Alexandra Lodge Care Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 11 November 2016 and was unannounced.

Accommodation for up to 19 people is provided in the home on two floors. There were 15 people using the service at the time of our inspection. The home provides personal care for older people.

A registered manager was in post and she was available on the second day of the inspection visit. 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.

People were unnecessarily restricted and put at risk of avoidable harm due to a lack of appropriate equipment. Staff did not always safely manage identified risks to people. Safe infection control and medicines practices were not always followed.

Staff understood their responsibilities to protect people from the risk of abuse. Sufficient numbers of staff were on duty to meet people's needs during our visit. Staff were recruited through safe recruitment processes.

Not all staff had received all relevant training and observations suggested that the training received was not effective in a number of areas. People's rights were not always fully protected under the Mental Capacity Act 2005. The mealtime experience was poor for one person and systems to ensure that people received sufficient to eat and drink could be improved.

External professionals were generally involved in people's care as appropriate, however, the service had not always promptly responded to professional guidance when required. Staff received appropriate induction, supervision and appraisal.

Staff were kind but did not always respect people's privacy. Staff did not always effectively respond to one person's distress. People and their relatives were involved in decisions about their care though this could be improved. People's independence was not always promoted.

People could receive visitors without unnecessary restriction and advocacy information was available to people.

Care records did not always contain information to support staff to meet people's individual needs. People were supported to take part in activities.

A complaints process was in place and staff knew how to respond to complaints.

The provider was not meeting their regulatory requirements. There were systems in place to monitor and improve the quality of the service provided, however, they were not effective. People and their relatives were not fully involved in the development of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were unnecessarily restricted and put at risk of avoidable harm due to a lack of appropriate equipment.

Staff did not always safely manage identified risks to people. Safe infection control and medicines practices were not always followed.

Staff understood their responsibilities to protect people from the risk of abuse.

Sufficient numbers of staff were on duty to meet people's needs during our visit. Staff were recruited through safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received all relevant training and observations suggested that the training received was not effective in a number of areas.

People's rights were not always fully protected under the Mental Capacity Act 2005. The mealtime experience was poor for one person and systems to ensure that people received sufficient to eat and drink could be improved.

External professionals were generally involved in people's care as appropriate, however, the service had not always promptly responded to professional guidance when required.

Staff received appropriate induction, supervision and appraisal.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind but did not always respect people's privacy. Staff did not always effectively respond to one person's distress.

People and their relatives were involved in decisions about their care though this could be improved. People's independence was not always promoted.

People could receive visitors without unnecessary restriction and advocacy information was available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always contain information to support staff to meet people's individual needs.

People were supported to take part in activities.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider was not meeting their regulatory requirements.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective.

People and their relatives were not fully involved in the development of the service.

Alexandra Lodge Care Home

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.

This inspection took place on 8 and 11 November 2016 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with three people who used the service, seven visitors, two health and social care professionals, a housekeeper, two kitchen staff, three care staff and the registered manager. We looked at the relevant parts of the care records of 10 people, two staff recruitment files and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Risks were not always managed so that people were protected from avoidable harm and were not unnecessarily restricted.

People did not feel restricted. A person said, "I can walk around with my walker and go in my room or the lounge. I've been taken on the bus to town with a wheelchair to do some shopping." However, we found that some people had been unnecessarily restricted. People told us that they enjoyed going into the garden area, however, staff told us that people could not access this area freely and could only access this area with staff supervision.

We found that appropriate equipment was not in place for all people who used the service. As a result, some people were unnecessarily restricted. A relative said, "I've had no concerns about the moving around of [my family member]. But I'm a bit puzzled why [they] are in bed. I've not been told." Information in this person's care records stated that they had been assessed by an external healthcare professional three weeks ago. The advice given was that a specific piece of equipment was required to move them safely. This equipment was not available. Another person was receiving care while in bed. We were told that equipment was not available to move this person safely. Their care records stated that they were awaiting a hoist. This entry had been made in September 2016.The failure to have equipment in place unnecessarily restricted people's freedom.

We observed staff assisting people with moving from their chairs to other parts of the home. They did not always do this safely and in line with best practice guidelines. We observed staff assist people by placing their hands underneath their arms on a number of occasions. This is not a safe moving and handling procedure and increased the risk to the person's safety. It was clear that a hoist may have been needed to move some people safely within the home. A hoist was not available and people were placed at risk of avoidable harm.

Risk assessments were in place, although some of these lacked detail and were not always regularly reviewed. Risk assessments had been completed to assess people's risks of developing pressure ulcers, falls and nutritional issues. However, these had not all been reviewed regularly and risk assessments were not in place in all areas for all people. One person's pressure risk assessment had not been reviewed since December 2015 though their mobility had deteriorated since then. Another person who was at nutritional risk did not have a nutritional risk assessment in place and their pressure risk assessment had not been reviewed since January 2014. This meant that there was a greater risk that appropriate action would not have been identified and taken to minimise the risk of people being put at risk of avoidable harm.

One person was found to be sitting awkwardly in their chair. They were slumped over the side with no support from a cushion. We asked a member of staff to reposition this person, which they did. We checked the person's care records and found an assessment of this person's mobility had been carried out which stated the person could reposition themselves independently in their chair. From our observations this was not correct. We asked a member of staff whether this person could reposition themselves. They said in their

opinion they could not. This meant the person's care records did not accurately reflect this person's current needs and could place their safety at risk.

Another person was assessed as at risk of falls. Their records stated that they needed to be supervised at all times when sitting in the lounge. We observed that they were left unsupervised in the lounge on a number of occasions for minutes at a time. This placed them at risk of avoidable harm.

There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly. However, people's repositioning charts had not always been fully completed to show that staff had supported people to change their position as frequently as stated in their care plan. We also saw that one person, at risk of skin damage, was not sitting on a pressure cushion at all times.

Parts of the premises were not safe and people were put at risk of avoidable harm. Water temperatures were not being checked in all areas and we observed that water temperatures were too high in a number of rooms. Radiators were not covered and would be a risk to people if they fell against them. There were also no records to show that regular flushes of water outlets had taken place to minimise the risks of legionella.

We found there were gaps on a number of people's Medicines Administration Records (MAR) charts indicating a medicine had either not been administered or the administration had not been signed for. This could lead to a person being given their medicines twice. Staff had also signed to say that they had administered medicines more frequently than prescribed. This meant that staff were not administering medicines safely by maintaining an accurate record.

Creams had not always been signed for when administered and we observed a staff member talking with a person about applying cream to their legs, which were red and clearly looked very sore. They asked the person if they could get up out of their chair to go back to their bedroom for this to be completed. The person was not responsive to the staff member's request. The staff member discussed this with another member of staff to establish the best way to support this person. The staff member then left the room. We observed this person throughout the day and saw that no staff member returned to apply the cream. This meant the person did not receive the care they needed and placed their health at risk.

A relative said, "I've no worries with [staff] managing [my family member]'s medication but I'd like [them] to have more painkillers or a different type. I told the staff but they won't up it." We saw that a number of people were regularly not receiving medicines as prescribed. Staff were treating them as medicines to be given only 'as required'. We observed a person tell staff that they were experiencing pain. Staff responded quickly to this and gave the person some prescribed painkillers. We checked the person's MAR and found this painkiller was not being given as prescribed. The person should have been receiving this painkiller four times a day, but records stated for the past two weeks that they had only received it once a day. There were a number of examples of this for other people. This meant that medicines were not being effectively managed to ensure that people received them safely.

Liquid medicines and creams were not always labelled with the date of opening to ensure they were only used for a period of time when they were most effective. We saw that some eye drops were still in the medicines fridge available for use past their expiry date. PRN protocols were not in place to provide staff with guidance on when to administer 'as required' medicines. Handwritten additions to the MAR charts had not been signed by two staff members to ensure that no errors had been made when copying the medication label.

Most areas of the home were clean; however, some parts of the lounge were dusty and difficult to clean as there were a large number of items on shelves and tables. Staff did not always follow safe infection control practices. A staff member brought a person's denture into the lounge in a piece of tissue without wearing gloves. We observed another staff member touching a person's tablets before the person took them.

Cloths, mops and buckets were not safely managed to minimise the risk of infection. Detailed cleaning schedules were not in place to ensure that all areas of the home, including all equipment, were cleaned regularly. No separate sluice room was available for the cleaning of commodes and bottle urinals. Soiled laundry was not being handled safely to minimise the risk of infection. Only 16 of 22 staff had received infection control training.

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

People told us that they felt safe living in the home. A person said, "I feel fine here, It's lovely." A relative said, "I'm happy that [my family member] is safe enough."

A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

Staff had attended safeguarding adults training and were aware of the signs of abuse and the actions they would take if they suspected abuse. There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

Accident forms were completed and actions taken to minimise the risk of re-occurrence were documented. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening.

People told us that generally they felt that staffing levels were appropriate although several people said that when staff were busy, they had to wait for the toilet or to go to bed. A person said, "I can usually find someone if I need anything." However, another person said, "Sometimes they're short, like at bedtimes. We have waits." Relative's views were also mixed. A relative said, "I'd say there seems to be enough [staff] on at a time." However, another relative said, "Sometimes there's not enough [staff], noticeably when people need help to go to the toilet and staff are busy."

Staff told us there were sufficient staff to meet people's needs. During our inspection the main lounge area was supervised by staff most, but not all, of the time. One person sitting in the lounge was not supervised as required as a result of this. Calls bells were responded to quickly throughout the inspection. We saw that staff provided support in a timely manner throughout most of our inspection but there were some delays in moving two people from the dining room after lunch. The dining room was cooler than the rest of the home and these two people were cold as a result of the wait.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People told us that staff supervised them taking their medicines. A person said, "[Staff] don't move until

you've took them." Another person said, "They always stay with me while I have them." Most relatives were happy with how medicines were managed. A relative said, "Oh crikey yes, I know they manage [medicines] well." Another relative said, "There's no problem with medicines."

Staff told us that they had received medicines training and their competency to administer medicines had been assessed. Records confirmed this.

We observed the administration of medicines and saw staff checked whether people were ready for their medicines before administering them and stayed with people until they had taken their medicines. Medicines were stored securely and temperature records showed that staff were regularly checking to ensure that medicines were stored at an appropriate temperature. Each MAR contained a photograph of the person to aid identification, a record of any allergies and their preferences for taking their medicines.

People told us that the home was clean. A person said, "It's all kept nicely here. They clean it every day." A relative said, "The place is lovely and clean."

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that staff were competent. A person said, "I find them very good and nice." A relative said, "They're brilliant staff. We're dead chuffed with them all." Another relative said, "They seem very capable."

Staff told us they felt supported. They also told us that they received an induction, regular supervision and appraisal. Records confirmed this.

Staff told us that they received regular training. However, training figures showed some gaps in the attendance of most courses including mental capacity, health and safety, fire safety and managing challenging behaviour. Some staff practices we observed during the inspection suggested that training was not always effective in the areas of moving and handling, medicines and infection control.

People did not raise any concerns regarding consent. A relative said, "They always explain before moving [my family member]." We saw that staff talked to people before providing support and where people expressed a preference staff respected them.

The Mental Capacity Act (MCA) 2005 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.

We saw that mental capacity assessments and best interests documentation were not always in place when people did not have the capacity to make a decision. This meant that there was a greater risk that their rights had not been protected in this area.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We observed that some DoLS applications had been made and the registered manager told us that they would be continuing to review this area to ensure that DoLS applications had been made for all people that required them.

When people presented with behaviours that others might find challenging sufficient guidance was in place and we saw staff respond appropriately to a person who was displaying some behaviours that might challenge.

We saw care records for some people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and most had been completed appropriately. The registered manager agreed to contact the relevant professional to review one form that had not been correctly completed.

People told us that they had plenty to drink. A person said, "We get lots of drinks here." A relative said, "Absolutely [my family member] gets plenty of drinks. They're always being offered something."

We observed a staff member asking a person if she would like a drink. The person declined saying that they did not want to use the toilet again. The staff member explained how it was important to drink and quietly brought her a half cup of squash, which the person accepted.

People and their relatives were happy with the food provided by the home. A person said, "The cooked breakfast is nice. We have lovely lunches. The teas are nice, we have all sorts. Then tea and biscuits at bedtime. If we're not well, they bring us it in our rooms." Another person said, "It's jolly good food. I eat up well usually." A relative said, "She's on a very soft puree diet now. She polishes it off and the beautiful puddings. She has the same as everyone else, just pureed." Another relative said, "She absolutely loves the food! It looks good to me too. I hear them ask her about choices."

We observed the lunchtime meal in the main dining room. Most people received food promptly and the food looked appetising and well presented. Most people received appropriate assistance from staff if they required it; however one person was not appropriately supported and did not receive their food promptly.

We observed one person living with dementia who had remained alone in the lounge, separated from the other people who used the service. Staff told us that this person ate alone in the dining room after everyone else, to avoid disturbing other people when she vocalised. At 2.45pm, after staff handover, the person was eventually assisted to the dining room. She was seated at a table, facing the wall. One kitchen staff member, new on shift, served her lunch that had been left covered for re-heating by the previous kitchen staff. The meal was not explained, just put down with an impatient tone, "That's your dinner [name of person]. Now eat up." The staff member gave the person a drink and left the room.

We observed that the person was left alone for 10 minutes to eat. The person became distressed at times, saying "I don't know what I'm doing" and "Please don't leave me alone" and "Help me, help me, please help me" and "I don't know what to do". They also occasionally banged their fork or spoon on the plate. We gave verbal reassurances to the person, who ate half of her meal at intervals and unaided. A staff member returned once to briefly check on the resident, standing over them and asking them to eat some more.

The kitchen staff member then returned five minutes later and said, "Just have your pudding if you don't want your main course." The unfinished meal was removed with no attempt to assist the person to eat more. A dessert bowl was put in front of the person, again with no explanation. The person was assisted back to the bedroom having eaten only half of their dessert. The lack of support this person was receiving meant that they were unable to complete their meals and were at risk of not having enough to eat and drink.

Food and fluid charts were not always fully completed when people were at nutritional risk. No fluid targets had been set for people and we saw that people's daily fluid inputs were not being totalled to ensure that they were receiving sufficient to drink.

Most people's weights were being regularly recorded, however, one person who could not be weighed, had not had any alternative methods of estimating weight completed since January 2016. Staff confirmed that the person had been eating well and had not suffered any weight loss. We saw where people were at risk of gaining or losing too much weight guidance had been requested from a GP and followed by staff.

People told us that they saw external health professionals. A person said, "We get everything done for us. The hairdresser comes every week and I get the chiropodist. The optician came once too." Another person

said, "The nurse comes in to bandage my legs." A relative said, "[My family member] has the nurses coming in and the doctor."

Documentation within people's care records provided evidence of the input of district nurses, GPs and opticians. We saw that prompt action had not been taken in response to advice provided by external professionals regarding moving and handling equipment.

Limited adaptations had been made to the design of the home to support people living with dementia. Not all people's bedrooms were clearly identified and not all bathrooms were clearly identified. There was no directional signage to support people to move independently around the home and the call bell sound was very loud and could cause people distress.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring. A person said, "They look after us nicely." Another person said, "I feel special here. They're kind and look after us." A relative said, "Without any doubt they're caring."

We observed staff interact with people in a kind and caring way. We saw people were happy and relaxed with staff and enjoyed their company. Staff took time to sit and talk with people and to listen to what they had to say. We saw staff respond to people's distress or discomfort in a timely manner and reassurance was offered when needed. This included a friendly arm around the shoulder or the holding of a person's hand. The staff showed warmth for the people they cared for.

We observed one person did not receive the same level of interaction from staff. This person sat alone, facing away from others throughout the inspection. The person regularly cried out in distress. The staff attended in a timely manner and sat with the person for short periods of time. Some staff sat and held this person's hand and offered reassurance, however when others sat with them they were writing notes and did not engage in meaningful conversation. This was disrespectful for this person.

This person's care records stated they needed to wear glasses all of the time to enable them to see properly. We noted for the first two hours of the inspection they did not have their glasses on and were becoming increasingly distressed. We raised this with a member of staff. They were found and quickly given to the person, which immediately improved the person's mood. The failure of the staff to notice this person was not wearing their glasses meant this person was caused unnecessary distress. We also saw that another person was brought to the lounge without staff checking that the person was wearing their dentures. This meant that staff were not always taking sufficient care when supporting people.

We received mixed views on involvement with care planning. People who used the service did not have an awareness of their care records. Some families told us they felt involved, others did not feel informed. A relative said, "I feel in the loop with how [my family member] is." Another relative said, "We know everything. We get copies of [our family member's] care plan and they keep us in touch." However, a third relative said, "I'm not aware of any paperwork. They always ring if [my family member] is ill or something happens. But I don't recall seeing any care plan before." Another relative said, "I saw the care plan at the start but not since."

We saw some signatures showing people's involvement within their care records. Although this was not present in all care records. Advocacy information was available for people if they required support or advice from an independent person. Advocacy services act to speak up on behalf of a person, who may need support to make their views and wishes known.

We looked at the care record for a person who had difficulties in communicating verbally. No guidance was in place for staff on how to understand the person's wishes and strategies staff should use to maximise people's understanding and enable them to indicate their wishes.

People told us that their privacy was respected. A person said, "They always knock and let me call out first." Another person said, "[Staff] knock then peep in. They shut my curtains, keep me private." A relative said, "They always shut [my family member's] door and curtains when they're [providing family member with personal care]." However a relative said, "There's no privacy in conversations in the lounge, others listen in and chip in with comments when I'm talking to [my family member]." We observed that there were no areas where people could easily have privacy except their bedrooms. We also saw that two bedrooms next to each other did not have a full solid wall between them. A curtain was in place across a gap in the wall but this would not stop sound travelling between the two rooms. This did not ensure those people's privacy.

We saw staff took people to their bedrooms to support them with their personal care and saw staff knocked on people's doors before entering. However, we observed a staff member talk about a person who used the service to another staff member in front of other people sitting in the lounge. This did not respect the person's privacy.

We observed that people who were able to walk were encouraged to be independent. We observed staff encouraging people to make decisions on going to the toilet, and returning to the lounge or their bedroom. However the lack of appropriate equipment meant that not all people were as independent as they could be.

People could visit the home without unnecessary restriction. A relative said, "We come in any time at all." Another relative said, "I come when I want."

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always contain sufficient accurate information to support staff to provide personalised care for people that met their individual needs. Information regarding people's life histories, likes and dislikes was generally limited.

We reviewed the care records for a person with diabetes and found their main care plan referred to their diabetes, however, there was no specific guidance about the symptoms of low or high blood sugar levels. This meant that staff would not have sufficient guidance to support them to identify signs of deterioration in the person's health condition.

Records showed that sufficient guidance was not always in place for people at risk of developing pressure sores. One person, who was at risk, had no guidance in place. Another person's records lacked specific details such as how regularly the person should be repositioned. Moving a person too infrequently could increase the risk of pressure sores developing, and moving a person too frequently could cause the person unnecessary distress.

A person was visually impaired and their care records did not provide sufficient guidance for staff on how to support them in this area. Another person was at risk of falling and their care plan did not state that they needed to be supervised when sitting in the lounge but their risk assessment did contain this information. We observed that the person was not supervised in the lounge at all times.

Another person had been diagnosed with a specific health condition. There was very limited detail in the person's records about how this could affect their day to day health and how staff could support the person. The person's manual handling care plan also stated that they were independent; however, we observed that they needed staff supervision when mobilising.

People told us that they received personalised care that was responsive to their needs. A person said, "I've only to mention something and they'll do it for me." People told us that call bells were responded to promptly. A person said, "We get a quick reply." Another person said, "They're not usually too long."

People told us that they could have showers or baths when they wanted them. A person said, "You can have a bath every day if you want." Another person said, "We can have a shower when we like." A relative said, "[My family member] has a shower quite often and always looks clean."

People's views were mixed on the activities offered at the home. A person said, "There's always something on. I like bingo and music things best. We get driven out to places now and then." Another person said, "I play bingo. There's not something on every day so we watch TV. I've been taken shopping sometimes."

Relatives' views were also mixed. A relative said, "I don't see much going on in here. [My family member] had the odd trip out to Skegness." Another relative said, "There's probably not enough for [my family member] to do. It's a very limited social life here. [They] enjoy the Sunday singalong and the fish and chip night."

However, at third relative said, "[My family member] seems content. [They] don't read any more so [they] like the singalongs and exercise to music person. [They] went to Skegness on the trip earlier."

We spoke with a staff member based in the lounge, who told us that care staff carried out activities. There was no activities coordinator employed at the service. The staff member told us that bingo and bean bag games were popular. Occasionally they arranged a film night with pizza and a monthly fish and chip supper was bought in locally. The patio area was used whenever possible, with supervised access on the ramped access from the lounge. We were told that a manicurist visited monthly and also a complementary therapist who did hand massages and chatted to relax people who used the service. A music motivation therapist visited twice a month.

We observed a staff member playing a game of chair skittles with several people and also chatting to residents in the lounge. The television was on mute with subtitles, while a CD of popular songs played. Several people had been given hardback picture books to look at for reminiscence. A staff member was based in the lounge and interacted well much of the time, but also spent periods sitting watching people and anticipating their personal care needs.

People raised no concerns about making complaints. Relatives told us that they would feel comfortable making a complaint. A relative said, "If you raise a problem, they do take notice and try and resolve it." Another relative said, "I would go to the [registered] manager if I had a complaint."

We saw that complaints had been handled appropriately. A complaints procedure was in place and a copy was in each person's bedroom and displayed in the home. There was a clear procedure for staff to follow should a concern be raised. Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received. However it was not effective as it had not identified and addressed the issues of concern that we found at this inspection. These shortcomings placed people at risk of avoidable harm.

We saw that audits had been completed by an external health and safety organisation, the registered manager and other staff working at the home. Audits were carried out in the areas of infection control, medication, health and safety and mealtimes but a care record audit had not taken place. We found that care records were not always accurate.

A medicine audit carried out after the first day of our visit had not identified all of the issues that we had found on the first day. The infection control audit had not identified the unsafe infection control practices that we identified during our visit.

Improvements to the service had not been made or sustained following inspections by us. The CQC inspection in 2013 had identified breaches of regulations. At our inspection in March 2015 we found that all regulations had been complied with and the service was rated 'Good'. However, at this inspection we have again identified a breach of regulations. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were not fully involved in the development of the service. People were not aware of any meetings for people who used the service. Relatives told us they had not attended any meetings. A relative said, "No, I've never been to anything here." Another relative said, "There's a meeting this month I heard. The first one I think." No recent meetings for people who used the service and their relatives had taken place. The registered manager told us that a meeting would take place the following week.

No surveys were in place to obtain the views of people who used the service on the quality of care provided to them. We viewed the results of the most recent relatives' survey, which asked relatives for their views on the quality of the service provided at the home. This included people's activities, the quality of the care and whether they were treated with dignity. The analysed results stated that 32% of relatives had rated the home overall as 'excellent', 60% as 'good' and 8% as 'satisfactory'.

People felt that the atmosphere of the home was good. A person said, "It's nice, I like it here." A relative said, "It's a pretty good atmosphere. It's an okay place." Another relative said, "It's a good place."

The provider's values and philosophy of care were displayed on the walls of the home. A whistleblowing policy was in place. Staff told us they would be prepared to raise issues using the processes set out in the policy.

Relatives told us that the registered manager was visible and approachable. A relative said, "She's diligent and conscientious." Another relative said, "Brilliant. She's marvellous and so easy to chat to."

Staff were very positive about the registered manager and were confident they would be listened to and the manager would act on any concerns they raised. A staff member said, "A staff member told us "The manager works 10am until 9pm often. She's marvellous, so dedicated. She's always here and so hard working." Staff told us that they received feedback in a constructive way.

The provider was not meeting their regulatory responsibilities. The provider had not been correctly registered since April 2015. The provider is registered as a partnership but this partnership discontinued in April 2015. The provider had not made an application to register with a different legal entity. The registered manager told us that they would be submitting the application immediately.

A registered manager was in post and was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She told us that sufficient resources were available to her to provide good quality care at the home. We saw that regular staff meetings took place and the registered manager had clearly set out her expectations of staff. However, staff meeting minutes lacked detail and would not provide sufficient information for staff who had not attended the meeting.

We saw that statutory notifications had been sent to the CQC when required and the current CQC rating was clearly displayed.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were put at risk of avoidable harm due to a lack of appropriate equipment. Staff did not always safely manage identified risks to people. Safe infection control and medicines practices were not always followed. 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. 17 (1)