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Alexandria's Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 29 December 2016 and was unannounced. Alexandria's Residential Care Home is a care home providing personal care and accommodation for up to 18 older people. There were 14 people living in the service at the time of our inspection, 13 of whom lived with dementia or other cognitive impairment.

There was a new manager in post who had applied to be registered with the Care Quality Commission (CQC) and their application was in progress. A registered manager is a person who has registered with the 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 our last inspection in October 2015, we had identified breaches in regulations and had requested the provider to take action regarding: staffing levels and the quality monitoring systems including records. We also identified shortfalls and had made recommendations in the management of accidents and incidents; the emergency contingency plan; infection control; staff induction, training and supervision; the personalisation of care plans; the involvement of people and staff in the running of the service. At this inspection we checked that remedial actions had been taken and we found that all necessary improvements had been implemented.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures in place which included the checking of references. Staff received essential training, additional training relevant to people's individual needs, and regular one to one supervision sessions.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There was a system in place to assess people's mental capacity and appropriate applications to restrict people's freedom had been submitted to the DoLS office as per legal requirements. The manager had considered the least restrictive options for each individual and was in the process of

submitting more applications.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food. Staff knew about and provided for people's dietary preferences and restrictions.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

Some activities were provided to people that were suitable for people living with dementia. However these were provided by care staff until an activities coordinator could be recruited. The manager had plans to improve the provision of activities at the home. We have made a recommendation about this.

Staff told us they felt supported by the manager and the provider. The manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service.

There was a system of monitoring checks and audits to identify any improvements that needed to be made. The manager acted on the results of these checks to improve the quality of the service and care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to make decisions by staff who sought their consent appropriately. The manager had submitted appropriate applications in regard to the Deprivation of Liberty Safeguards (DoLS) and had considered the least restrictive options.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to. They respected their privacy and dignity.

Appropriate information about the service was provided to people and visitors. Relatives described the way staff and management communicated with people in positive terms.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments.

Activities that were suitable for people who lived with dementia were provided by care staff until an activities coordinator could be recruited.

People and their relatives' views were considered and acted on.

Is the service well-led?

Good

The service was well-led.

Emphasis was placed by the new manager on continuous improvement of the service. The provider and manager had taken remedial action to address the shortfalls that were identified at our last inspection in October 2015.

A system of monitoring checks and audits identified any improvements that needed to be made and action was taken as a result.

The provider and the management team sought feedback from people, their representatives and staff about the overall quality of the service. They welcomed suggestions for improvement and acted on these.

Alexandria's Residential 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 carried out 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 was carried out on 29 December 2016 and was unannounced. The inspection team included two inspectors.

The manager had not received and completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report. Before our inspection we looked at records that were sent to us by the manager and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report.

We looked at eight sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and three staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with nine people who lived in the service and four of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also 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.

We spoke with the manager, four members of care staff, the cook, and one domestic staff. We also spoke with a local authority commissioning officer to obtain feedback about their experience of the service.

At our last inspection in October 2015, we had identified breaches in regulations and judged the service to be 'Requires Improvement'.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "Yes I do feel safe here", "There is always staff around". Relatives told us, "The staff come quickly when they are needed."

When we inspected in October 2015, we found that the provider was in breach of Regulation 18 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not deployed sufficient numbers of suitably qualified, competent, skills and experienced staff to meet people's needs. At this inspection, we found that the manager had increased staffing levels taking into account people's specific needs. There were sufficient numbers of staff on shift to meet people's needs in a safe way. We reviewed rotas for the previous month and saw that the number of staff on shift was appropriate and people's requests for help were responded to without delay. There were three staff members on shift and this meant that it was possible to meet people's needs. Some people preferred to spend time in their rooms rather than coming into the living area. Staff regularly checked on them and ensured that support was provided when they needed it.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were able to identify different forms of abuse and were clear about their responsibility to report suspected abuse. 75% of care staff had received specific training in the safeguarding of vulnerable adults and 25% were scheduled to receive this training shortly. The manager had a current copy of the local authority multi-agency safeguarding procedures and they understood their responsibilities for reporting concerns. Staff were aware of the whistleblowing procedure in place within the home and they expressed confidence that the culture in the home supported staff to speak up if they had any concerns. Staff we spoke with expressed the view that the manager would take action if concerns were reported to them.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. Checks relevant to the environment such as legionella testing, servicing of the lifts, appliances and fire protection equipment were carried out by an external contractor. Portable electrical appliances were checked to ensure they were safe to use. There was a range of environmental risk assessments that had been completed to ensure that staff were aware of the steps they needed to take to keep people safe. Repairs were undertaken in a timely manner and staff confirmed that they were able to get equipment repaired as and when required.

Systems were in place to ensure that they service was secure and visitors signed in on entry into the home. There were alarms on the doors to alert staff if people left the home in case it would not be safe for them to do so. We saw that one person tried to leave the home through the conservatory door. The alarm sounded and a staff member came to wait by the door for the person to come back in again. Staff were aware of the need to ensure that people were safe by knowing where they were within the home.

When we last inspected in October 2015, we had recommended an emergency contingency plan to be established in the event of the service becoming unsafe or unusable. The provider had taken remedial action. There were detailed plans in place concerning how the service would manage an emergency. People

had individual personal emergency evacuation plans in place that detailed the level of assistance they would require if it was necessary to evacuate the home. These plans were updated regularly and were included in the 'grab bag' by the door. This meant that information was available for staff in case of an emergency. Staff had received appropriate training in fire safety and they were familiar with the steps to be taken in case of a fire. There was appropriate signage to show where the fire exits and fire equipment was within the home. Regular checks on fire equipment were carried out and there was a fire risk assessment that had been completed by an external contractor.

When we last inspected in October 2015, we had recommended the implementation of an effective system to for identifying and responding to risk trends regarding accidents and incidents. The provider had taken remedial action. At this inspection we found that accidents and incidents were being appropriately monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. The manager reviewed all accidents and documented what actions they had taken. For example, one person had experienced a fall that meant they had been admitted into hospital and the manager had documented their contact with the local authority to inform them of this event; another two people had experienced a fall and the manager had analysed the circumstances of the falls to establish any possible common factors and minimise future risks.

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. There were specific risk assessments in place for people who were at risk of falls, of malnutrition or at risk of skin damage. Each risk assessment included clear measures for staff about how to keep people as safe as possible, taking into account people's individual circumstances and preferences. Staff applied these measures in practice, such as checking people hourly at night, providing fortified drinks, and for repositioning a person in bed. Staff helped people move around safely and checked that people had the equipment and aids they needed within easy reach.

Medicines were managed safely in the home and people received their medicines as prescribed. There was a system in place for managing medicines and appropriate levels of stock were kept within the home. An audit trail was maintained and this meant it was possible to account for all of the medicines that had been received into the home. Staff signed the medicines administration records (MAR) appropriately to document administration. When PRN (as and when required) medicines were administrated, staff completed notes to document why the medicines were administered. Medicines were regularly audited by the home's manager to ensure that medicines were managed appropriately in the home. Staff who administered medicines had received training to provide them with the skills and knowledge they need to do this safely. The manager checked that staff were able to administer medicines safely by observing them and asking about their understanding of the process for administering medicines.

Medicines were appropriately stored and medicines that required refrigeration were kept in a dedicated fridge. The temperature of the fridge and the room in which the medicines were stored were monitored to ensure that they stayed within range. The medicines trolley was secured to the wall in the treatment room when not in use. Controlled drugs were appropriately stored and regular checks were made to ensure that they were accounted for and any discrepancies would be identified in a timely manner.

The home was clean, tidy and well presented. A housekeeper was employed and they maintained cleaning schedules to ensure that all areas of the home were regularly cleaned. There were suitable laundry facilities available including an industrial washing machine with a sluice cycle. Laundry was segregated and soiled items were cleaned at the required high temperature. Staff were observed using personal protective equipment (PPE) as and when it was appropriate. When we last inspected in October 2015, we had

recommended that areas in the bathrooms and laundry floorings be sealed to ensure they could be cleaned effectively. The provider had taken action. These floorings had been sealed, however a bathroom floor had not been sealed properly. We discussed this with the manager who scheduled for the job to be re-done without delay.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started in their service until it had been established they were suitable. Staff members had provided proof of their identity and right to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. People and their relatives could be assured that staff were of good character and fit to carry out their duties. Although there were no staff members currently being managed under disciplinary procedures, there was a policy in place which the manager would follow if necessary.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "They [staff] are good, they look after us well", "The food is good", "They take care of my leg, they're good." A relative told us, "The staff seem to be efficient, we have no complaints."

When we last inspected in October 2015, we had recommended that the arrangements for staff training and supervision to be reviewed. The provider had taken remedial action. Staff received essential training to enable them to carry out their roles effectively. New staff received a thorough induction that incorporated the Care Certificate during the first twelve weeks. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Essential training was provided that included dementia care, mental capacity and Deprivation of Liberty Safeguards (DoLS), safeguarding, infection control and manual handling. More training in dementia care was scheduled to take place. One care staff had received enhanced training in dementia care and was a dementia champion. Staff approached the dementia champion when they needed specific guidance.

There was a system in place to record and monitor staff training and highlight when refresher courses were due. Staff were reminded to attend scheduled refresher courses. Staff received quarterly one to one supervision sessions to discuss any difficulties they may have and identify any additional training needs. They were encouraged to gain qualifications and 70% of care staff had gained or were studying for a diploma in social care. The cook was completing further vocational qualifications and told us they felt well supported in their role. A member of staff told us, "We get good support we only have to ask." Staff were scheduled for an annual appraisal of their performance. The manager had carried out observations of staff practice and competency checks after staff had completed training in medicines administration.

The manager and care staff used a two-way communication book and referred to it several times a day. There was an effective system of communication between staff to ensure continuity of care. Staff handed over information about people's care to the staff on the next shift twice a day. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. The handovers we witnessed provided clear information about a person who was appearing unwell, and of the actions that had been taken as a result. Follow up action was taken from one staff shift to another.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were trained in the principles of the MCA and the DoLS and were able to tell us of the main principles of the MCA. There was a system in place to assess people's mental capacity and this process had been followed in regard to DoLS. The manager told us there had not been other cause to assess people's mental capacity to date. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The manager had considered the least restrictive options for each individual and was in the process of submitting more applications.

Staff sought consent from people before they helped them move around, before they helped them with personal care and with eating their meals. A relative told us, "They always are very polite, they don't take it for granted and they ask before they help my mum." A member of staff asked a person who had sneezed if they would object to being helped. The help was provided only when the person had consented.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. People's families or legal representatives were contacted in advance of reviews and invited to participate. They had been requested to sign on people's behalf when appropriate. There was a key workers scheme in place and the relatives we spoke with knew who their loved ones' key worker was. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need.

People told us they enjoyed the food they had and told us they were very satisfied with the standards of meals. They told us, "The food is always good" and, "I am happy with the meals, no doubt." A relative had written a comment, "Excellent food; Mum is gaining weight." Several people had their breakfast late in the morning as they preferred, and cooked breakfasts were available when requested. We observed lunch being served in the dining area and in people's bedrooms. The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were offered a choice of two main courses and of alternatives. At lunch time, the cook was preparing a range of different meals according to the needs and preferences of the people who lived at the home. Appropriate records were maintained in relation to the safe storage and preparation of food within the home. The cook confirmed that they had a sufficient budget at their disposal to provide people who lived at the home with healthy and nutritious food that suited their tastes. They told us that the people who lived at the home preferred 'old fashioned' types of food such as shepherd's pie and fish and chips. People were consulted about their preferred food at monthly residents' meetings and their wishes were reflected in the menus that were prepared. Staff presented people were with options regarding their evening meal. A lighter cooked meal was served at supper time and people were served a selection of refreshments, hot drinks and home-made cakes or biscuits several times a day. People were offered a glass of wine with their meal or sherry in the evening.

People were weighed monthly or weekly when there were concerns about their health or appetite. Two people's food and fluid intake was appropriately recorded and monitored. When fluctuations of weight were noted, people were referred to the GP or a speech and language therapist (SALT) when necessary, and their recommendations were followed in practice, such as providing them with thickened fluids, cutting food in small manageable portions or helping them sit in a particular position when eating.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with a local GP surgery. A chiropodist visited every six weeks to provide treatment for people who wished it. An optician service visited yearly or sooner when needed. People were offered routine vaccination against influenza when they had consented to this. When people had become

unwell, they had been promptly referred to healthcare professionals. For example, to a GP, a dietician, a tissue viability nurse or to a mental health team. Four people had been referred to district nurses when they had swollen legs or ulcers. The district nurses provided guidance to staff with clinical issues and their recommendations were followed in practice.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "All the staff are very kind" and, "I can't fault them, very nice people." Written compliments from relatives included, "The care is excellent", "The staff are helpful at all times and always ready to help" and, "I am very grateful for all the help and support from all the staff and management for myself and mum; for looking after her wellbeing and dignity with very good care." Members of staff told us, "'There's a family feeling here", "I would want my family member to be cared for here" and, "It's really caring and people get the care they deserve."

Visitors were welcome and were warmly greeted by staff. The manager had requested visitors to schedule their visits outside mealtimes, so that people and staff could concentrate on food intake and encourage people with small appetite. People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay.

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. There were people who lived at the home living with dementia who sometimes became distressed if they became confused. We saw that one person became distressed later in the day during our inspection. Staff supported this person by acknowledging their feelings and then helped them to engage in an activity to provide distraction and lessen their distress. This was effective and the person appeared to respond positively to the sympathetic approach that was taken by the staff supporting them. A person cuddled a doll and staff helped them place the doll gently in a pram. The member of staff told us, "This is comforting for this resident to see the doll is handled gently, we all know how important it is for her." Another person had complained of pain and staff spent time with them to calm them down and distract them from their pain after having administered pain relieving medicine. We heard staff interacting with people in their bedrooms and found that all staff were attentive, respectful and patient.

People were assisted discreetly with their personal care and bathing needs in a way that respected their dignity. Staff closed doors while helping people with personal care; a member of staff encouraged a person to close the door when they used a toilet facility. A person told us, "They cover me in between washes and getting dressed." People could have as many baths as they liked and a relative we spoke with confirmed this. People's privacy was respected as people were given the choice to have their bedroom doors open or closed; staff knocked on people's doors and waited before entering. People's records were kept securely to maintain confidentiality.

Staff knew how to communicate with each person. Staff were lowering their position so people who were seated could see them at eye level. They used people's correct and preferred names, spoke clearly and smiled to engage people who smiled in return. Staff noted people's body language when they were not able to communicate verbally and understood individual signs of distress. When people had hearing impairment, their communication care plans indicated how best to talk with them and be understood. A person's care plan in communication included instructions to staff to ensure their hearing aids were in place, and that

they were functioning before conversing with them. We observed staff following these instructions in practice.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people in the home were well presented with comfortable clothing and footwear. People part-washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, remain in their bedrooms, or stay in bed. A person had chosen not to shave and this was respected. At mealtimes and during activities, people chose where they liked to sit. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence.

Clear information about the service and its facilities was provided to people and their relatives. People were provided with a leaflet titled, 'Welcome to our Home', and with a comprehensive 'Service User's guide. The guide was comprehensive and provided information about every aspect of the service included how to complain. This information was available in large print to help people with visual impairment. It stated that staff assistance was available to explain the guide if this was required. The name of each person's key workers was displayed on the back of each bedroom door. Photographs of people, or images of their choosing, were displayed on bedroom doors to help people if they had difficulties orientating themselves in the home. A person had chosen photographs of their favourite dogs to identify their bedroom. Menus were offered in a pictorial format when necessary, to help people make their choice.

People could be confident that best practice would be maintained for their end of life care. The home had a policy in place to provide guidance for staff concerning how to care for someone who was at the end of their life. This included the information that 'visitors should be encouraged to spend as much time as they want with the dying person'. There was also detailed information concerning what should happen if a person did not have relatives or visitors. The policy noted 'As the time of death becomes imminent, should there be no visitor present a willing member of staff will be asked to stay with the person in our care to give them comfort in their last hours'. When people had expressed their wish regarding resuscitation, this was appropriately recorded.

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When appropriate, people were invited to take part in 'advance care plans' (ACP) and were supported by staff during the process. The manager was in process of completing these plans with people and their families. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. The home was well supported by a local hospice palliative care specialists who offered guidance when needed.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their needs. They told us, "They [staff] know me" and, "They help me." A relative told us, "Mum settled in straight away; she is happy and this is my main concern" and, "The staff watch over the residents, they go to my mum when she needs them, they got to know her well." A relative had written a comment, "The staff are very helpful at all times, always ready to help."

When we last inspected in October 2015, we had recommended that care plans be personalised to reflect their preferences; that the provider involve people and staff with the running of the home taking account of their suggestions. The provider had taken remedial action. People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments gave a clear account of people's needs in relation to their medicines, communication, nutrition, continence, skin integrity and mobility. They were person-centred and noted people's family history, their interests and special requirements about end of life care when people wished to talk about this. The manager had selected a new care plan format and had ensured that each person in the home had a new and updated care plan that reflected their likes, dislikes, life history and preferences. Care plans included details such as how many pillows people preferred; when they liked to get up and go to bed; their favourite food and hot beverages, the type of music and activities they enjoyed. Staff we spoke with were aware of people's care plans and were able to describe people's individual preferences.

People's care plans reflected their current needs as these were reviewed and updated appropriately. Staff sat with people to involve them during the reviews of their care, when they were able and willing to contribute. A relative confirmed to us that they were invited to participate in the regular reviews of their loved ones' care plan.

Staff were vigilant about people's needs and responded to any changes. One person chose to remain in bed all day and night and appeared low in mood. The manager had alerted their GP and their local authority case manager requesting a re-assessment of their psychological and medical needs. Another person had been referred to their GP as their appetite had reduced over a couple of days, and had informed their next of kin. When a person had come back to the home following a period of hospitalisation, the manager had sourced and provided a recliner chair for them, to enable them to keep their legs elevated. One person preferred to sleep in the lounge and this choice had been accommodated.

Each person living in the home had two key workers allocated to them. The key workers ensured that people had what they needed, such as toiletries and clothing, and established a link between families and the manager when necessary. A relative told us, I know which keyworker to talk to if we have any problems, in case the manager is not in the house.

Some activities were provided to people that were suitable for people living with dementia. Since our last inspection, the provider had employed an activities coordinator however they had left the service and care staff had taken over the role until the post could be filled. Staff presented people with options of daily

activities, such as puzzles, quizzes, reminiscence games, film afternoons, singing, pampering, art and crafts and a themed party had been held at Halloween and Christmas. They told us, "We try to always give choice and sometimes it changes and some people can make choices some days and not others but you always try". They were able to describe the preferred activities of individual people and they knew which people enjoyed singing and having music on. Some people preferred their own company and staff respected their wishes. However, as only one care staff was available to provide activities, they were unable to engage all the people living in the home. On the day of our inspection, they provided activities to a group of seven people, and other people were not kept occupied during the day. A member of staff told us, "The activities are resident-led, we look at their care plan and offer options to them based on their interests; the problem is, they [people] often decline, maybe because they are confused. I am sure we could do more and better, if we had specialised training; it will be good to have a proper activities coordinator to engage with residents more and take the lead."

The manager had plans to improve the provision of activities at the home. They had sourced specialist guidance concerning activities for people with dementia through an organisation that provides practical tools and support to help adult social care organisations recruit, develop and lead their workforce. They told us, "This is a work in progress, we are actively recruiting so that outings can be organised, and in the meantime we make sure people are not bored; there is an activity going on every day; a singer and musician come once a week and we are in the process of increasing this because the residents really enjoy this and singing along." We recommend that activities that are suitable for older people including those who live with dementia are provided by staff who have received appropriate training, to provide a varied programme of outings and daily activities to stimulate people's mind and interests.

The manager sought and obtained feedback from people and their relatives about all aspects of the service. They had scheduled quarterly 'Residents meetings' that were appropriately documented. At these meetings, people were encouraged to voice their opinion about the food, the staff, the activities, their room and their environment. People had expressed the wish to 'go out more'; as a result, the manager had organised a barbeque outside and had requested relatives to take their loved ones out whenever possible. The manager told us, "Once we get an activities coordinator we will be able to organise outings in small groups." One person who had wished not to participate in the 'Residents meeting' as they preferred to remain in their room had been visited by the manager in their room to provide their feedback. They had expressed the wish to have a regular visitor to come and chat with them and as a result, the manager had approached a volunteer organisation to provide a weekly visit. At each review of their care plan, keyworkers sat with people and involved them in the reviews, gathering their feedback about their experience of living in the service and reporting to the manager.

A satisfaction survey was in progress as the manager had sent questionnaires to people's relatives. They were asked questions about whether they felt welcome in the home and sufficiently informed and involved; about their impressions about safety in the home, privacy, the staff, the food and the manager. Eleven relatives had responded at the time of our inspection and their feedback was positive although one had commented, "The activities could do with being more enriching." The manager was auditing the results to identify whether any improvements could be made in the home, and had explained to the relative that a vacancy for an activities coordinator was being advertised. Another relative had commented, "The overall care has improved over the last six months."

Quarterly staff meetings were scheduled to take place and the last one had been held in December 2016, at which staff had been invited to contribute with any feedback and suggestions about the running of the home. Staff had discussed their wish to have new uniforms and as a result new uniforms had been ordered. These meetings were complemented with ad-hoc meetings to discuss any concerns about people's

individual needs. A staff satisfaction survey was scheduled in January 2017.

People we spoke with were aware of how to make a complaint. One person told us, "If I have to complain I just speak to any of the staff and my son would speak to the owner if things don't get done." A relative knew that the complaint procedure was outlined in the 'Service User's Guide' and displayed in the home. No complaint had been sent to and received by the manager since they were in post. The manager told us, "Any complaint we would receive would be investigated and responded to in line with the provider's policies and procedures."

Good

Is the service well-led?

Our findings

People, relatives and staff were complimentary about the management team. A person told us, "It is well managed, the staff know what they are supposed to do, the manager is nice and the owner is often here." Relatives' comments included, "The home's really on the up since the manager took over", "You run a tight ship, and a good one", "Residents are the manager's first priority", "The manager has made positive changes" and, "Long may she stay." A local authority Commissioning Officer told us, "The manager is very open and honest and has been fundamental in improving the service."

The manager had been in post since February 2016 and was in the process of being registered by the Care Quality Commission. They told us, "I look forward to driving more improvements in this home; the staff are dedicated and the owner is committed and supportive." They spoke to us about their philosophy of care, referring to the 'Mum's test' telling us, "I tell the staff to treat residents as they would their own family and we all aim to make the home a place where we would be happy to see our own parents cared for, here." The provider was actively seeking to recruit a deputy manager to support the manager with the day to day running of the home.

Staff were positive about the support they received from the manager and the provider. They reported that they could approach the manager or the provider with concerns and that they were confident that they would be supported, saying, "The manager sorts out problems straight away so there is no build-up; the owner is often here and also very approachable." Staff described the new manager as, "firm and a good leader", "approachable" and, "operating an open door policy."

When we inspected in October 2015, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records had not been consistently maintained, such as staff files, people's care plans, staff training records and monitoring records. The provider had taken remedial action. At this inspection we found that these records had been appropriately reviewed, updated and maintained.

The manager had made many improvements in the service, such as introducing a resident of the day scheme. The scheme meant that on a scheduled day in the month, a particular resident was visited by their keyworker, the cook, the domestic staff and the manager to seek their feedback, ensure their care plan was personalised, reviewed and updated; check their environment and that they had all that they needed. The manager had written new care plans for each person living in the home; set up a new training programme and developed a staff induction to include the Care Certificate; scheduled staff supervision and staff meetings; created new policies and procedures for the home; introduced a new system to monitor the maintenance of the premises; carried out and scheduled satisfaction surveys, and had installed a 'grab bag' by the exit that contained vital information in the case of an emergency. They had also enlisted the services of a more local pharmacy provider, thus speeding up processes relevant to people's medicines. Since the manager had been in post, the provider had purchased an activities board, new chairs in the lounge, new kitchen appliances, a new bench for the garden and replaced four floorings and work surfaces in the kitchen. New staff uniforms and badges had been ordered.

There was a system in place to monitor the quality of the service and drive improvements. The manager had established a system to regularly gather the views of people, their relatives and staff, analyse the results and act on implementing any improvements that may be identified. Audits in infection control were carried out twice a year. Every two months, audits were carried out in regard to people's care plans, medicines, the environment, and health and safety. One audit of the kitchen had highlighted a shortfall in food labelling and as a result this had been remedied; one audit in medicines had shown gaps and an error in the recording of medicines and as a result a member of staff had been provided with additional supervision. As a result of an audit in health and safety, three emergency lights had been replaced and the first aiders list had been displayed. When an audit had identified a shortfall, the manager checked that an action plan was set up, and monitored the plan until completion.

The manager completed a twice yearly 'pre-inspection report' on all aspects of the home and reported their findings to the provider. Their reports were based on the regulations of the Health and Social Care Act 2008 and determined whether the home was compliant with these regulations in preparation for any inspection from the CQC. The last report dated December 2016 which was used as an improvement plan by the manager included the monitoring of the recruitment of an activities coordinator and their intent to request the provider to implement a conversion of two bathrooms. The manager participated in twice yearly local providers' forums, to discuss policies, procedures and practice. They were fully aware of updates in legislation that affected the service and had sought guidance from an organisation that provides practical tools and support to help adult social care organisations recruit, develop and lead their workforce.

The manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The service's policies and operating procedures were fully accessible to staff for guidance and appropriate for the type of service. Records were kept securely and confidentially. They were archived and disposed as per legal requirements.