and they preferred the older carers to assist them. Another person told us that some care workers were inconsiderate when being repeatedly requested for support with their personal care, and the care staff were not attentive enough. Another person told us their mail was being opened rather than being given directly to them. Two people told us they thought the care staff were sometimes rude.

We saw that staff were sometimes rushed and one care worker told us they were doing their duties and had little time for social interactions. Most people told us they missed interaction with others, and were grateful for the chance to chat with us. One person told us "Thank you for treating me like a human being, rather than a three-year old like most people do."

Are services caring?

We saw screens being used to protect a person's dignity when they were being hoisted in the communal lounge area. Bedroom doors were closed when people were being given personal care. Most staff knocked on people's doors before entering their rooms and addressed people personally when entering the room. During lunch we saw some people had bibs placed around their necks without any requests or explanations being made.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People were not always protected against the risks of receiving inappropriate or unsafe care. The care provided did not always meet their needs or ensure the welfare and safety of the person. This was a breach of the relevant legal requirement (Regulation 9). The action we have told the provider to take can be found at the back of this report.

Most people were in their rooms or in bed during our visit. We saw that some people's call bells were out of reach, some were not being responded to in a timely manner and some were not present. The manager and staff told us that some people did not have call bells as they were unable to use them and people would call out or staff would make regular checks. Records showed that risk assessments were in place for people that were not able to use call bells and care plans required staff to check people's welfare regularly. Some people told us that they had to shout for staff who did not always respond. We rang one call bell and did not receive a response from staff after 15 minutes. We looked for staff who then attended to the person's needs. We heard another call bell operating continually in one room. We asked the care staff about this and were told that it was because it had not been reset. The care staff went into a room and turned off the bell. The registered manager told us that call bells were switched to emergency if they were not answered after five minutes. However, staff told us that the emergency system had been disabled as there had been a fault where all calls were going on to the emergency system. Records showed that call bells were regularly tested to check they were operating. However a system was not in place to regularly monitor call bell response times. People were at risk of not receiving care when it was needed as the system for responding to peoples requests for care was not operating effectively.

We spoke with two people who needed assistance from care staff in getting to the toilet. We saw one person had to wait a long time to have a call bell responded to. Another person had to regularly leave the room and seek out a care worker to help with their toilet needs as their call bell was not being responded to. Three people told us they there were long delays in receiving a visit from their GP. The manager told us that this had been an issue in the past but there had been a change to the homes GP and people's access to the GP had been improved. Records showed that weekly GP visits took place.

Staff told us and records showed that they had asked most people their likes and dislikes and what makes them sad or happy. Pictures were used to help people communicate where necessary. Most staff were aware of people's needs. For example we were told that one person did not like to come to group activities but liked a hand massage and their nails painted. This was reflected in the person's care plan. However, some staff we spoke with were not aware of people's interests or life histories and were focused on the care task for example supporting the person with their mealtime, and personal care needs. We saw that some people did not express their preferences and were not encouraged by staff to do so. One person told us, "I just accept whatever they do, they don't have time for a discussion about things, they come in and go out."

We saw people participating in activities which included "Play your cards right" which 15 people were engaged in and were enjoying. The activities programme also included board games, shopping and religious services. Staff told us and records showed one person who liked to discuss football and another who did arts and crafts in their room. Most people were in their rooms during our visit. Two people told us they would like to go out more and get a paper from the local shop. The activities programme showed one to one sessions. Staff told us that people received one to one activities several times a week. However, records showed that this totalled between 20 minutes and one hour per week. One relative told us, "My only concern about this home is that mum is left on her own a lot. I wish she had more interaction with members of staff. I feel it would help her so much." Most care staff we observed were providing task orientated care with little social interaction with people.

The provider had a complaints policy and procedure to handle and respond to complaints. Records showed individual complaints had been investigated and responded to appropriately. Appropriate action was taken and staff were told of any learning points arising from a complaint or concern. However, some staff we spoke with were not aware of the provider's complaints policy and procedure.

The provider had some systems in place to obtain people's concerns or complaints. Residents meetings were held to obtain people's views. We saw many people were cared for in their rooms and did not attend the meetings and we found no evidence that they were asked for their concerns

Are services responsive to people's needs?

(for example, to feedback?)

or complaints apart from what they wanted to eat. Some people did not communicate verbally and others did not have the capacity to understand. However, we did not find any evidence that people were asked for their views using formats that they would understand. Some people told us they did not like to make a fuss or complain. One person told us they were concerned about making comments that may get another person using the service or a member of staff into trouble.

Relatives told us that they could approach the manager with any concerns. The manager told us they had an open door policy and had also introduced a weekly evening surgery to improve access for relatives and friends that were unable to visit during the day.

Records of residents' meetings showed the issues people raised which included suggestions for the menu and a request for more male carers and a comment that everyone loved the cat. However, the minutes did not show who would be dealing with the issues raised or if items from previous meetings had been dealt with.

Records showed people's capacity to make decisions was assessed. These involved people who had power of attorney and independent mental capacity advocates to make decisions in people's best interest where necessary. Most staff we spoke with were aware of some requirements of the Mental Capacity Act 2005.

People's records showed that people, those significant to them and advocates were involved in making decisions about peoples care. Other professionals including GPs, speech and language therapists and palliative care specialists were also involved.

We saw and were told by staff that one non-English speaking resident was communicated with by staff using key words they understood such as "hungry" and "toilet", and one member of staff spoke the person's language. Records showed relatives were involved in this person's care planning.

Are services well-led?

Our findings

The service had a registered manager in post.

The provider sought staff, relatives and most people's views. Residents' meetings showed that some people were asked for their views. Some people told us that were not listened to and were not given choices. We did not find any evidence that those people who did not or were unable to attend residents meetings were asked for their views in a way they could participate.

Staff told us that they had a good relationship with the manager and felt part of a team. Most staff told us they were encouraged to raise any concerns or issues and these would be dealt with by management. Records of staff meetings showed staff had discussions about how to improve care. Staff told us how they would deliver care to maintain a person's dignity and respect. One care worker told us, "It is lovely working here and there is really good leadership from the nurse and team leader.'"

Relatives' meetings, the manager's open door policy and a weekly surgery where the manager was available at a specific time were used to obtain views from relatives. Most relatives and visitors told us that the manager was approachable and would deal with any issues. However, one relative told us that the home did ask for feedback occasionally, but that they had not noticed much change as a result. "I know my mother can be very difficult at times, but sometimes her challenging behaviour is down to frustration, boredom and fear, I wish she could have more stimulation, and human contact rather than lying in a bedroom on her own all the time."

The provider had a system in place to manage accidents, incidents and complaints. They were reviewed and monitored monthly by the registered manager to establish any themes. However, we found that it was not clear from the individual reports we saw what action was taken regarding the specific incident or accident. The registered manager told us that any themes or action to be taken were fed back to staff through staff meetings. Records of staff meetings showed that improvements to the service were discussed but did not show if they were due to an accident or incident.

Staff were mostly appropriately supported by the provider and registered manager to deliver care and treatment to people to an appropriate standard. Records showed and the manager and staff told us that staff supervisions and appraisals had mostly been completed although there were some recent gaps in the supervision schedule. Staff had received additional training and refresher training. One care worker told us, "It's brilliant working here and you get good training." Another member of staff told us, "I love my job. I feel very well supported and if I need something for the residents I'll ask the manager, and she'll get it for me. She's very approachable."

Records showed staffing levels were assessed by establishing the dependency levels of people individually and where they were located in the home. The assessment included people's mobility, social dependency, behaviour and personal hygiene and estimated the number of care hours each person required per day. Three people told us there was sometimes a long wait to receive care. We were told by some staff that there were sometimes problems with staff phoning in sick on the day of their shift which created problems with cover. However, we were told that bank staff were available and activities staff would help with feeding people where necessary. We were also told of concerns that one unit had two care workers for ten people but they were very stretched when one person was on their break. Another unit required all 11 people to each be hoisted by two staff. The manager told us they had recently increased staffing on one unit due to the increased dependency of the people using that service.

The provider was regularly monitoring and auditing the quality of the service. This included audits of the home environment, infection control and medicines. Accidents/ Incidents and complaints were also audited. A local authority Dignity in Care audit showed that the home was 94 percent compliant and further training was identified and scheduled for staff. Records showed actions were identified with timescales for completion. Each unit provided a 24 hour handover report to the manager which included reports of any incidents, complaints, staff sickness and the action taken by the nurse in charge.

The manager told us and records showed planned improvements had been identified for the home which included a programme of refurbishment of the environment and end of life care training for staff.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 (1) (b) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of service users** The registered person did not take proper steps to ensure service users were protected against the risks of receiving inappropriate or unsafe care by delivering care that met the their needs and ensured their welfare and safety.

Regulated activity	Regulation
	Regulation 11 (1) (b) (2) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 **Safeguarding service users from abuse** The registered person did not take reasonable steps to respond appropriately to any allegations of abuse and did not have suitable arrangements in place to protect service users against the risk of control or restraint being unlawful or otherwise excessive.

Regulated activity	Regulation
	Regulation 12 (1) (a) (b)(c) (2) (a) (b)(c) (i) HSCA 2008 (Regulated Activities) Regulations 2010 **Cleanliness and infection control** The registered person did not ensure that service users, persons employed and others are protected against risks of acquiring an infection by having an effective system to assess risks, and to prevent and control and the spread of an infection. There were not appropriate standards of cleanliness and hygiene of the premises.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 14 (1) (a) (c) **HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs** The registered person did not ensure that service users were protected from the risks of inadequate nutrition and dehydration by means of a choice of suitable and nutritious food and hydration in sufficient quantities to meet service users needs and support to enable service users to eat and drink sufficient amounts for their needs

Regulated activity	Regulation
	Regulation 15 (1) (c) (i) HSCA 2008 (Regulated Activities) Regulations 2010 **Safety and suitability of premises** The registered person did not ensure that service users and others were protected against the risks of unsafe or unsuitable premises by means of adequate operation of the premises

Regulated activity	Regulation
	Regulation 17 (1) (a) (2) (a) HSCA 2008 (Regulated Activities) Regulations 2010 **Respecting and involving service users** The registered person did not make suitable arrangements to ensure the dignity of service users. The registered person did not treat service users with consideration and respect.