Hill Care 1 Limited

Alderwood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Alderwood on 23 and 24 January 2017. This was in response to concerns we had received regarding the management of medicines.

The home was last inspected on 05 March 2015 when the service was rated as good overall in four of the key lines of enquiry (safe, caring, responsive and well-led). The service was rated as requires improvement in effective and a recommendation was made in regards to the environment.

Alderwood is a care home in the Worsley area of Salford, Greater Manchester and is owned by Hill Care 1 Limited . The home is registered with the Care Quality Commission (CQC) to provide residential care for up to 39 people. There were 31 people living at the home at the time of the inspection.

At the time of our inspection, there was no registered manager in post. The home had a manager that had commenced in post 03 January 2017. The home manager had applied to the Care Quality Commission (CQC) to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care and meeting people's nutrition and hydration needs. We also made two recommendations regarding staffing and equipment. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe living at the home.

We found medicines were managed safely. Prior to conducting the inspection, we had received information of concern regarding the management of medicines. We found the issues had been as a result of external factors that had been resolved at the time of the inspection.

We received negative feedback from people living at the home and their visitors regarding staffing levels at the home. A formal dependency tool was used to determine staffing numbers but we observed people were left for periods of time and we have made a recommendation with regards to staffing levels in the detailed findings of this report.

The provider had suitable safeguarding procedures in place and staff were able to demonstrate they knew how to safeguard people and were aware of their roles, responsibilities and the alert process. Appropriate employment checks had been conducted before new staff commenced employment in the home, to make sure as far as possible that they were of suitable character to work with vulnerable people.

The service had a training matrix to monitor the training requirements of staff. Staff received appropriate training, supervision and appraisal to support them in their role.

People were supported in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We received poor reviews from people regarding the food choices offered and we saw instances were people's preferences were not met. People's hydration and nutrition needs were appropriately assessed but the provider could not consistently demonstrate that people's needs were being met as the records didn't demonstrate this and the person had not gained weight.

We observed people living at the home were living with sensory impairment, memory issues or living with dementia. In consultation with people, dementia friendly resources and minor adaptations had been made to support people's orientation around the home.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who lived at the home. Staff treated people with kindness and respect. People's privacy and dignity was maintained and we observed people's independence was promoted.

We looked at five care files which contained detailed information about people living at the home and how they wished to be cared for. Each file contained detailed care plans and risk assessments but people told us they did not feel involved in planning their care, people expressed not knowing what a care plan was and we found the care plans we looked at had not been consistently reviewed in line with requirements.

There was an activities coordinator in post but they were observed to be working in isolation which meant momentum was lost during activities and we saw people become disinterested as a result of frequent interruptions.

People and their visitors knew how to make a complaint. They told us they were confident in the manager and we saw complaints had been resolved in the required timeframes. The staff had also received compliments regarding the care and support provided to people and their relatives.

The provider had effective procedures in place to measure the quality of the care received. It was evident that areas identified had been addressed and there was a clear audit trail of actions implemented.

The management were honest and transparent throughout the inspection and acknowledged that further progress was required. The management demonstrated a commitment to address the issues identified in a planned and structured way.

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

We received negative feedback regarding staffing levels and the use of agency staff at the home but saw the latter had been addressed. We made a recommendation to review staffing levels.

Processes had been implemented to ensure people's medicines were managed safely.

Staff were trained in safeguarding procedures and knew how to report concerns.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People had mixed opinion about the quality of the food and whether they were provided sufficient choices.

Staff received a comprehensive induction and had access to a range of training to support them in their role. Supervision was conducted regularly and staff received an annual appraisal of their work.

The service was working within the requirements of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring

The people we spoke with told us they received good care.

People were treated with kindness, care and respect by staff who promoted their independence.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

We looked at care plans to see what support people needed and how this was recorded. We saw most care plans were personalised but people told us they didn't know what a care plan was. We saw that care plans were not always reviewed on a regular basis.

The arrangements for social activities were adequate. There was an activity co-ordinator who provided group activities and outings each week.

A complaints procedure was in place and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

We found breaches of the regulations and there was no registered manager in post.

The manager promoted an open culture and they were visible and accessible to people, their relatives and the staff.

Senior management visited the home on a regular basis to undertake quality monitoring. There were effective systems in place to monitor improve the quality of the service.

Alderwood Care Home

Detailed findings

Background to this inspection

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

This inspection took place on Monday 23 and Tuesday 24 January 2017 and was unannounced. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports and safeguarding incidents. We also contacted any relevant stakeholders from Salford City Council which included safeguarding and the commissioning team.

During the inspection we spoke with people and viewed care records and documentation in order to help inform our inspection judgements. This included speaking with seven people that lived at the home, four visitors and one health professional. We spoke with the regional manager, current home manager, senior manager, three care staff, activities coordinator and chef. Records looked at included five care files, eight medication administration records (MAR), six staff personnel files, training records, building checks and any relevant quality assurance documentation.

We observed care and interactions in the communal areas which included the lounges and dining room. We also looked in people's bedrooms accompanied by the home manager and looked at bathrooms, toilets and the kitchen facilities.

Good

Is the service safe?

Our findings

During the inspection we asked people who used the service if they felt safe living at the home. Without exception, all the people we spoke to told us they felt safe. A person told us; "There is always someone about to help me If I need assistance." A second person said; "You can have a key to your room if you like, I don't bother but other people feel safe being locked in. Our rooms are locked when we are not in them, some of the residents wander into other people's bedroom if they are not locked." A third person said; "There is always people about. I have a buzzer if I need help. I can't go outside on my own. I go to a knitting group on a Thursday at the community centre next door a member of staff takes me. That makes me feel safe."

We looked at the procedure for managing medicines within the home. Prior to conducting our inspection, we had received information of concern that medicines were not being managed safely. The issues raised had been in relation to prescribed medicines running out and not being available when people needed them.

We looked at the previous three months medication administration records for eight people. We saw people's allergy status and whether the person had capacity to consent to their treatment was recorded. Risks were identified on the MAR. For example, if the person had dysphagia and was at risk of choking. The record also contained the person's picture to reduce the risk of medicines being given to the wrong person and documented how people liked to take their medicines and any support they may require.

We saw arrangements were in place to ensure medicines to be administered before or after food were given at the correct time. We noted two people had refused to have their medicines earlier but they were deemed to have capacity and their GP had been informed of their decision. Where people received variable dose medicines or medicines on set days each week, we found these medicines had been administered as required.

We saw 'when needed' (PRN) medicines were supported by a PRN protocol form which contained written instructions detailing the medicine, dose, minimum time between doses, the maximum dose that could be given within 24 hours and the reason for administration. We saw staff made a medication note on the the reverse of the MAR when PRN had been administered. This recorded the date, time, dose, reason for administration and whether the PRN had been effective.

We looked at the system in place for ordering medicines to ensure there was sufficient supply to administer medicines safely. We found there had been issues encountered with the supply of medicines to the home but the management were able to demonstrate how they had worked proactively with the clinical commissioning group (CCG), GP and the pharmacy to resolve this. We found the issues had been as a result of external factors outside the provider, management and staff's control and was not as a result of the ordering systems within the home. We were satisfied that this had been resolved at the time of the inspection and that the management had done everything feasible to bring a prompt resolution to the issue.

There was an appropriate safeguarding policy and procedure in place. Staff were able to describe the service process and the local authority protocols. All the staff spoken with were able to describe types of abuse and the procedure to follow if they had a concern for a person's welfare. A staff member told us; "I've had training to think of when working with vulnerable adults. Safeguarding could be; monetary, physical, verbal, withholding medication or food. It could involve not supporting people's personal care. I would go straight to my manager. I could go to social services and CQC if necessary.

People were protected against the risks of abuse because the service had a robust recruitment procedure in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection, we looked at six staff personnel files. Each file contained a job description, application form, interview questions, and a minimum of two references and evidence of a DBS (Disclosure Barring Service) check being undertaken. This helped to keep people safe and ensure appropriate recruitments decisions were made when employing staff to work with vulnerable adults.

On the day of the inspection there was the home manager, two senior and three care staff on duty. We were told this was the ratio of staff on duty daily at the present time as staffing was based on people's dependency to calculate the required care staff.

We reviewed the homes staff rotas between the period of 26 December 2016 and 22 January 2017. We found the number of staff required was provided but prior to the inspection the home had relied upon the use of agency staff frequently to achieve the required numbers. The management and staff confirmed that recent recruitment had addressed the staffing deficit in order to reduce agency use and establish a consistent staff team.

Although staffing was confirmed to be calculated based on people's dependency, during the inspection, we observed little flexibility in the staffing compliment to meet people's individual needs and preferences. This was further corroborated by the negative feedback received from people and their relatives regarding staffing levels at the home.

People we spoke with and most of the visitors we spoke with thought that there was insufficient staff on duty to meet people's needs. One person told us; "No there's not enough staff. There is a lot of agency staff who just stand about. We have to tell them every single thing. We pay a lot of money to be here we should get a better service. They (Agency staff) make you feel a nuisance. I have heard other residents saying, sorry to bother you. Sometimes people who can't go to the toilet themselves have to wait a long time for assistance, some of them do it in their pad, and then they get upset." A second person said; "They are always short staffed. They get a lot of agency staff who just stand around the usual staff are run off their feet." A third person told us; "No not always enough staff, I get very upset when I have to wait especially for the toilet."

A relative told us; "No, I don't feel there is enough staff, especially at night. Last Saturday we were here at 10pm and there were only three staff putting people to bed. People were just left alone in the lounge on their own."

A staff member said; "There are odd occasions when we need agency staff. It's improving though as some new starters. Most days we have five staff on and that's fine." A second member of staff said; "Five is enough when it's regular staff. It's not if one of the staff is agency because they don't know people's needs. It depends who's on and the dependency of the people at that time as to how many staff are needed."

We recommend that the service re-evaluates the current dependency tool, to ensure there are sufficient and

consistent numbers of staff available, to safely and responsively meet the care needs of people living at the home.

People's care records contained identified areas of risk. Risk assessments were in place for bed rails, falls, manual handling, mobility, nutrition, personal care, waterlow, continence and fire. All expected risk assessments were in place and reviewed timely in line with people's care plans. We saw where risks had been identified, there was a detailed care plan identifying what action had been taken to mitigate the risk. For example, a person that was identified as being at high risk of falls was supported by two carers for all transfers, their nurse call was always to be in their reach, staff completed hourly observations and the person had a pressure mat transmitter next to their bed. These mats trigger an alarm if the person starts to get out of bed so staff can offer assistance. This meant staff were identifying risks to individuals and taking action to reduce those risks.

We saw each person living at the home had their own PEEP (Personal Emergency Evacuation Plan) in place which provided staff and emergency services with all the appropriate details about how to evacuate people from the building safely in the event of an emergency.

When an accident or incident had occurred, these were investigated and preventative measures had been put in place to keep people safe. We saw the manager completed an accidents and incidents analysis to ascertain trends and put things in place to reduce the risk of the incident re-occurring. For example, one month the manager had concluded a high infection status amongst people was contributing to the number of accidents. We saw referrals to the GP, occupational therapists and falls team had been completed.

We looked at the service's health and safety file. All certificates and records for issues such as gas safety, lift, legionella testing, nurse call bell, dishwasher, laundry, and electrical installations were up to date. The heating was an eco-heating system but we found it was cold in certain areas of the home. We saw daily temperature checks had been completed by the maintenance engineer since November 2016. We raised our concern with management that certain areas of the home felt cold. The regional manager requested the maintenance engineer check each bedroom and room within the home again and requested kitchen staff close the exterior door as they felt this was contributing to the reduction in temperature in that area of the home.

The management had conducted a risk assessment and installed oil radiators in rooms where people had expressed feeling cold so that there was an additional heat source. Although we saw a risk assessment had been conducted, we recommend maintenance and the provider continue to keep the oil radiators under review to satisfy themselves that risks are not posed to people living at the home with these radiators in use.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home told us they were dissatisfied with the variety of food on offer at the home. A person told us; "We are never offered a cooked breakfast only cereal and toast every day. If you ask for an egg they think you have gone mad." A second person said; "I am having an omelette today, I am only getting it because you are here. I have asked for one in the past and been refused."

We looked at the person's daily food records and ascertained this was not the first occasion they had received an omelette when requested. We also saw there was an all-day breakfast option as a meal choice on the two weekly menus.

However, we observed the mealtime experience at both breakfast and lunch and found people's preferences and choices were not appropriately met. We saw a person that didn't like orange was accommodated with a glass of blackcurrant but there was inflexibility in the meal option. We observed people were offered porridge, weetabix, cornflakes, rice crispies or toast with jam and marmalade. We heard a person tell a staff member they fancied something different and the person mentioned sausage and eggs. The staff member responded by saying or a "cooked breakfast" which the person indicated that they would like. The staff member looked uncomfortable and laughed this off persuading the person to have "a lovely piece of toast with jam."

At the time of the inspection there was a two week menu in place that people told us had been devised by management. We found the menu was repetitive and the evening meal was sandwiches and home made soup every day. We saw the sandwiches were pre-made during the course of the day and cling filmed in the fridge ready for the evening meal. We were told by the regional manager that menu's had been discussed at the residents meeting held on 29 December 2016 and people living at the home had been consulted about what they wanted on the menus. We were told people had been having taster dishes to trial the new menus and that there were plans to implement the new menus following the inspection.

People told us they had expressed a preference to eat in their bedrooms but said this wasn't accommodated and they were required to eat in the dining room. We observed staff were persistent in waking a person up that had fallen asleep in the coffee room to go to the dining room for their dinner. Initially it had just been one member of staff attempting to wake the person but they enlisted the help of a second staff member. The person was difficult to waken and initially kept falling back to sleep. Neither staff member voiced leaving the person to sleep and offer them their meal when they naturally awoke. The staff did wake the person and despite the person's reluctance to go to the dining room, the staff persuaded the person and accompanied them to the dining room for their dinner.

We saw daily food and fluid monitoring was in place but the nutritional plan and fluid charts did not document people's recommended daily intake. This meant staff did not have the required guidance to inform them as to what would be the person's recommended daily intake. This placed people at risk of infections and skin breakdown if people's hydration needs were not met.

We found staff were knowledgeable regarding people's dietary needs and they were able to tell us who required assistance or had specialist dietary needs. For example, fortified or a soft diet as a result of dysphagia and being at risk of choking. The chef also had a list of which people required these risks managing to ensure they prepared the food in line with recommendations.

We saw people received their food and drinks to the required consistency but observed when people were provided drinks, those people that required their drinks thickened or fortified waited for an hour after people without specialist dietary requirements had had their drink. A visitor said; "I usually make drinks for us but not for [person] because they have thickeners in theirs so I don't make them one. I have noticed on numerous occasions that they are left out of the drinks round." This comment meant that our observations were not an isolated occurrence.

We saw fruit and cake was provided as a snack during the day but a person living at the home and a visitor separately commented to us that this was not a daily occurrence. We explored this further and ascertained that snacks were offered but that it was not common place to receive fruit and cake together or on a plate.

We looked at the records for people requiring milky drinks due to weight loss and found the record did not demonstrate that milky drinks had been provided in line with the community dieticians recommendations. We looked at the person's weight record and established they had not gained weight to support milky drinks no longer being a required area of need.

This was a breach of Regulation 14 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider could not demonstrate they were meeting people's nutritional and hydration needs.

We informed the management following the inspection of our observations and they acknowledged there was work to be done in regards to the kitchen and meeting people's individual nutritional needs and preferences which they assured us would be addressed.

People we spoke with who lived at the home and relatives told us they thought most staff were trained to be able to meet their needs or their family members. One visitor told us; "The core staff all appear well trained. They handle [person] very well and I have seen them handling other residents safely."

There was an induction programme for new staff that included the Skills for Care Certificate. The certificate has been developed by a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life.

We looked at the training and support in place for staff. From our discussions with staff and from looking at training matrix, we found all staff received a range of appropriate training applicable to their role. This gave them the necessary knowledge and skills to look after people properly. Staff had access to training such as: safeguarding, dementia awareness, mental capacity & deprivation of liberty safeguards (DoLS), medication, infection control, pressure care, fire awareness, moving & handling. A staff member told us; "We definitely get enough training." A second staff member said; "I've worked in care 20 years but I've covered all the basic training again; moving & handling, fire, food hygiene. I have the NVQ 3 and I have my own personal file for conversion to the care certificate."

All the staff told us they received regular supervision and an appraisal. We saw documentation to confirm supervisions took place but noted a decline in the frequency of supervisions for a period of time prior to the

last registered managers departure. The provider brought in an interim manager prior to the appointment of the current home manager and we saw they had identified this and addressed the issue. Staff told us they found supervision sessions to be supportive and was an opportunity for praise as well as addressing learning and development needs. One staff member told us; "We get regular supervision. I had my last one just before Christmas. They are supportive and a good opportunity to chat about how things are."

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 authorisation 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. We found the provider and the manager was open and honest regarding the homes position in regards to DoLS. The new manager had found that the previous manager at the home had not maintained the DoLS matrix and had not submitted all the required DoLS applications to the Local Authority despite people living at the home having been identified as requiring authorisations.

The new manager was in the process of completing this as we were undertaking the inspection and this had been completed and the matrix updated prior to us completing the inspection which meant the area identified had been addressed. The staff we spoke with were able to demonstrate they had a good understanding of MCA and DoLS and the circumstances in which an authorisation would be required.

We looked at how the home sought consent from people. Each care plan contained consent forms; photography, medical and personal belongings which people living at the home had signed. We saw people's consent was not consistently sought when staff were providing care. We heard staff seek people's consent at breakfast as to whether people wanted the radio on and a consensus was reached as to the radio channel. However, we observed staff support a person in to the dining room at lunchtime when the lunchtime meal was underway. There was a couple sat at a dining table and the staff member sat the person at their table without seeking the person or the couple's consent to this. During the meal, one of the couple presented as unwell and despite the person they had seated at the table protesting to being moved during the meal, staff did not explain to the person why they were moving them or seek their consent to this.

The bedrooms we saw were well furnished and were personalised with people's own belongings. Observations during inspection showed that consideration had been given to our previous recommendation to look at making the environment more dementia friendly. There was signage in place on the walls directing people to toilets, lounges and bedrooms. There was also some tactile areas in the downstairs corridors. However, corridors were stark and handrails were not easily identified. We raised this with the regional manager and they told us the home was not a dedicated dementia care home. It was confirmed that people living at the home had been consulted regarding the environment following our last inspection and we were told people had stated that they did not want to live in a dementia environment.

Good

Is the service caring?

Our findings

People who lived at the home that we spoke with said they were well cared for. A person said; "I am very happy with the care provided. All the permanent staff are lovely especially [staff member], he is always full of fun and in a good mood." A second person said; "I like all the staff they all look after us very well."

Staff told us they enjoyed working at Alderwood and had positive relationships with the people living there. The staff members we spoke with were motivated and spoke positively about people and expressed their enjoyment at working at the home. They told us they felt positive about the new team and that they could meet people's needs. A staff member told us; "The staff here are brilliant, caring natured and get stuck in to do the job. We've gelled as a team and that benefits the people living here." A second staff member said, ""The care here is good but I'd like to spend more time with people. I wish I could just have a chat."

We saw relationships between people living in the home and the staff supporting them were warm, respectful and dignified. Everyone in the service looked relaxed and comfortable with the staff and vice versa. Staff were observed holding hands with people when speaking with them during meals. Staff engaged in conversation when supporting people and there was appropriate 'banter' and laughter observed at these times. Staff got down to people's eye level when asking them what they wanted to eat and whether they wanted a drink.

People told us staff were polite, respectful and protected their privacy. We were told they always knocked on their doors before entering their bedrooms. A person told us; "the staff make me feel very confident and relaxed when having a shower. "They always wash my feet for me and the other parts I can't' reach. They put me at ease."

Staff described how they protected people's privacy and dignity. A member of staff said; "When supporting people to the toilet, I'm discreet. We don't shout to the person across the room. When using the hoist we make sure ladies skirts are tucked under them or use a blanket over their legs. We don't leave a bathroom door open when people using the toilet." A second staff member said; "When assisting with personal care, I close curtains and doors. Explain things before doing them and maintain conversation throughout."

We observed staff maintain people's dignity on a number of occasions. On one occasion staff had noted at breakfast that a person had spilled porridge down the front of their clothes. Staff were discreet when they informed the person and at the person's request sponged the porridge off. The staff member pointed to their own tabard and asked if the person would like one to wear whilst eating to protect their clothes. The person agreed and the staff member quickly returned and supported the person to put the tabard on. We saw staff used a screen to block a person from other diners when they became unwell during the lunchtime meal so they were given privacy whilst staff attended to their needs.

We observed staff undertake care task and observed them to be kind, patient and sensitive. We observed two staff supporting people with their meal. This was done on a one to one basis and they were observed providing reassurance to the person, not rushing them and they clarified with the person that they were

ready for the next spoonful before getting it ready for them.

We looked at how people were supported to maintain their independence. We observed staff motivating people and supporting people during moving and handling. We saw two staff assisting a person into their wheel chair. The staff gave the person constant praise for trying to move a few steps and reassured the person throughout that they were doing well and told them they wouldn't let the person fall. The person completed the manoeuvre by taking small steps and when they were seated in their wheelchair we saw they were smiling and we heard them thank staff for their help.

We asked staff how they promoted people to retain their independence. A staff member told us; "I don't assume people always want me to help them or do it for them. I'd always offer but if declined, I'd stand back and let people try for themselves. I'd offer again if struggling." A second staff member said; "I don't rush people and give them chance to do things for themselves." A third staff member said; "I encourage people to get up and get themselves dressed and socialise with others."

Requires Improvement

Is the service responsive?

Our findings

People living at the home and their visitors told us staff were not always responsive to their needs. A person said; They get people up and then herd them in to the foyer before taking people to the dining room and starting to serve breakfast."

People we spoke with who needed assistance told us they could choose to get up in the morning whenever they liked but said they were not always able to go to bed at the time of their choosing. People who were independently mobile told us they didn't go down for breakfast until after 09.30 as the dining room did not open until that time and people were left waiting in the foyer. People also told us they were not accommodated a bath or shower whenever they liked.

We observed occasions during the inspection when staff were not responsive to people's needs. We saw four people remained in the dining room after breakfast because they had fallen asleep. One person was slumped in their chair but despite staff walking past them, they did not put a cushion under the person or attempt to make them more comfortable.

We saw prior to people moved to the home, people had a pre-admission assessment completed to determine the home and staff were equipped to meet the person's needs. We saw these provided a focus on communication, mobility, washing/dressing, eating/drinking, continence, sleeping, hearing, sight and activities. This would enable staff to establish what people's care needs were and the type of care people required prior to them moving in to the home.

During the inspection we looked at five people's care files. We saw information was captured regarding people's social history which included where people were born, their life when young, education, marriage, whether they had children, where they lived, employment, skills during working life, social skills, who they keep in touch with, activities hobbies, most interesting part of their life and things the person enjoyed. People's bathing preference was documented and their likes and dislikes information was completed.

We saw people had care plans in place for; maintaining a safe environment, eating and drinking, elimination, skin integrity, mobility, personal care and dressing, recreational needs, sleep and communication. During the inspection people told us they didn't know what their care plans were and did not feel involved in planning their care. We also found that care plan documentation did not demonstrate people's engagement. We found reviews of people's care had not consistently been completed. Out of the five care files looked at, two people had received a review of their care, one person had not lived at the home long enough to have their care reviewed and two people that should have had a review hadn't.

This was a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider could not demonstrate they were providing person centred care.

On the first day of the inspection, we noted people slept a lot through the day. People were sat in front of the television and there was no other stimulation offered. We were told the activities co-ordinator did not work

on a Monday which was the day of the first inspection visit.

We looked at the activities planner for December 2016 and the activities that had been scheduled included; coffee morning, bingo, women and gentleman's club, resident's meeting, craft sessions, baking, dancing with dementia at an external venue, bents trip, movies, carols and people's birthday's had been celebrated.

The provider employed a part-time activity co-ordinator who worked 25 hours a week at the home. On the second day of the inspection, following breakfast we observed the activities coordinator engaging people in actives in the dining room. We noted there were no other staff supporting the activity which meant the activities coordinator had to break off from the activity to support people when they needed assistance. We observed people become disinterested in the activity as it lost momentum as a result of the interruptions.

The activities coordinator told us the activities planner had not been effective in generating enthusiasm for activities so they had devised a new planner and started a monthly newsletter in November 2016 which they delivered to everybody's room and detailed upcoming events. We saw in December, people had made decorations and there had been more entertainers in the home due to Christmas. The activities coordinator had made connections with a local school and they came in the home and did christmas carols and the local nursery did show and tell.

People we spoke with told us they didn't get to go out of the home much or do many activities. They also told us they didn't have a choice regarding the activities offered. We told the activities coordinator this had been the feedback received and they were observably upset by this. The activities coordinator told us it didn't rest well with them that people didn't feel their preferences and needs were being met.

The activities coordinator told us activities were discussed at the resident meeting in order to establish what people wanted. The activities coordinator also completed a recreational activities assessment with people and developed a profile which identified whether people wanted to participate when it was a large group. They also maintained a list of activities offered and declined. We saw in people's record they had recently been supported to Bents garden centre and the Lowry. The activities coordinator told us there was a community centre next to the home which they had offered people to attend. They also told us they had offered various activities; knit and chatter and baking but people had either declined or there had been a low uptake of people.

A staff member had also told us; "There is something happening every week. Over Christmas, we had more things going on and entertainers coming in. People went to bents and the Lowry. They do bingo, there's a TV in the reception area and we sit and talk to people as much as possible."

We looked at the results of a recent survey that had been conducted. We found the survey required strengthening as the survey did not capture people's opinions to analyse the information to improve the quality of care received. The survey identified the person and their room number which meant people were less inclined to give honest feedback. The default answer on the survey was no comment. There was also no analysis of past surveys completed to demonstrate how this had led to improvements. The comments regarding the quality and choices of food offered were negative but had not been addressed.

We looked at how complaints were handled. The provider had effective systems in place for people to use if they had a concern or were not happy with the service provided to them. We looked at the complaints received since our last inspection and found they had all been handled in line with the complaints policy and a reply to the complainant had been corresponded in the required timeframe. A complaint log was maintained which detailed, the date the complaint received, name of complainant, address, nature of

complaint, who investigated, outcome and lessons learned. Some of the people and visitors we spoke with had raised formal concerns and told us they had been handed appropriately. All the people and visitors we spoke with told us they would be happy to speak with the staff or management if they had a concern or a complaint.

The home also maintained a record of compliments which people's relatives had made about the care provided at the home. We looked at a sample of these, with some of the compliments including; "Special thanks for all your devoted care and attention to [person]", Thank you for all the care you gave to [person], they didn't always show it but [person] loved all the staff. Thanks to the wonderful staff that cared for [person] so well, we will never forget your kindness."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, there was no registered manager in post. The home had a manager that had commenced in post 03 January 2017. The home manager had applied to the Care Quality Commission (CQC) to register. We were unable to assess the new manager's leadership skills due to them being new in to the post.

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

We asked staff what it was like to work at Alderwood and whether the provider nurtured a good culture within the home. One staff member told us; "I like it here. The new manager seems nice and I feel positive about the direction we are going." "When I started here, it felt the home was in crisis but the senior manager did a good job at turning it around. The new manager is good too. I would recommend this home to my friends or family looking for a care home."

The home manager had only been in post for three weeks when we undertook the inspection at Alderwood. People and visitors confirmed the home manager had introduced themselves and their role at the home was known. People and staff spoke positively of the new home manager and from our own observation on arrival at the home on the first day of inspection, we saw the home manager assisting staff to support people living at the home. We noted throughout the inspection that the manager interacted politely with people who lived at the home and people responded well to them.

During the inspection, we found the management to be open and transparent. Both the newly appointed home manager and the regional manager were honest regarding outstanding areas to be addressed. They acknowledged the progress made and that the priorities had been to sort the medication issues and recruit staff in order to establish a consistent team. The management had recruited new staff and reduced the reliance on agency staff. The management were already aware of the issues identified during the inspection and the home manager had a plan to address these areas timely.

We found there was a clear management presence at the home. The home manager was visible throughout the inspection and the regional manager was present to provide the new home manager with support through the process. The senior manager who had been in post following the previous manager's departure and the commencement of the new home manager also attended the home on the first day of our visit to support the inspection. We asked for a variety of information and documents to be provided on both inspection days and these were provided promptly

We saw there were various systems in place to monitor the quality of the service which were aligned with our key lines of enquiry (Kloe's). This included regular audits and checks undertaken by both the home manager and regional manager from Hill Care. These audits provided a focus on risks, safeguarding, maintenance,

recruitment, staffing, medication, infection control, weights, pressure care, DoLS, training, supervision, caring observations, care plans, complaints, meetings and surveys. We saw there were agreed objectives and action plans set if any discrepancies were identified. The home manager had developed an action plan to address shortfalls and drive improvements which detailed that was responsible for completing the action and timeframe for completion. We saw issues we had identified during the inspection were listed on the action plan as areas outstanding to be addressed. We saw the medication audit had been effective in identifying the issues and actions taken to remedy the audit findings had been implemented.

The home provider completed night and weekend spot checks which involved the regional manager coming in to the home unannounced at different times of the night and weekend to ensure staff were meeting people's needs at these times. This meant the provider ensured standards were maintained at these times when there was not a management presence within the home.

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw the management had ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements.

We saw team meetings were conducted regularly. Minutes were taken at all team meetings. We looked at the minutes from the most recent staff meeting which had been conducted November 2016. We saw actions and matters arising from the previous staff meeting were discussed. Other topics such as staffing, roles, complaints and lessons learned, standards expected, inspections, health and safety, policy and procedures, team work and communication had all been agenda items at the meeting. Staff confirmed these meetings were regular and that they felt able to contribute.

We looked at the minutes from the recent resident and relatives meetings that had taken place. We saw the agenda items covered for the staff meeting were formed from the outcome of the resident and relative meeting to address the issues that had arisen. Agenda items at the resident and relative meetings included; communication, personal care, staffing and use of agency staff, infection control and management arrangements.

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 Care was not designed in consultation with people or reviewed in conjunction with people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider could not demonstrate they were following health care recommendations and meeting people's nutritional needs. Reasonable arrangements were not made to meet people's preferences.