Nicholas James Care Homes Ltd

Alexander House - Dover

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 26 and 31 August 2016 and was an unannounced inspection.

The service is registered to provide accommodation and personal care to 46 older people who may also be living with dementia. At the time of this inspection there were 30 people receiving the service. The premises are two large detached properties that have been connected by means of two conservatories. The accommodation is provided on each of the three floors and all of the bedrooms are single occupancy. There is a small enclosed garden area at the rear of the premises and a large paved courtyard between the two main buildings which is shielded from the main road by gates.

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

At the previous unannounced, inspection of this service on 29 and 30 June 2015, a requirement notice was served as the provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people or supporting people with their behaviour. We asked the provider to take action and the provider sent us an action plan. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had not taken appropriate action with regard to these issues and remained in breach of this regulation.

Since the last inspection there had been some staffing issues. The registered manager and deputy manager had been dealing with the staffing issues with support from the provider. The provider agreed that, on reflection, this had taken the managers away from the day to day management of the service. The registered manager and management team were reviewing and trying to improve the day-to-day culture in the service, including the attitudes, values and behaviour of staff.

When people needed support with their behaviours potential risks had not been fully assessed and measures were not in place to reduce the risks to keep people as safe as possible.

Care plans did not always have up to date moving and handling risk assessments to ensure people were moved safely in line with their current needs.

People were not fully protected from harm or abuse as the registered manager had failed to report incidents between people living at the service to the local safeguarding authority in line with safeguarding protocols. Accidents and incidents were recorded but there was no further analysis to reduce the risk of further events.

There was insufficient staff on duty to ensure people's needs were fully met. On the day of the inspection the

registered manager confirmed that staffing levels were not up to the optimum levels due to staff sickness.

People were at risk of harm as they were not always receiving their prescribed medicines. The storage room for medicines was not the correct temperature to ensure the medicines were safe to use.

People's mental capacity had been assessed and when required authorisations to deprive people of their liberty (DoLS) had been processed through the local authority. However, the registered manager had failed to ensure that specific recommendations made by the local authority to guide staff how to care for a person were included and followed when planning their care.

People's privacy and dignity was not always upheld. There were two occasions when staff were disrespectful to people, one of which caused some distress to a person. Relatives told us the staff were kind and caring. People were supported by their relatives to be involved in planning their care and to make decisions about their daily lives. They were encouraged to remain as independent as possible.

The information in care plans varied. There were areas that showed people received person centred care while other parts of the plan such as mobility and behaviour lacked information to ensure people received their care in a way that suited them best. Although care plans had been reviewed regularly, the main care plans had not always been updated with people's current needs.

There was a lack of oversight and scrutiny of the service. The provider had failed to comply with the requirement notice from the previous inspection. Checks carried out on the service had not highlighted the shortfalls in this report.

The systems in place to gather people's views lacked analysis to show continuous improvement of the service. Records were not always up to date or accurate.

People health care needs were monitored and they had access to health care professionals when needed. Systems in place to monitor if people had enough to drink were not clear to show how staff encouraged people to drink enough to keep them healthy. Nutritional risk assessments ensured that people were provided with a suitable range of food.

People enjoyed the activities and were encouraged to maintain their hobbies and interests. There were systems in place to ensure that complaints and concerns were addressed and responded to appropriately.

Staff received the relevant training to carry out their roles. Staff had received supervision and appraisals to discuss their current practice and training and development needs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Risks associated with people's care had not always been identified. There was a lack of detailed guidance for staff to mitigate risk when supporting people with their mobility and to manage and support people with their behaviour.

Staff had not reported incidents to the local safeguarding team when people were at risk of harm.

There was insufficient staff on duty to ensure people's needs were fully met.

People were not receiving their medicines safely and the temperature for storing medicines was too high to ensure medicines were effective.

New staff had been recruited safely and environmental and equipment checks were regularly carried out to maintain people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity had been assessed but recommendations made by the local authority DoLS assessor had not been followed and used to plan people's care.

Systems in place to monitor if people had enough to drink were not clear to show how staff encouraged people to drink enough to keep them healthy. People said the food was good and they had a variety of food to choose from.

Staff received individual supervision and an annual appraisal to address training and development needs.

People had access to health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect as loud remarks made by staff when people had accidents were not always respectful.

People were supported by their relatives to be involved in planning their care and to make decisions about their daily lives. They were encouraged to remain as independent as possible.

People's personal information was stored securely but records were not always accurate and up to date.

Is the service responsive?

Requires Improvement

The service was always responsive.

Not all parts of the care plans were person centred to ensure that people received their care in a way that suited them best.

Although care plans had been reviewed regularly, the main care plans had not always been updated with people's current needs.

People and their relatives were able to discuss their views at regular meetings. People enjoyed the activities and were encouraged to maintain their hobbies and interests.

Formal complaints had been investigated and resolved, and then responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to comply with the requirement notice from the previous inspection.

Checks and audits had not identified shortfalls found during this inspection. Audits identified actions to be taken but there was no evidence that a system was in place to check the actions had been completed by staff.

Accidents and incidents were recorded but there was no further analysis to reduce the risk of further events.

The systems in place to gather people's views lacked analysis to help work towards continuous improvement of the service.

The registered manager and management team were reviewing

and trying to improve the culture in the service, including the attitudes, values and behaviour of staff. Records were not always up to date or accurate.	

Alexander House - Dover

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 26 and 31 August 2016 and was unannounced. The inspection was carried out by three inspectors. We spent some time talking with people in the service and staff; we looked at records as well as operational processes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority. On this occasion the provider had not received a Provider Information Return (PIR) to complete. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We gathered and reviewed information about the service before the inspection, including previous inspection reports and notifications. A notification is information about important events, which the provider is required to tell us about by law.

We received information of concerns from whistle blowers which included concerns about staffing levels, poor practice, staffing conduct, inappropriate moving and handling, and safeguarding issues. These incidents were referred to the local safeguarding team for further investigation.

We spoke with six people who used the service, the operations manager, the registered manager and nine staff.

We observed staff carrying out their duties, communicating and interacting with people. We reviewed people's records and a variety of documents. These included eight people's care plans and risk assessments, training and supervision records, staff rotas and quality assurance surveys.

After the inspection we contacted three social care professionals and the local safeguarding team who had had recent contact with the service.

The previous inspection on 29 and 30 June 2015 found a breach of regulation 12 relating to how risks to people were managed.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe living at Alexander House and relatives told that they felt that their loved ones were safe.

At our last inspection in June 2015 the provider had not assessed all of the risks to people's health and safety and failed to mitigate risks to people. The provider sent us an action plan telling us how they were going to improve. At this inspection improvements had not been made and there were still shortfalls in managing risk to make sure people were as safe as possible.

Potential risks to people were identified regarding moving and handling and supporting people who had behaviours that could be challenging but full guidance for staff on how to safely manage the risks was not available.

Moving and handling risk assessments did not always have clear guidance of how to move people safely and consistently. One person's risk assessment stated that they needed the support of one staff member and a 'stand aids' hoist. (This is a hoist that the person is given mechanical support to stand up and transfer from a chair to a wheel chair and the person needs to be able to follow instructions when moving.) The risk assessment stated that 'one carer is needed to assist XXX with transferring; two carers may be needed in the evenings to comfort XXX if the person was more confused or struggling to follow directions'. There was no information to confirm what 'assist' meant to this person or how to support hem with their behaviour when being moved. The person's mobility had deteriorated and they required more support. They now needed a 'full hoist' and two staff to help them move. There was no information on how or why this decision was made and by whom. There was no guidance for staff on how to move the person safely using the full hoist. The registered manager was employing agency staff on a regular basis and there was a risk that they would not have the full guidance to ensure people were being moved consistently and safely.

Some people required support with their behaviour. There were risk assessments and charts to monitor behaviour. The risk assessments identified the possible triggers for behaviours like 'loud noises caused frustration and were frightening'. The guidance was to 'keep the surroundings calm and support through distress and anxiety'. Staff told us that here had been a lot of incidents where people and staff were at risk of harm or injury from behaviours. There was no guidance in place for staff on what action they needed to take when incidents occurred to make sure people were safe and protected from harm. In the space of five days from 4/08/2016 three people had been slapped by one person and staff had also been slapped and punched. This person's behaviour had been having a negative impact on people for several months. Staff were unsure about what was the best action to take on these occasions and were not consistent in managing behaviours. Another behavioural risk assessment stated that half hourly observations needed to take place day and night. The record used to record the half hourly observations had not been consistently completed to show that these observations had taken place.

Accidents and incidents that happened, like people falling were recorded by staff. There had been a lot of falls during the night and in the late afternoon. Systems were not in place to analyse accidents and incidents

to look for trends to reduce the risk of events re-occurring. For example, it had not been picked up that most accidents were occurring during the early evening and at night.

There was a high number of staff vacancies and the registered manager told us that there was an on-going recruitment drive. The registered manager was using agency staff to cover these vacancies especially at night time. During one week in August, six agency staff covered thirty two day shifts and three agency staff covered eleven night shifts. The registered manager told us that agency staff received an induction and in some cases, those who were used long term had also received supervision. However, there was a risk that agency staff would not know the people well and the lack of details in the records and risk assessments could lead to inconsistent and unsafe care.

Relatives told us they thought there was enough staff to look after people and that they were very patient with people. They said that the staff were good at dealing with difficult situations. Staff said, "The dependency of the people is higher now and there is not always enough staff on duty". "We could do with an extra pair of hands at tea time; we used to have a member of staff to do the teas, but not now".

The registered manager stated that the current staffing levels were appropriate to people's needs. The staff worked across the two houses. People were able to walk between the two houses so the number of people in different areas changed constantly. The duty rota showed that there should be five care staff and a senior member of staff on duty plus the registered manager. On the first day of the inspection a staff member had called in sick and had not been replaced. Some people needed the support of two members of staff to support them. On several occasions there were no members of staff in the lounge areas which left people at risk.

Staff told us they struggled to fully meet people's needs when there was a senior member of staff and five care staff on duty due to people's mobility and behaviour needs. They told us that when they were fully staffed there were times when there was not enough staff on duty especially getting people up in the mornings, when one member of staff was completing the medicine round or in the afternoons when staff were making the sandwiches for tea. There told us there were occasions when staff were not available as there were seven people who needed two members of staff to support them to go to the bathroom or help them with their personal care. At lunchtime we observed that the staff were rushed and did not have to give people the support they needed so managers stepped in to help support people.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were at risk of falling and other people presented with behaviours that posed a risk to others, the risks of these incidents occurring increased when no staff were in the vicinity. On the second day of the inspection the service had the rostered amount of staff on duty. We observed some people get up from their chairs and they were unsteady and some people became agitated. For periods up to 10-15 minutes there were no staff available to make sure people were safe and getting the care and support that they needed when they needed it. There had been a high number of falls at the service and there had been incidences when people posed a risk to others.

People were not fully protected against the risks associated with the unsafe use and management of medicines. We looked at the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. A number of prescribed tablets had not been given to people, even though the medicine records had been signed to indicate that they had been given. There were also gaps in the

medicine records so the registered manager could not be sure that people had taken their medicines.

On 25 August 2016, seven people did not receive their night time medicines as the senior member of staff on duty responsible for administering medicines had signed the medicine records with the letter 'R' which means that the person refused to take their medicines. Three other people's records had blank entries for this date. There was no record that these medicines had been offered or given to people.

The service had two separate medicine rounds, one for each section of the premises. The ten people who did not have their medicines lived on one side of the premises and none of them had received their night time medicines on 25 August 2016. The registered manager took action to investigate this issue and ensured that a trained member of senior staff was on duty each night to administer the medicines safely. .A full audit on medicines was also undertaken and appropriate health care advice sought. Safeguarding alerts were also raised for further investigation. On the second day of the inspection the management team had completed an audit on the medicines and had taken action to reduce the risks of people not receiving their medicines when they needed them.

One person's medicine record stated that they needed to take their prescribed medicine each night at 21:00. The note on the record stated 'only stop taking if your doctor tells you. Take with or just after food, or a meal. Take with a full glass of water'. Out of the 25 days the medicine should have been given, there were three blank columns, ten 'R' denoting refusal and three records of 'S' denoting they were sleeping which means the person only received their medicine on nine days out of twenty five. There was no explanation on the back of the record to say why this had occurred and what if any action had been taken.

An audit of three people's medicine showed that the records did not match the number of tablets left in stock. One person medicine records showed that 25 tablets had been administered; however there remained seven tablets in the boxes instead of three which indicated that this person did not receive their medicine for four days. On another two people's medicine records it showed that all doses of the prescribed medicine had been administered, however one extra tablet was in one box and two were in the other box. They had not received their medicine on one day.

Another person had three medicines to take in the morning. The stock of this medicine received was 28 tablets for each medicine. Records showed that the medicine had been signed by staff as given on 25 days therefore they should have been three tablets in stock. The actual stock of this medicine was seven. Therefore, on four occasions this person did not receive their medicines as prescribed by their doctor.

Some people were on special medicines to prevent their blood from clotting. The effects of this medicine needed to be closely monitored by blood tests. The medicine was prescribed to be given at different doses on different days and adjusted to meet people's specific needs. The medicine record for this special medicine showed that on occasions the medicine record had not been signed. This indicated that people had not received the medicine they needed as prescribed by their doctor which left them at risk of not receiving the treatment they needed to keep them healthy and well.

One person's records showed that on three days an 'S' had been entered on the medicine record denoting that they were asleep at the time of the medicine round. There was no record to show that staff returned to give the person their medicine later, or what action they should take if the person was consistently sleeping at that time, and not taking their medicines, for example, asking the doctor if the medicine could be taken at a different time.

One person needed to have their prescribed medicine on a weekly basis. For two consecutive weeks in

August 2016 this had not been administered. There were blank entries on the medicine records for these dates. This record had been audited and noted the person had not taken their medicine but there was no evidence that any further action had been taken.

The temperature of the medicine storage room was 26 degrees. This was too hot for medicines to be stored safely to ensure that they remained effective. There was no record that the temperature had been recorded regularly. The fridge temperature was at the maximum safe level, there were no records that the temperature had been regularly recorded. This did not ensure the medicine was stored at the correct temperature and remained fit for use.

On the days of the inspection staff were not able to find any references or information about the medicines people were taking that would inform them of the effects, side effects and contraindication of medicines. They had no information about the implications for people if they missed their medicines or what the side effects of some medicines were.

Hand written entries on the medicines records had not always been signed by two members of staff to reduce the risk of errors occurring. The amount of tablets received from the pharmacy had not always been recorded on the medicines records which meant that audits would not be able to identify if people had received their medicines when they needed them.

The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people or supporting people with their behaviour. The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. Staff were not ensuring that people received their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they remained effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had policies and procedures for ensuring that any concerns about people's safety were reported to the relevant outside agencies like the local authority safeguarding team. There were incidences of concern which involved altercations between people. These had been recorded by staff but the management team had not followed procedures by firstly reporting them to the local council safeguarding team who would have discussed the issue and then a decision would have been made on how to proceed. People were not fully protected from abuse as policies and procedures had not been consistently followed to make sure people were safe and protected.

The provider had failed to ensure that people were protected from abuse as appropriate referrals to the local safeguarding authority had not been processed in line with safeguarding protocols. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Checks on equipment such as the regular servicing of hoists, and the servicing of boilers and equipment were in place. Rooms were checked weekly to ensure equipment was working.

The registered manager was implementing an action plan to address the issues raised by the recent fire and rescue service visit which included having the two fire panels linked. Checks on the fire call bells had been recorded and the fire risk assessment was being reviewed.

Systems were in place to evacuate people from the premises and each person had a personal emergency evacuation plan in place. Arrangements were in place in the event of an emergency. The provider had a

business continuity plan in place and an 'on call system', outside of office hours, was in operation. This was covered by the registered manger and deputy manager so that staff could seek further guidance if needed.

The registered manager had implemented a plan of redecoration and repairs. Substantial redecoration, painting had been undertaken and flooring had been replaced. The plan was on going and at the time of the inspection a new wet room was being fitted so that people had easier access to facilities.

Staff were aware of the whistleblowing policy, and knew that some staff had used this in the past and concerns had been raised. The registered manager was familiar with the process to follow in these circumstances and what action needed to be taken to investigate and resolve such issues.

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. The provider's recruitment policy was followed. Application forms were completed and reasons for gaps in employment were discussed at interview. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable. Information had been requested about staff's employment history. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People told us that that they received the care they needed. One person said, "I am happy here and enjoy the food even though the portions are large".

Staff told us there was always training available and they had an annual appraisal to develop their skills.

At the lunch time, staff were attentive but were not always able to respond straight away to people as they were rushing between each lounge to make sure people had the help they needed. The management staff helped people with their meals as there was not enough care staff on duty to make sure people had the support they needed. There were times when the staff were rushed between the three lounges and the garden to make sure people had their meals and to offer people sauces and drinks as they ate their food.

Staff were recording the amount of fluids that people were drinking. There was no guidance for staff on how much people should be drinking and what action they should take if they were not drinking enough. The amount of fluids people drank each day was totalled up but care plans were not clear how staff were to support and encourage people to drink enough to keep them healthy. This was an area for improvement.

People told us the food was good. One person told us they were insulin controlled diabetic and the staff made sure their food was prepared in line with their medical condition. A relative said, "The food is excellent, the meals are very good". "The food is brilliant. There are always lots of fresh vegetables and the meals are well cooked and well presented. There is a choice at every mealtime".

The four weekly menus were on display which showed a varied and balanced choice. Staff knew people's likes and dislikes and their specific dietary needs. People's nutritional needs were assessed in their care plan and any specific dietary needs were recorded. When people needed extra calories to boost their diet, fortified drinks were available and supplements, such as cream and full fat milk were used to enrich food.

Staff sat at the same level as people supporting them to eat, one person was handed their food on a fork and the staff explained that once they did this the person would continue with their meal independently. After this was done for the person they continued to eat their meal. People chose to eat their meal where they wanted, some in the three communal lounges and some chose to eat in the garden.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was

working within the principles of the MCA.

Staff asked people for their consent before they offered support. People's capacity to consent to care and support had been assessed and assessments had been completed with people. The registered manager and staff knew people well and had a good awareness of people's levels of capacity. When people lacked capacity staff followed the principles of the MCA and made sure that any decision was only made in the person's best interests. When a person was unable to make a decision, for example, about medical treatment or any other big decisions, then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest. Everyone got together with people to help decide if some treatment was necessary and in the person's best interest.

If people refused something this was recorded and respected. One person did not want to get dressed. The staff respected the person's wishes. They left them alone and then asked later. Staff told us that they supported people to make decisions by giving them time to understand the situation. Staff were aware that some decisions made on behalf of people who lacked capacity should only be made once a best interest meeting had been held.

Some people were constantly supervised by staff to keep them safe. Because of this, the registered manager had applied to local authorities to grant DoLS authorisations. Applications had been considered, checked and granted for some people ensuring that the constant supervision was lawful. However, in one person's assessment, recommendations had been made by the local authority DoLS assessor. These recommendations had not been implemented in the person's care plan to ensure that the recommendations were being followed.

We recommend the provider ensures that staff follow and support any recommendations made in DoLS authorisations in line with the Mental Capacity Act 2015 Code of Practice and Deprivation of Liberty Safeguard guidance.

Staff used the least restrictive ways to support people. During the inspection people were supported to make day to day decisions, such as, where they wanted to go, what they wanted to do, and what food or drink they wanted.

The provider had a training programme which provided face to face training and on-line training. The registered manager had identified that some staff had not completed the necessary training to make sure they could undertake their roles effectively and safely. Some staff had not completed the training even though it had been emphasised to them that it needed to be completed. The registered manager was addressing this issue with individual members of staff.

The registered manager kept a training record which showed when training had been undertaken and what training needed to be completed. This included details of some courses related directly to people's health and support needs like dementia, challenging behaviours, epilepsy, diabetes and mental capacity and DoLs training. Some staff had not completed these training courses and were unable to explain to us what impact these areas had on people.

New members of staff completed an induction programme which included shadowing more experienced members of staff to get to know people and their routines. Staff told us that they completed an induction and they felt very well supported by the registered manager and staff

A staff member told us, "The induction I am receiving here was much better than previous places I have

worked. Everybody helps me out. I will learn very quickly. They are very good staff and the manager and deputy are supportive". Staff had received supervision and an annual appraisal with their line manages to discuss their training and development.

People told us that the staff looked after their health care needs. One person told us how they were supported by the community nurse on a daily basis. Another person told us how good the staff were when they needed medical attention in an emergency.

A relative said, "The staff always keep me updated with my relative's care and call the doctor if needed. Staff seem to know them very well and notice if they are not well".

Relatives said that staff always contacted them to let them know if their loved one was unwell.
People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. When people had problems eating and drinking they were referred to dieticians. If a person was unwell their doctor was contacted.

Each person had a pressure area care plan to reduce the risk of them developing pressure sores. The plans gave staff guidance of what to look for if people's skin was beginning to become unhealthy. There were instructions to liaise with their doctor or community nurse for further advice.

People were supported to attend appointments with doctors, nurses and other specialists as they needed to see them. Visiting professionals like district nurses went to the service on regular basis and were available for staff if they had any concerns. Relatives told us that the staff responded promptly when their family member needed to see a doctor or to attend any other health related appointments.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were caring, they said, "The staff are very good and cheerful."

Relatives said, "The staff are lovely. I come at different times every day. They are always welcoming". "The care here is excellent". "We are always offered tea or coffee". "I have been to a few homes and the staff here are very caring and attentive. My (relative) gets anything they ask for and the staff anticipate my relative's needs". "My relative used to be a keen gardener so they have a room overlooking the garden. Their room is lovely, it's got all their own things in and it's like home from home except you are not lonely and there is always someone around to chat with". "The staff are brilliant; they are really good at their jobs. The cleaning staff do an excellent job too. There is always good interaction with staff and people who live here".

A health care professional said, "They treat people with privacy and dignity and staff are always polite and respectful". "This is like a home from home, I would recommend the service".

The service was part of the dignity champion national scheme. Dignity champions ensure that everyone is treated with dignity as a basic human right, not an optional extra. The ten point challenge, which describes the values and actions, to provide quality services was on display to ensure people were treated with dignity and respect. However, there was one occasion when a member of staff made a remark which was very disrespectful and did not uphold people's privacy and dignity. In a loud voice, in front of people sitting in the small lounge, a member of staff used an expletive to request a spillage was removed from the floor.

There were other incidents observed in the lounge that were disrespectful. A person living with dementia was undecided about whether they wanted a drink, a staff member impatiently said, "Well do you want it or not"? The person was confused and unsure of what to do. They were comforted by a person sitting next to them. Another person was shouting wanting to know the time but there was no member of staff to respond to them.

People were not consistently being treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Act 2008 (Regulated Activities) Regulations 2014

People had choices about how they wanted to spend their day. One person said, "The staff ask if I am ready to go up to bed, they are often busy and have a lot to do". Another person told us that they chose when they wanted a bath and what clothes to wear. One relative said, "Sometimes my (relative) wants to stay in their dressing gown and that's fine the staff respect their wishes. The staff let them do what they want". Another said, "There are plenty of places to wander around and see different people. People can go where they want to. They get a change of scenery and can talk to different people".

People were supported by their relatives to be involved in planning their care and to make decisions about their daily lives. They were encouraged to remain independent. One person was asked if they wanted to help to make some milk shakes. They went off to the kitchen with the member of staff and made the drinks, then handed out straws and glasses to people. Each person was asked what flavour they would prefer or were

offered other drinks of their choice.

Staff assisted people to go to the bathroom, they encouraged them to walk with their walking aid rather than use the wheelchair. Staff spoke to them respectfully, letting them know they were there if they needed additional support. A second member of staff pushed the wheel chair behind them to reassure the person and to make sure they were as safe as possible.

People's bedrooms were personalised with photographs of people who were important to them and their interests. People's personal space was respected; we observed staff knocking on people's doors before entering.

People's religious beliefs were supported. The service had regular visits from the local church groups and people attended church if they wanted to.

If people needed additional support to make decisions about their care, advocacy services were available. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Staff and relatives told us that visitors were welcome at any time. During our inspection there were relatives who visited. They told us that they visited whenever they wished. Staff were welcoming and polite and spent time updating people about their relatives.

People's care plans and associated risk assessments were stored securely in a locked office to protect confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People and relatives said they were satisfied with the care and support at the service.

A relative told us, "My (relative) is very happy here. We have no complaints. We wouldn't put up with anything if it wasn't right, we would certainly let the management know".

Relatives told us if they had any concerns they were dealt with quickly. They said they would speak to the registered manager if they had any issues and felt confident that they would be 'sorted out'.

A relative said, "My (relative) had a very early hospital appointment. When we arrived the staff had made sure they were all ready to go. They had, had an early breakfast and were waiting for us to arrive. Staff were very busy but they made sure that everything was sorted".
Relatives told us that were involved in planning their relative's care. On relative said, "They talk to me about the care and support my relative needs and they write it down in their care plan".

Care plans included information about people's personal care, moving and handling, history of falls, nutritional needs, skin care, communication, oral hygiene, and medical history. However, in areas such as mobility and behaviour further personalised information was required to ensure people received their care in line with their individual needs.

One person suffered from epilepsy. Their care plan did not say what staff should do if the person did have a seizure and what action they needed to take to make sure the person was safe and receiving appropriate intervention. The care plan did not give guidance for staff on action to take and at what point they would need to contact the emergency services if the seizure went on for too long.

The majority of care plans had been completed when people first came to live at the service and although they had been regularly reviewed the main care plans had not been updated. When people's needs or information had changed this was sometimes only written on the review document and had not been updated in the main care plan. For example, one main care plan was completed in 2014 and parts of the plan had not been updated since then to reflect the person's current needs. This was evident when records showed that one person's relative had passed away and although this was written on the review notes in one part of the care plan, other parts, such as the end of life wishes had not been updated.

One person's mental capacity assessment review sheet had been updated on 12/04/2016 and stated the person's capacity had not changed, but a deprivation of liberty recommendation dated 04/04/2016 had been made. The recommendations stated that this person was at risk of falls and their dementia was having an effect on their balance and co-ordination, therefore, at all times a person should be supported by two members of staff with their mobility. Staff had not been following this practice as the care plan stated and the person was being support by one staff with a stand aid hoist. The registered manager was not aware that a recommendation had been made. The person's care had not been planned to comply with the conditions of the authorisation.

Each person had an activities file that recorded the activities people did on a daily basis and whether they participated, engaged and enjoyed the activities. These files also contained information about people's backgrounds, interests and lifestyles before they needed care and support in a residential care home. They files were personalised and gave a 'picture' of the person. One file recorded, 'X is a loving and maternal person who likes having someone to chat to and hold hands with. X enjoys affection. X loves ballroom dancing'. The files also contained information about how to support people if they became restless and agitated. One file stated, 'The best way to calm X down is to go to a quiet area and gently brush X's hair and stroke her hand'. Care staff told us they did not look at or use this information to support people to make sure they received care in the way that suited them best because they did not have time?.

The provider had not ensured that care plans were person centred, were updated with people's current needs and were planned to include the DoLS recommendations made by the local authority. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Before people came to live at Alexander House the registered manager and deputy manager carried out a pre-admission care needs assessment to ensure that the service would be able to meet their individual needs. People and their relatives were invited to look round the service before making their decision to live there.

The service employed an activities organiser who organised individual and group activities for people. The activities person completed an activities assessment which looked at what people enjoyed doing and what hobbies they had. Activities were then arranged like music, dancing and exercise. On the days of inspection people were supported to look after the plants and hanging baskets. People had 'pamper' sessions and enjoyed singing and gardening

People were enjoying activities of their choice at the time of the inspection. The activities organiser had detailed person centred activity plans in place for each person.

Relatives told us that there had been improvements with social activities. They said that people were doing more activities. They told us about guitarists and musicians who came to the service to entertain people. People had really enjoyed the experience.

The activities organiser supported people to go into the garden to water plants, make milk shakes and took time to chat to individuals as they went about their tasks. There were other planned activities which were flexible for people to enjoy. These included bingo, knitting, singing, listening to music, manicures and hand massages. Outside entertainment such as animal therapy, health exercises and a bowling activity were also provided. The service had hens in the garden and people enjoyed collecting the eggs. People were able to use 'electronic tablets' to keep in touch with family or look at photographs. There was a spacious conservatory, which was bright, clean and well decorated with photographs and pictures on the walls. Tables had been set out with board games and there was a piano in one corner, however it was far too hot to sit in on the day of the inspection and there were no blinds to protect people from the bright sunshine.

People and relatives told us they did not have any complaints but would speak to staff if they had any concerns. Each person had a copy of how to complain in the service user guide which was given to people when they first moved into Alexander House.

There was a written complaints procedure. Any complaints were tracked and monitored by the registered manager to check they had been resolved. People had opportunities to raise any concerns. One person told us that if they had a complaint they would speak to staff or to the registered manager. Staff told us that if

they had any concerns or issues they spoke with the registered manager who listened and then took any necessary action. Documentation showed that all concerns and complaints were recorded, investigated, and were responded to.

One person told us that the only complaint they had was when their washing went missing but this had been resolved quickly and a new system was put in place to reduce the risk of their clothes going missing again.

Inadequate

Is the service well-led?

Our findings

The nominated individual responsible for the service agreed with the shortfalls in the care plans, risk assessments and monitoring charts. They also agreed there was a lack of oversight and scrutiny of the service. (The nominated individual is a person nominated by the organisation who is responsible for supervising the management of the service provided.)

Since the last inspection there had been some staffing issues. The registered manager and deputy manager had been dealing with the staffing issues with support from the provider. The provider agreed that, on reflection, this had taken the managers away from the day to day management of the service.

The nominated individual took immediate action to rectify the issues with medicines and arranged for additional support for the management team to address the shortfalls in the service.

Relatives told us they were satisfied with the care being provided. One relative said, "I think the registered manager is pretty good at their job". "I am overall satisfied with the service".

The provider and registered manager did not have an oversight of the service as people were at risk of not receiving the care, treatment and support that they needed in the safest way. At our last inspection in June 2015 a requirement notice was served for a breach of regulation 12, as the provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people or supporting people with their behaviour. This notice had not been complied with and there was a continuous breach of this regulation.

When incidents of negative behaviour occurred between people living at Alexander House, the registered manager had failed to report this information to the local safeguarding team in line with safeguarding protocols so it could be investigated.

There had been twenty three accidents/incidents in July 2016. Seven of these occurred at night, thirteen in the afternoon/evening and three in the mornings. The registered manager had not analysed these to recognise the rising number of accidents/incidents in the afternoons which might indicate that staffing levels were not sufficient to make sure people were safe.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had not always submitted notifications to CQC in an appropriate and timely manner in line with regulations. The information in the notifications and other reports requested was not always detailed enough for CQC to judge that the service was taking the appropriate action in line with the regulations.

Although regular checks on the service, such as health and safety, accidents/incidents, care plans, and medicines had been carried out, the shortfalls in this report had not been identified. When issues had been

raised there was no evidence how the management team ensured that action had been taken and improvements had been made.

The managers did a 'daily walk around' to check the service. This included updating care plans, and asking people if they were satisfied with the service. On the walk around on 20 July 2016, the form stated 'always record in full what has happened throughout the shift, ensure you update care plans/handover etc'. There was no evidence to show this action had been rechecked by the registered manager to show if staff had improved in this area. At the time of this inspection the care plans had not always been updated to inform staff of people's current needs.

The last quality assurance survey for residents/relatives was carried out in June 2015 and for staff in May 2015. The activities organiser had asked some quality questions to people at their last meeting in May 2016 but this had been a general discussion with no evidence that any further action was taken when comments were made about the service. The management had also encouraged people to complete reviews on their website which were positive but there were no systems in place to analyse and respond to the information gathered including what, if any, actions were needed to improve the service. Other relevant bodies, such as health care professionals and relatives had not been surveyed to gather their views about the service since 2015.

Records were not being completed properly or accurately. Risk assessments did not have full details of how to manage risks and keep people safe. Care plans had not always been updated. Fluid charts were not completed accurately to show that people were receiving the drinks they needed to keep hydrated. There was no information on the charts to indicate what the acceptable level of fluid was for each person and what action staff should take if people were not drinking enough.

The registered manager was aware that people were unable to sit in the conservatory in hot weather as there was no shade. At the previous inspection in June 2015 we were told by the registered manager that blinds had been ordered for the conservatory so that people would be able to use this facility in the summer but these had not been fitted at the time of the inspection.

Staff meetings were carried out separately for each house, as well as general staff meetings. Minutes of the meetings did not show that issues raised had been dealt or followed through to confirm appropriate action had been taken.

The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They had failed to seek and act on feedback from relevant people, on the services provided to continually evaluate and improve the service. Records were not completed or accurately. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were stored securely to ensure people's confidentiality. Staff personal details were kept in locked offices with restricted access, and only senior staff had access to staff files. People's care plans and daily notes were kept in a dedicated office, which was key coded to prevent unauthorised access.

The service had links with the community. They provided 'meals on wheels' to approximately 20 people who lived in the community. They had also formed a friendship with a local charity to encourage and support people with art therapy.

There was a business development plan in place and areas of the service had been redecorated, including

the empty rooms and communal areas. Some furniture in the communal areas had been replaced and the small back garden had improved.

Staff told us the registered manager was approachable and would listen to their concerns. They said, "We work hard to make sure residents are well looked after, we treat them all with dignity". "We treat people like we treat our family". "We are a good home, we do our best".

The registered manager and deputy managers covered on call arrangements at weekends to support staff with any guidance or emergencies.

The provider had displayed the CQC rating from the last inspection in July 2015 on their website. A copy of the report summary was in the entrance hall.

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 had not ensured that care plans were person centred, were updated with people's current needs and were not planned to include the DoLs recommendations made by the local authority

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not being treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people or supporting people with their behaviour.

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 had failed to ensure that people were protected from abuse as appropriate referrals to the local safeguarding authority had not been processed in line with safeguarding protocols.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They registered provider had failed to seek and act on feedback from relevant people, on the services provided to continually evaluate and improve the service. Records were not completed or accurately

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.