Lifestyle Care Management Ltd

Alexander Court Care Centre

Inspection report

320 Rainham Road South
Dagenham
Essex
RM10 7UU

Website: www.lifestylecare.co.uk

Date of inspection visit:
28 November 2016
29 November 2016
05 December 2016

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Alexander Court Care Centre provides 24 hour care, including personal care for up to 82 older people. This includes nursing care for people living with dementia and those with physical needs. The service is a large purpose built property. The accommodation is arranged across five units over three levels. There are three units for people living with dementia and one unit for young people with physical disabilities, all providing nursing care. There is also a residential unit for older people. There were 69 people living at the service at the time of our inspection.

The service had a registered manager who had been at the service since May 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 10 and 11 March 2016 we found five breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found the service required improvements regarding infection control, staffing levels, medicines management, access to nutritious food and drink and quality monitoring of the service. We imposed conditions on the registration of Alexander Court Care Centre.

We inspected Alexander Court Care Centre on 28, 29 November and 5 December 2016. This was an unannounced inspection. At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Risk assessments were not always fully completed or reviewed in a timely manner. Some people's risk assessments did not include guidelines for their medical condition or for managing a specific risk. We found concerning practices with the management and administration of medicines.

Care plans did not fully reflect people's needs or preferences and people were not always supported to take part in meaningful activities of their choice appropriate to their level of need.

The service was not always proactive in ensuring people received treatment as required at the time they required it. The service did not always maintain the dignity of people living at Alexander Court Care Centre. The service was not working within the principles of the Mental Capacity Act (2005).

People using the service and their relatives told us they did not think there were enough staff at the service to meet their needs and waited for unacceptable periods of time for assistance.

Staff were not always supported to receive training to enable them to fulfil the requirements of their role. The quality monitoring systems in place had not identified the issues identified during our inspection.

People and their relatives told us they felt safe using the service. Staff knew how to report safeguarding concerns. We found recruitment checks were in place to ensure new staff were suitable to work at the service. Staff received appraisals and supervisions.

People using the service and their relatives told us the service was caring and we observed staff supporting people in a caring manner. People and their relatives knew how to make a complaint.

There were effective and up to date systems in place to maintain the safety of the premises and equipment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not always managed and administered safely.

Risk assessments for people using the service did not always contain guidance for staff to ensure risks were minimised and managed.

People using the service and their relatives did not think there were enough staff to meet their needs

People and their relatives told us they felt safe. There were robust safeguarding and whistleblowing procedures in place and staff understood what abuse was and knew how to report it.

Recruitment checks were in place to ensure new staff were suitable to work at the service

The provider carried out regular equipment and building checks.

Is the service effective?

Inadequate

The service was not working within the principles of the Mental Capacity Act (2005).

The service was not always proactive in ensuring people had access to health care services.

Staff were not always supported to receive training to enable them to fulfil the requirements of their role.

People had access to nutritious food and drinks.

Staff received appraisals and supervisions.

Is the service caring?

Requires Improvement

The service was not always caring. The service did not always maintain the dignity of people using the service.

People using the service and their relatives told us the service

was caring

The service enabled people to maintain links with their cultural and religious practices.

Is the service responsive?

Inadequate

The service was not responsive.

People's health and support needs were not always reflected in care records.

People were not always able to take part in a programme of activities in accordance with their needs and preferences.

There was a complaints process and people using the service and their relatives said they knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

Effective systems were not in place to monitor the quality of the service.

Staff told us they found the registered manager to be approachable.

Alexander Court Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

On the first day the inspection team consisted of two inspectors, a pharmacy inspector and a specialist advisor in medical care. A specialist advisor is a person who has professional experience in caring for people who use this type of service. On the second day both inspectors were accompanied by an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the third day the inspection was carried out by one inspector.

Before the inspection we looked at the concerns raised and information we already held about this service. We had received information of concern regarding staffing levels and falls for people using the service. We looked at details of its registration, previous inspections reports and monthly reports and information the provider had sent us. We contacted health professionals and the host local authority and clinical commissioning group to gain their views about the service.

During the inspection we spoke with 22 people and six relatives of people who used the service. We spoke with 23 members of staff. This included the registered manager for the service, two senior managers, the clinical lead, , the chef, activity co-ordinator, maintenance person, administrator, two external staff visiting the service, four nurses, two senior care assistants and seven care assistants.

We examined various documents. This included 15 care records and risk assessments relating to people who used the service, 43 medicines records, eight staff files including staff recruitment, training and supervision records, minutes of staff meetings, audits and various policies and procedures including adult safeguarding procedures. We used the Short Observational Framework for inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service in March 2016 we found significant concerns. The kitchen at the service was not kept clean and food preparation areas within the kitchen were untidy and cluttered. Medicines were not always managed or administered safely. Pain assessments were not carried out for people who may require medicines for pain relief. We did not see documented evidence of GP medicines reviews and we found issues with the supply of medicines for people using the service.

There were concerns regarding risk assessments for people who were identified as being at risk of choking. People using the service and their relatives thought there were not always enough staff available to meet their needs.

At this inspection we found the service was not safe. Risk assessments were carried out for people using the service and identified the actions needed to minimise and manage risks. The risk assessments included risks associated with specific medical conditions, pressure areas, mobility and falls, bed safety rails, behaviour that challenges the service and nutrition. However, risk assessments were not always fully completed or reviewed in a timely manner. Some peoples risk assessments did not include guidelines for their medical condition or for managing a specific risk.

The service provided support with PEG feeding to people. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medicines to be administered directly into the stomach, bypassing the mouth and oesophagus. The PEG feeding was overseen by the nursing staff at the service. Where this support was given care plans and risk assessments were not always in place. There was little guidance for staff about the care people needed or the risks associated with PEG feeding, the risks of choking if people on a PEG feed are fed orally and it was unclear if staff had undertaken appropriate training.

During the inspection we were concerned that it was not clear to staff when people were unable to eat or drink because they had a PEG feed in place. We looked at one person's care plan and risk assessment and found there was no guidance for staff in the list of controls relating to any contraindication of giving food or fluid orally. We found their care plan did not contain suitable and sufficient risk assessments and guidance for staff to effectively manage this risk. This meant that this person was at risk of harm from staff offering fluids orally because of a lack of information to guide practice and to keep the person safe from harm.

On 7 December 2016 we asked the registered manager for information about staff training and competency and how staff at Alexander Court Care Centre support people who, because of a medical condition, are at risk of choking and those with PEG feeding tubes in situ. We received a response on 13 December 2016. We looked at a sample of risk assessment reviews carried out by the service in response to our request. There was no guidance for staff in the list of controls relating to any contraindication of giving food or fluid orally. This information was not written into the persons care plan which still lacked detail to guide staff. On reviewing the information received we remained concerned that the issues identified by the inspection team

were not recognised as an area of risk for people using the service.

People using the service were not always kept safe from the risk of choking. During the inspection we found one person calling out for assistance. They were in obvious distress because they had begun to choke during their breakfast. After assistance was sought we looked at their risk assessment and care plan. Their care plan identified one need as "[Person] is at high risk of choking, due to her medical condition." The guidance for staff to minimise the risk included thickening of fluids in line with recommendations from the speech and language therapy (SALT) team, their position when eating, signs of choking and to check the person regularly.

One staff member told us, "When [person using the service] is going to eat we sit her upright. Her meals have to be the right consistency. We have to monitor during mealtimes. We don't leave her for long." We noted the guidance for staff in the care plan and risk assessment had not been adhered to at the time of the incident witnessed by the inspection team. The person had not been positioned correctly and was left to feed themselves while lying on their back. The service had failed to follow guidance to manage and mitigate the person's risk of choking. The care plan did not contain suitable and sufficient risk assessments and guidance for staff to effectively manage this risk. The risk assessments did not reflect complete guidance in line with the Speech and Language Therapy assessment.

Another person's risk assessment stated, "Due to [person's] medical condition [person] is at risk of falling from wheelchair." "[Person] must not be left unattended on the wheelchair." During the inspection we noted that this person was seated in their wheelchair for extended periods of time and was left unattended without staff support on three occasions. We discussed this with the registered manager. They told us they would address this and review or update the care plan and risk assessment. They said the person chose to spend most of their time in their wheelchair and was at low risk of falling or slipping from it. However we did not see records that this change had been reviewed or the information given to staff involved in the persons care and treatment.

We found the service did not always take appropriate action to ensure people were safe when moving around the service. At the time of our inspection the service was undergoing a programme of refurbishment to the communal corridors including people's bedroom doors and to the shared bathrooms and shower rooms. We found the process was not always well managed to ensure the safety of people using the service. During the inspection we found rooms used as temporary storage areas for equipment and used by contractors were left unlocked. We brought this to the attention of the registered manager who arranged for the rooms to be locked. We looked at risk assessments carried out by the service on 17 October 2016 prior to commencement of the refurbishment. Risks identified for people using the service included trips, falls and ingestion of hazardous substances. The control measures stated, "Contractors to keep their equipment in a secured locked cupboard or room. Ensure these rooms are locked at all times. A review of the risks was carried out on 14 November 2016. These control measures were not adhered to by the service. This meant people living with dementia were at risk from entering these areas.

One person using the service told us they were happy about the refurbishment but said they were "Bothered by the smell" and they "Would have like to be moved first but they (staff) didn't tell me."

Medicines were not safely managed and administered by the service. This puts people at risk of harm from their medicines. We found concerning practices with the management and administration of medicines. We looked at 43 Medicines Administration Records (MAR) and saw that three people whose medicines were administered covertly did not have their covert administration record form reviewed regularly. The forms were completed over one year ago. Some of the medicines on the forms had been stopped and no longer

taken by the person.

Information on the covert administration record forms was inaccurate, and pharmacist advice was not correctly followed. People prescribed medicines, which the pharmacist advised should not be crushed because of the risk of reactions were not safely administered. Staff told us these medicines were crushed and mixed with food. This practice was concerning as it meant people were at risk of harm from taking this medicine crushed.

This meant the service failed to ensure the correct information was available to staff with regards to peoples medicines. People were therefore at risk of unsafe administration and management of medicines.

During the inspection we found when reviewing medicines administration records that some people had not taken their medicines as prescribed within the last month. Staff told us that the service had experienced problems with the GP surgery over the previous three month period with regards to issuing repeat prescriptions; therefore some people did not receive their medicines as prescribed during November 2016. The service raised this with the local safeguarding team on 8 November 2016 for investigation.

We found people had missed medicines that were taken to treat and manage a number of potentially serious medical conditions. One person had missed medicines to manage their diabetes, inflammatory disorder, high blood pressure and for prevention of blood clots. Another person had missed medicines used to treat a skin condition. By missing prescribed medicines people could potentially be at risk of severe deterioration of their health.

Some medicines taken as needed or as required are known as 'PRN' medicines. Some people were prescribed PRN medicines for pain relief and there were several entries on medicine administration records charts stating that people had refused pain relief when offered. We found staff were not carrying out regular pain assessments for people prescribed these medicines. There were no assessment tools or documentation seen of how and when assessment was carried out particularly for people who could not communicate easily.

Records were reviewed of daily room and fridge temperature monitoring for the clinical rooms where medicines were stored. Fridge temperature monitoring was inappropriately documented because staff did not know how to read the minimum and maximum temperature from the medicines fridges but were recording the current temperature only, without re-setting the fridge. On the day of inspection we recorded a maximum temperature of 12°C on one of the fridges. This was outside the recommended fridge temperature range of 2 and 8°C, therefore we were not assured that medicines kept in the fridge were stored safely.

We found that unwanted medicines disposed or returned to pharmacy were not appropriately documented and could not all be accounted for. We saw a partly completed returned or destroyed medicine form, with no signature or date of completion. Staff showed us recent documentation of medicines disposed of. We double checked this list against the items in the clinical waste disposal and noted that two items on the list relating to 67 tablets of Metformin 500mg and 77 tablets of Hyoscine Butylbromide 10mg were not in the clinical waste disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy. The service did not keep accurate records of unwanted medicines disposed of. Therefore they were unable to demonstrate that medicines were appropriately disposed of.

The above findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

People living at Alexander Court Care Centre and their relatives told us they did not to think there were enough staff at the service to meet their needs and waited for unacceptable periods of time for assistance. People told us waiting times increased during the weekends and at night. People using the service did not always have the opportunity for regular baths and did not always have the opportunity to go outside the home to carry out activities due to staff shortages.

One person said, "Sometimes there's enough staff and otherwise not. But there's not enough to take me out" Another person told us "There used to be more staff. There's probably not enough now." A third person said, "When you ring the bell, sometimes I have to wait. The bell will ring a while. They tell me you've got to wait a minute. We're busy doing [person using the service]." A fourth person told us, "Once I rang the bell at night and nobody came. I don't ring at night anymore."

Relatives told us people using the service were left on occasion without staff support. One relative told us, "There's times when there's no staff in the lounge. As soon as last week there was no staff in the lounge. I saw new staff left on their own on their first day in the last few months. I've stopped people falling off their chairs and one resident's daughter gave a resident a sweet and they started choking but no staff were in the lounge and I couldn't find them." They told us, "My [relative]was slipping off his chair and only one staff was there who couldn't leave to get help." "There's not enough staff here, only see one staff for ages." Another relative when asked if they thought there were enough staff said, "Staff don't stop, they're on the go all the time. Some staff are new and you can see they are not settled in."

Staff told us there were sometimes staff shortages and that the service needed more care assistants. One staff member said, "Sometimes there's not enough staff if sick or cancel. Not enough staff." Staff were moved between the units of the service to provide cover for staff absence. One staff member said, "We just get on with it if we can't get staff. As a nurse you just have to be the nurse and the carer. The carers get moved wherever there's a need for staffing." External staff employed by the provider who were working at the service during the time of our inspection told us, "They (staff) do their best. They're short staffed and under stress. People call out and staff are often too long. They work their way down to them eventually."

On one unit for people living with dementia and nursing needs we noted that the reduced number of staff at lunchtime meant some people waited up to ten minutes for staff to support them with their meals. By this time their food may have been cold but they did make more effort to eat when encouraged or supported by having their food cut or a spoonful offered to them. However, the encouragement was not consistent as staff had several people to encourage and were moving around the dining room so that people reluctant to eat stopped eating as soon as they were left.

Staff on the units responded to call bells within an acceptable time. However we noted at times people were left in the communal lounges without supervision when their care plans specifically stated they should not be left unattended. We observed one person, who had been taken to the communal toilet by a care assistant, came to the door with their underwear down looking for help. We saw the care assistant was then called from the lounge area to attend to the person by the registered manager who happened to be passing by.

Throughout the inspection we observed there was little social interaction between staff and service users beyond those relating to completion of immediate care or support tasks.

We spoke with the management team about the concerns of people using the service and their relatives

about staffing levels at the service. They told us, "We are overstaffing." They said they were "Not sure if it's the balance of staff or the number of residents." Staffing rotas for the months of August to November 2016 on all units showed fluctuations in staffing levels at weekend and at night. From the staffing rotas it was unclear how staff were allocated.

People using the service were at risk of not having adequate staff available to meet their needs. The above findings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe at the service. One person told us, "I feel free here. I feel safe." Another person told us "I never feel unsafe here." Relatives told us they felt their family member was safe living at the service.

The service had a safeguarding policy and procedure in place to guide practice. Safeguarding training for staff was mandatory. Staff told us and records confirmed they completed e-learning on safeguarding. Staff were knowledgeable about the process for reporting abuse and knew who to notify. The service had a whistleblowing policy and procedure. Staff we spoke with knew how and where to raise concerns about unsafe practice at the service.

The provider had a staff recruitment procedure in place. Staff were employed subject to various checks including references, proof of identification and criminal record checks. Records showed that appropriate checks had been completed on staff to ensure they were suitable to work in a care environment. Nursing staff had their registration status with the Nursing and Midwifery Council checked by the service to ensure they were registered to practice. The recruitment practice in the service was robust.

Medicines received from the pharmacy were recorded in the medicine administration records (MAR) and the quantity remaining could be reconciled with the administration records which were clear and accurately documented. Controlled drugs (CD) medicines were stored safely and securely. Other medicines were also stored in locked trolleys and cupboards, although during the inspection we found a number of medicines left out in one of the clinical rooms.

On 23 December 2016 we contacted the registered manager requesting confirmation that sufficient medicines were available during the Christmas and New Year period for people using the service. They confirmed medicines were available.

Infection control policies and procedures were in place. A member of the nursing team had the lead role for ensuring infection control procedures and processes were adhered to by staff. This staff member also worked closely with the housekeeping team. Records showed infection control audits were carried out monthly. Staff we spoke with were clear about infection control procedures including those put in place when people using the service had symptoms of a suspected infection. Training records showed staff had completed the appropriate training in infection control. We saw staff wearing aprons and gloves when serving meals, carrying out cleaning or preparing to support people with personal care. We observed staff washing their hands and removing aprons before leaving peoples rooms or moving to different areas of the service.

Cleaning rotas included cleaning of all areas of the service and records confirmed this was carried out. We inspected the main kitchen and food preparation areas within the service and found these to be clean and well organised. This meant the service had processes in place to minimise the risk of the spread of infection.

Accidents & incidents were managed by the service. We saw records of incidents that had taken place involving people who use the service and noted recommendations had been made and recorded in the accident file to prevent reoccurrence. Serious incidents were reported to the local authority safeguarding team and the Care Quality Commission as appropriate. Staff we spoke with knew the procedure for reporting accidents and incidents.

The service had one full time and one part-time maintenance staff responsible for the internal and external maintenance of the premises. We found appropriate building safety checks had been carried out and any issues identified were addressed. This included audits of the environmental health and safety. For example records showed boiler, water hygiene and electrical checks were carried out annually. Other checks on equipment such as hoists, water temperature and fire alarms were carried out monthly or weekly as required. All communal areas of the service were checked daily by one of the maintenance team and registered manager and any repairs logged and completed.

Inadequate

Is the service effective?

Our findings

The service was not always effective. At our last inspection of the service in March 2016 people using the service were unhappy with the quality and variety of food. People using the service did not always receive appropriate meals to manage medical conditions. The service did not adequately monitor, identify and manage people's nutritional needs. At this inspection we found improvements in the quality and variety of meals and people received appropriate meals to manage their medical conditions. However, we found concerns in other areas.

The service had a program of training which was divided between mandatory training and essential training for staff who required it for their role. Mandatory training included moving and positioning, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, infection control, food safety, health and safety and dementia. Essential training included medicines, pressure care, prevention and management of pain and first aid. There was a system in place to monitor when staff were due to refresh their training.

We looked at training records and found some staff were not up to date with required training. Customer service and dignity in care training had not been completed by nine staff. Three members of the management team had not attended fire safety training for managers and two had not attended health and safety for managers. We found 12 staff had not completed training in understanding and managing behaviour that challenges. Records showed that ten staff had last updated this training in 2013 and nine staff in 2014. Of the 77 staff employed at the service, four had not completed diet and nutrition training, 11 staff had completed the training in 2014 which meant their knowledge may not be up to date. Of the 22 nursing staff employed by the service two had not completed a PEG feeding competency assessment. The service had a total of 17 new staff who following our request for information had been booked for a competency assessment to be completed by 21 December 2016.

Refresher training was not always carried out in a timely manner. We found ten staff had not attended refresher training in dementia awareness since 2014 and two staff had not done so since 2012. Fire safety had not been completed by 51 staff since 2015 and by one staff member since 2014. Health and safety training had lapsed for 16 staff who completed this in 2015. Moving and positioning practical training had not been completed since 2015 by nine staff and since 2014 by four staff. Moving and positioning theory had not been completed since 2015 by nine staff and by two staff since 2014.

This meant, staff were not always supported to receive training to enable them to fulfil the requirements of their role. The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection the majority of people who used the service had authorised DoLS in place because they needed a level of supervision that may amount to deprivation of liberty. The service had completed all appropriate assessments in partnership with the local authority. The provider had sent in notifications to the CQC about the decisions of applications submitted for Deprivation of Liberty Safeguards.

Nursing and care staff were able to tell us about MCA and DoLS and we saw records of training they had attended. However, some staff were not confident in their explanations about DoLS or knowledgeable about any conditions.

We looked at the information held on file regarding DoLS applications and authorisation. We selected a sample of four people using the service with DoLS authorisation with conditions to review. We found one person had standard DoLS authorisation with conditions valid for 12 months which stated '[Person] to be allowed with supervision to visit the community 3 times a week provided it is safe.' We discussed this with staff. They were not aware of the condition and were unable to locate any information to demonstrate that the condition was supported or implemented. We later saw a "Trip Attendance Log" for this person held by the activity co-ordinators which showed that they had attended a local shopping trip on four occasions in a two week period.

Another person had standard DoLS authorisation with conditions stating, 'Ensure [person] is offered/supported to access social activities in the care home and increase 1:1 social stimulation. Information to be noted in care plans. 2) Ensure that [person] is supported to wear his splints as part of his day to day care'. We saw their care plan included the information detailed in the DoLS conditions. We spoke with staff who were unable to demonstrate that the conditions as noted in the DoLS were being supported or implemented. They were not aware of these conditions and needed to look through various documents and speak with other staff to locate any information. We saw this person did not have splints on and staff later located these in a chest of drawers in the person's bedroom. Staff told us they had not applied the splints. There was no information in the persons care plan regarding the use of the splints and guidance for staff on how they should be applied.

We discussed our findings with the registered manager they told us they were "Embarrassed and very disappointed" that care files lacked evidence that the DoLS conditions were supported or implemented. They said they would ensure that this was rectified and would review this for people using the service. We were concerned staff were not knowledgeable about peoples DoLS authorisations and any conditions on authorisations to deprive a person of their liberty were not always being met. This meant the service was not working within the principles of the MCA. The above findings were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to best interest decisions in the care records of people using the service. The decisions were recorded and a contribution from and signature of significant others such as their relative.

Staff were knowledgeable about how to obtain consent. They told us they would ask permission and explain what they were about to do before carrying out care and we observed staff asking people before they carried out aspects of care or support. Peoples care records showed they had signed consent to care where able to do so.

We saw records of visits to the service from various health care professionals. There were records of visits from the chiropodist, district nurse, optician, psychiatrist and dietician. Peoples care records contained information relating to various appointment letters following referrals. However, people using the service told us they did not always have the opportunity to see health professionals when requested in a timely manner. One person said. "When I came here I was supposed to have physio. The hospital said I should have it to get strong. They (Staff) say I don't need it now because I can do a bit more but I've still got little control over my hand." Another person told us, "The physio only came twice and then nothing happened. It's not the home's fault."

When asked if they had access to services such as chiropody and the optician, one person replied, "It's difficult to get somebody. I've told the carers but nobody has come." Another person told us that although an optician visited the service they were unsure if they were able to see them. However, another person said, "We get our feet done here and the hairdresser comes once a week. I think I could see an optician if I wanted one."

The service had weekly visits from a GP practice. Some people were not happy with the service they received. One person said the doctor was generally in a rush when they were seen and that on the last visit the doctor "Didn't even sit down."

Health professionals we spoke with told us they had concerns about staff knowledge of people's changing needs in order to make referrals to their service.
Records showed and staff told us new staff had been provided with an induction program so they knew what was expected of them and had the necessary skills to carry out their role.

Staff had supervision meetings with their line manager every two months. Clinical staff told us they received supervision from the deputy manager or clinical lead. Staff we spoke with told us they found it useful to meet with their manager and to talk about their personal development needs and how they were progressing in their role. Staff told us and records confirmed annual appraisals had been completed or planned for staff working at the service.

People had mixed views about the meals provided but told us there had been improvements. One person said, "I am pleased with the food. I can choose different food if I don't like what I chose before." Another person told us, "I like the food. They would prepare something if I asked for it." A third person said, "The food's quite good. It's always on time. I quite enjoy it sometimes." However some people told us they thought the quality of the meals was "fair" and they would prefer if foods like fish fingers were not on the menu so often.

We observed lunch and supper on the first day of our visit. Staff were seen washing their hands and wore disposable aprons and gloves during meal times. One staff member took responsibility for the serving of food and staff worked together to ensure everyone was served without any unnecessary delay. People were not rushed and were not served their deserts until they had finished their main meal. Staff were aware of people's individual preferences as well as their specific dietary needs.

Food was transported from the kitchen to each unit in a heated trolley. Staff checked the temperature of food before serving and recorded this on the food temperature chart held in the unit kitchenette. We noted that food looked appetising and was served hot or cold as appropriate. There was little waste and people appeared to enjoy it. People using the service were encouraged to sit at the dining table and those unable to or who chose not to eat at the table, ate in the lounge or their bedroom.

We saw staff asking people what they would like to eat the following day for their main meal, which they recorded on the menu template. People chose their meals in advance from the menu but were able to change their menu option if they wished to do so. We tasted lunch and supper on the first day of our visit. Lunch was; pork and apple goulash, smoked haddock, mash potato, parsley potatoes and mixed veg with rhubarb crumble and custard for dessert. One person was seen to have an omelette and another had rice with their meal. Supper consisted of; fish fingers with baked beans, or sandwiches. Staff told us that vegetarian options were available when requested and those with special dietary needs were also catered for such as those with diabetes or those in need of pureed or soft food diets. The food tasted was of an appropriate texture and acceptable taste.

People had access to sufficient fluids throughout the day. One person told us, "There's plenty of drinks. I ask if I want more." We observed staff offering hot drinks (tea and coffee) at set times throughout the day and refilling cold drinks at other times. Staff were heard giving encouragement and reminders to people to have drinks.

Staff knew the individual healthcare needs and personal preferences of people they supported during lunch. We observed some people were given clothing protectors during meal time and others used napkins. Clothing protectors were put on and removed as and when meals were served or finished.

The chef had adapted the menu since our inspection in March 2016 and was aware of the dietary needs of people using the service. They told us, "We've had to raise our game and it's up to me to do really good meals. All the [catering] staff are there with me." They told us and we saw records that they attended daily unit meetings where they sought feedback on the meals provided and were informed of any changes to people dietary needs. We saw a choice of soups made with fresh ingredients and a supply of fresh fruit and vegetables used for meal preparation and for people to eat during the day. Milkshakes, homemade rice puddings and porridge were fortified with cream and full fat milk for people at risk of malnutrition due to their medical condition. There were diabetic meals and desert options available. Pureed deserts and meals were made to replicate those on the menu. For example each component of a lemon meringue pie was pureed and then layered to give the effect of the desert.

We saw there was evidence of action plans in the care plans for people identified as being at risk of malnutrition. At the time of our inspection the service was receiving input from the dietician services to improve assessment and monitoring of people who may be at risk of malnutrition and to ensure information was shared between the staff on the unit and the kitchen staff so people received the appropriate diet to meet their needs. Fluid and food charts were completed for people using the service and their weight was monitored monthly or more often if necessary. Records showed referrals were made to the dietician if required.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring. The service did not always maintain the dignity of people living at Alexander Court Care Centre. One relative told us, "My [relative] waited one hour to be changed. We saw [relative] was soaking wet from spilling tea on himself and I told them (staff) but was left for one hour before changing." The same relative recounted another incident involving their family member. They said, "I called them (staff) to say [relative] wanted to go to the toilet. I called the nurse. Carer came and felt [relative] on his front and said to me he's got a pad on. She said do it in your pad and we will clean you up later. I was there about another hour and no one came to change him. He had to go to the toilet in his pad with me there."

We observed a member of staff supporting a person with their meal in their bedroom. The door was open and we noted the staff member did not speak with the person and did not maintain eye contact. We asked the registered manager if the person was able to communicate. They said "Yes" and that the person was "Able to understand what was being said."

During the inspection we saw a person using the service ask a member of staff to help them sit up in their chair. They asked twice before the staff member pulled them into an upright position using the person's trouser waistband. We reported this to the lead nurse on the unit who went to the member of staff involved to address this practice.

We also observed a health professional changing the leg dressing of a person using the service in the communal lounge while the person was asleep. A staff member of the service was assisting the nurse but did not intervene to ensure the persons dignity and privacy was maintained while they received treatment.

This meant people were not always treated in a dignified and respectful way. These findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the negative feedback and the observations described above, many people and relatives told us they found the staff caring. One person said, "It's relaxing and people are kind." Another person said, "The staff aren't bad. They shut the door when they come in my room." A third person told us, "They are pleasant here. Not over the top. They speak to me nicely and they're not bossy." One relative when asked if staff were caring said, "They all seem kind." Another relative told us they thought staff were caring and they said, "[Relative] was made Resident of the Day. She was made a great fuss of."

Observations showed staff interacting with people in a kind and compassionate way while supporting them or providing care. Staff told us how they promoted people's choice and privacy. They said they ensured doors were closed when assisting people with personal care. We observed staff discretely speaking with people who required personal care during the day and supporting them back to their rooms or the bathrooms where personal care could be carried out. Staff told us they offered people a choice of clothing when assisting them with getting dressed and people decided when they wanted to go to bed and wake up in the morning.

People using the service gave mixed responses when asked about their choices. One person said, "I have to go to bed at 10pm and get up at 8am because I need a hoist with 2 people." Another person said, "I don't know about choice of when I get up but they get me up." A third person said, "They tell me when to go to bed and when to get up." Other people did not share this view. One person told us, "I can get up at any time." Another person said, "I can get up and go to bed when I want. I get up when I please myself. They don't bring me a cup of tea. I go to breakfast."

Each person had a named nurse and a key worker who were responsible for overseeing the care the person received and liaising with other professionals involved in a person's life. Staff were able to describe how they developed relationships with people they cared for. This included speaking with the person and their family and gathering information about their life history, likes and dislikes. Care staff we spoke with knew people well but told us they moved between the units and sometimes it took time to become familiar with people's needs. They told us they relied on what was written in peoples care files.

People's needs relating to equality and diversity were recorded and acted upon. This included providing cultural and religious activities and access to their specific communities. For example, representatives from two religions visited the home to support people in their spiritual activities. One person told us their pastor was able to visit them at the service. Another person told us about their religious beliefs and responded, "The Bible" when one of the staff asked them what was their most important book. The staff member then sang a hymn and other people using the service joined in.

There were plans in people's care files regarding their wishes for end of life care. Where people were unable to make decisions regarding this, their relatives were fully involved. There were plans detailing the support staff needed to offer as a person's health deteriorated. The service worked with health professionals in end of life care.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. Care files did not contain sufficient guidance and information for staff relating to a person's communication, vulnerability, sexuality and cultural identity. Some care files contained confusing and contradictory information which made it difficult to understand the needs and dependence levels of the individual. We found care plans had some personalisation but not all offered sufficient information for staff to know how to manage or offer particular care and support. Care plans did not sufficiently cover all areas of concern or risk.

One person's care plan for skin integrity stated 'Shower at least once a week', 'Use moisturiser whenever she has a shower'. Their care plan evaluation stated, 'Skin is creamed daily to minimise dryness'. It was unclear if the cream should be used weekly after shower or daily and did not indicate if this was a prescribed cream or general moisturiser.

Another person's care plan for personal care stated 'female staff for personal care, full body wash every day, shower 2-3 times a month 'she cannot decide when to shower'. Their care plan did not provide specific information about their level of independence.

Some people whose first language was not English did not have care plans with clear guidance for staff about communication needs. One person's care file stated, '[Person] only understands few English words but is able to go along with the tides.' Their care file contained 20 words in "Non-English" language with English equivalent. We did not see records to indicate and staff were unable to confirm translation services were accessed to communicate with the person when involving them in their care planning or reviews.

Another person's care file stated '[Person] is unable to communicate effectively due to illness condition' and '[Person] can easily understand if somebody can speak his language'. Under the expected outcome or goal it was stated 'To ensure and promote meaningful verbal communication'. Their care plan evaluation stated, '[Person] communicates with signs and gestures'. It was unclear if English was the person's first language or not. We did not see that the service had made appropriate provision for this person to communicate with staff or other health professionals. We noted they had been unable to attend a hospital appointment because of concerns about their understanding of procedures to be discussed. This meant people were at risk of receiving care and support that did not fully reflect their needs or preferences.

People using the service had mixed views about activities. People told us they enjoyed group activities. One person said, "There are plenty of activities; I enjoy the bingo and quizzes. We also have dog racing which is a lot of fun." Another person said, "I've made some friends, there's people I can talk to if I go to the lounge but not everyone can have a conversation with you." A third person said, "Activities are excellent. A pity there's none at the weekends. There's sometimes one on a Saturday but there's none on the unit." Some people felt there were few opportunities to participate in individual hobbies they enjoyed. One person told us they enjoyed reading but because of their eyesight they were unable to do so. They had not been offered large print or talking books to help them maintain this interest.

Activities at the service were led by two activity co-ordinators. We spoke with one of the activities co-ordinators. They told us they had a planned outing with two people to do Christmas shopping on one day of our inspection. We asked what plans were in place for other people whilst they were on the outing. They told us all units had an arts and crafts session planned for the morning which would be led by the care staff. However, we did not see organised activities taking place in any of the five unit lounges we visited throughout the morning. There was widespread inactivity in the lounges apart from the TV being on.

We looked at the group activities timetable available in the activities file. Activities listed included table top games, card games, gentle exercise, knitting, sing-a-long, non-oven baking, skittles, arts and crafts, quiz, film afternoon and bingo. These activities took place in the activities lounge on the ground floor of the service. We looked at a 'Trip Attendance Log' held by the activity co-ordinators. Records for September and October 2016 detailed outings attended by people using the service. Records showed group outings involving up to four people using the service and at other times one or two people were supported to go out for a newspaper or short shopping trip. We noted that not many people went out. We saw a total of 15 trips however; eight of these trips were for the same person.

The activity co-ordinator explained that some people were offered the morning activity and others the afternoon activity. They said it was not easy for people to swap and go in the morning if they were due to go to the different activity in the afternoon as this would depend a on care assistant being available to take them. They said the activity programme was changed monthly so that people would have access to their favourite activities at some time.

There was a large notice board outside the activity lounge displaying pictures of the activities programme. We noted that this was not available on each unit where a list of activities in small print without pictures was pinned to notice boards. In some cases these were obscured by other notices.

In most unit lounges, there were a number of DVD's and a few games and puzzles. We did not see these being used. There were few magazines or reading materials seen. In other lounges we saw nothing available for people living with dementia. The activity co-ordinator told us they had been speaking to the registered manager about purchasing activities that were specifically for people living with dementia. They said this had been agreed.

On the first day of our visit we saw 17 people taking part in the afternoon bingo session in the ground floor activity lounge. We noted that the room was full and most people sat in the wheelchair they had been transported in. Not all people participated in the session however, the atmosphere was lively and people seemed to be enjoying the social interaction. Some people did not get the level of support needed to play the game fully. We observed that some people were missing numbers and no one was available to help them.

On the second day we observed eight people taking part in a game of chair basketball in the activity lounge. We noted seven of the eight people were seated in wheelchairs which seemed to restrict their arm movement. This was not recognised by the staff and not everyone was given the level of support they needed. These findings meant people were not always supported to take part in meaningful activity of their choice appropriate to their level of need.

The findings above where people were at risk of not receiving care, support or activities in line with their preferences were a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files included peoples personal details and plans for their personal care and physical well-being, weight, dietary preferences, sight, hearing and communication, oral health, foot care, mobility and dexterity, history of falls, continence, medicine usage, mental state and cognition, social interests, hobbies, religious and cultural needs, personal safety and risk, carer and family involvement, other social contacts or relationships and daily communication. Records showed care plans were reviewed each month by senior staff and updated as necessary. Each care file had a 'snap shot care plan' which was a one page document summarising the most important needs for the person and included individual likes and dislikes. However we found these did not always reflect information contained within the main care file.

The service had a complaints policy and procedure which was displayed in the service. The registered manager and staff were able to explain how they would deal with a complaint. People and their relatives knew how to complain if they needed to. One relative told us they had made complaints although not formally, regarding issues that concerned them. They told us that although they felt the management team listened to them they did not feel confident in the responses they were given.

Inadequate

Is the service well-led?

Our findings

At our last inspection of the service in March 2016, we had concerns about the leadership of the service. Peoples care records were not always fully completed or up to date. Quality monitoring systems in place did not identify issues we identified during the inspection such as incomplete records, concerns about nutrition and medicines management. Feedback from meetings for people using the service and their relatives was not acted on to improve the quality of the service. We imposed conditions on the registration of the service on 5 July 2016.

At this inspection we found significant areas of concern. The service had quality monitoring systems in place. Monthly reports of audits were submitted to the Care Quality Commission in line with the conditions imposed on 5 July 2016. The processes were not effective as they had not identified or addressed the issues above regarding the monitoring and assessment of risks relating to the health, safety and welfare of service users and others.

The quality monitoring systems in place which included audits of care plans, risk assessment reviews, medicines audits, staffing levels and staff training had not identified the issues identified during our inspection such as incomplete records, risk assessments for choking, staff competency assessments and staffing levels. The service did not always maintain accurate records of risk assessment and care planning reviews. This meant we could not see if previous risks were on-going or were no longer a risk. It was also unclear if people's needs had changed affecting the level of support needed.

On two occasions during the inspection, we requested call bell data for the three month period prior to our inspection. They said this was analysed by the service to ensure call bells were answered by staff promptly. The registered manager told us this information was collected and reviewed however they did not provide this information. We contacted the registered manager after the inspection and again requested the information which was submitted on 28 December 2016. They were only able to provide data for December 2016.

Meetings for relatives of people using the service took place. We looked at minutes of the meeting, chaired by the registered manager, held on 25 November 2016. We saw 12 relatives had attended. The meeting agenda covered; home refurbishment, clinical issues, housekeeping, kitchen and menu review, environmental health officer visit, activities and any questions or concerns. We did not see clear actions or target dates or named persons responsible to complete the actions.

The above findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the registered manager and management team were open about areas of improvement.

Relatives told us they thought the registered manager was approachable and "friendly." Staff told us they

enjoyed working at the service and found the management team approachable and supportive. One staff member said, "The team are generally co-operative but if staff don't understand we help them and work together. We correct each other and work together." Another staff member said, "Its good team working and supporting each other." The registered manager told us, "I'm really proud of strengthening and training the team." They said they had put care leaders on each unit and could see staff were working hard and improving.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that people who use the service receive person centred care and treatment that is appropriate and meets their needs and reflect their preferences.9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people using the service were treated with dignity and respect and their privacy ensured. 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure care and treatment for people using the service was not provided in a way that includes acts intended to control or restrain that are not necessary to prevent, or not a proportionate response to, risk of harm posed to the person or another individual if the person was subject to control or restraint.13(1)(4)(b)