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Alexandra House - Leicester

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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced inspection on 27 January 2016.

Alexandra House provides accommodation for up to 17 people who require nursing or personal care. At the time of our inspection 16 people used the service. People using the service have use of a large communal lounge, a smaller `quiet' lounge and a dining room. There is a small enclosed garden. Alexandra House is located in the village of Huncote in south-west Leicestershire.

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

People using the service were safe. Staff understood their responsibilities for protecting people from abuse and avoidable harm. They safely supported people with their mobility. People's care plans included assessments of risks associated with their personal care routines and their safety. The premises were maintained to ensure safe environment.

Enough staff were deployed to safely meet the needs of people. On occasions staff did not report for, the registered manager or, if they were not on duty the person in charge, was involved in providing care and support. This was the case on the day of our inspection. The provider had robust recruitment procedures to ensure as far as possible that only people suited to work at Alexandra House were employed.

The provider's arrangements for the management of medicines were safe. People received their medicines at the right times and when they needed them.

People using the service were supported by staff with the rights skills and knowledge. Staff communicated effectively with people. Staff understood and practised the requirements of the Mental Capacity Act 2005. They sought and obtained people's consent before providing care and support.

People using the service were supported with their nutritional and healthcare needs. They had access to health services when they needed them.

Staff were caring. They developed caring relations with the people they supported. They were attentive to people's needs and ensured their comfort. People were involved in decisions about their care and they were treated with dignity and respect.

People using the service received care and support that was tailored to their individual needs. They had opportunities to participate in activities though most chose not to do so. The provider was reviewing the range of activities and identifying new and more varied activities people could enjoy.

People using the service and their relatives were able to raise concerns and felt listened to.

The provider sought people's views and feedback about the service though the results of feedback were not always shared with people.

The provider had quality assurance procedures. These included reviews of risk assessments associated with people's mobility, but we found two people's falls risk assessments had not been reviewed after people experienced falls. Three out of eight recommendations from a food hygiene audit in April 2015 had not been acted upon.

The provider had not returned a Provider Information Return (PIR) we required. A PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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.

Staff understood and practised their responsibilities for protecting people from abuse and avoidable harm without restricting their independence.

The provider had effective recruitment procedures. Staff were effectively deployed. The need for additional staffing was going to be considered.

People were supported to have their medicines when they needed them.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the relevant skills and knowledge.

The manager had working knowledge of the Mental Capacity Act 2005, and staff were aware of their responsibilities under the Act.

People were supported with their nutritional and health needs.

Is the service caring?

Good

The service was caring.

Staff understood people's needs and developed caring relationships with people.

People or their relatives were involved in decisions about their care and support.

Staff respected people's privacy and treated them with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People experienced care and support that was centred on their personal needs.

People had opportunities to participate in meaningful activities. New and additional activities were being considered.

People knew how to raise concerns and complaints. Their feedback was acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider sought people's views about the quality of the service, but results of the feedback were not always shared with people using the service.

The provider had arrangements for monitoring and assessing the quality of the service, but not all identified improvements had been made.

The provider had not submitted a Provider Information Return.

Alexandra House - Leicester

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 27 January 2016 and was unannounced.

The inspection team consisted of an inspector 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. Our expert had experience of caring for older people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with 10 of the 16 people who were using the service at the time of our inspection and an ex-carer of one of the people. We looked at three people's care records. The registered manager was not present during our inspection, but we spoke with a manager who was in charge on the day. We also spoke with a senior care worker and three care workers. We spoke with the cook. During the inspection we observed how staff supported and interacted with people using the service in communal areas. We observed a medications round.

We looked at a staff recruitment file to see how the provider operated a recruitment process. We looked at staff training records and records associated with the provider's quality assurance of the service.

Before the inspection we contacted the local authority who funded some of the care provided at Alexandra House for their feedback about the service.

Good

Is the service safe?

Our findings

People using the service told us they felt safe at Alexandra House. A person told us, "First time I met with them, I trusted them straightway. I have no concerns about my safety". Another person told us, "You are asking if I'm safe, I'm more than safe."

The provider had safeguarding procedures that care workers we spoke with were aware of. They knew about the different kinds of abuse and how to identify and report concerns about abuse to the registered manager. They described how they identified signs of possible or actual abuse; for example change of mood, eating or sleeping habits and unexplained injuries. Care workers we spoke with told us they were confident that they knew enough about the people they supported to be able to identify if a person was scared or frightened. They told us they were confident that any safeguarding concerns they raised would be taken seriously by the registered manager. Staff we spoke with were aware of whistleblowing procedures under which they could raise safeguarding concerns directly with the local authority or Care Quality Commission.

People's care plans included risk assessments of activities associated with their care and support, for example personal care routines. Those risk assessments included information about how to support people safely and keep risk of harm or injury to a minimum. People who were assessed as being at risk of falls were supported in a way that minimised falls. Very few falls had occurred at Alexandra House. Those that had were investigated and the reasons a person fell were identified and action was taken to reduce the risk of falls. A person who had a fall told us, "If I fall the girls help me." We saw staff supporting people when they walked around the home. They did so in way to that encouraged people to be as independent as possible without endangering themselves. Staff gently supported people by their arm and gave people directions about where to step so they could get to where they were going safely.

When we spoke with people using the service none said anything to the effect that they felt not enough staff were on duty. They did however say that when they called for staff to assist them they were not kept waiting. A person told us, "If I use my buzzer the staff never keep me waiting long." A person told us that one reason they felt safe was because staff responded quickly when they called for assistance at night. They told us, "The night time staff respond quickly when I use my alarm." One care worker was on duty at night. Our observations were that staff attended to people's needs promptly apart from a one hour period during the morning. We heard staff ask people who called for assistance to wait whilst they supported another person. For example, we heard staff say "I'm coming [person's name], but I'm with [other person's name] at the moment" and "Just wait there for me, I need to help somebody else" and "Just stand there a minute for me." None of those people waited more than five minutes for support. We learnt that a care worker had not come to work on the day of our inspection which meant that only two rather than three care workers were on duty. They were supported by the manager who was an experienced care worker. The manager told us that ordinarily three care workers were on duty with support from the registered manager or manager, making four staff engaged in care work. Rotas we looked at confirmed that to be the case and the day of our inspection was not typical in terms of the number of staff on duty. The manager told us they would discuss staff deployment with the registered manager with a view to increasing minimum staffing to include four care workers.

A person told us, "I have my medication when I need it." They went on to say, "I know what my medications are for and I talk about them with staff. When I told them I thought I didn't need a medication they listened to me and looked into it." Records we looked at showed that people were given their medicines at the right times. We saw staff tell people what their medicines were for when they gave people their medicines.

The provider had safe arrangements for the management of medicines. Medicines were safely stored and medicines that were no longer required were disposed of safely. Only staff who were trained and assessed as competent to support people with their medicines did so. Some people using the service required what are known as `PRN' medicines. These are medicines that are given only when a person requires them, for example for pain relief. Each of those people had a PRN protocol in place to guide medicines trained staff about when to give people PRN medicines. People using the service and their relatives could be confident that the service had safe arrangements for supporting people with their medicines.

Good

Is the service effective?

Our findings

People using the service told us they felt staff had the right skills to be able to support them. A person using the service told us, "I can't find fault with the carers." Another person told us, "They (staff) are absolutely wonderful." I think they are well trained because they are good at doing their jobs." Other people told us that staff were good at their jobs. One said, "Whatever the staff do they do it fine."

Providers are required by regulation to induct, support and train their staff appropriately. In our guidance for providers we expect them to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction. The Care Certificate was introduced in April 2015. The provider had begun work to introduce the Care Certificate for all new starters. A care worker told us, "I've just started working towards the Care Certificate. During my first 12 weeks I was mentored by an experienced care worker."

Staff we spoke with told us their training was helpful and supported them to provide the support people using the service needed. A care worker told us, "The training is good. I've been supported to take a NVQ level 3 in health and social care." Staff told us they felt supported through supervision and training. A care worker told us, "The manager has been brilliant. Our training gets updated and I feel well supported."

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

The manager had a working knowledge of the MCA and how it applied in a care home setting. Where restrictions were in place these were the least restrictive and had been approved under the Deprivation of Liberty Safeguards (DoLS) which are a supplement to the MCA. Care workers we spoke with had an awareness of MCA and DoLS. They knew that the MCA protected people who lacked mental capacity to make decisions about their care and how decisions were made in the best interests of those people. We saw from training records that staff had received training about the MCA and DoLS.

Staff we spoke with told us they sought people's consent before they supported them with personal care and medications. They told us they did this because consent was something that was required by the MCA. We saw and heard staff asking people if they could support them then waiting for people's consent before supporting them. For example, we heard staff tell a person what their medicines were for then asking them if they would take them. We heard a care worker ask a person "How would you like me to help you?" When staff supported people they explained what they were doing and why.

We saw in a person's care plan that a person sometimes understood things better if staff spelled out a word after saying it. We saw two examples of that happening when a care worker was helping a person to another room and when a care worker explained to a person that their dinner was ready. We saw and heard staff

speak clearly with people and use gestures and signs to communicate.

People had positive views about the quality of the food. A person told us after lunch, "I enjoyed my meal". Another person told us about their meal, "It is quite filling. It was good." Another told us, "I really enjoyed my lunch. I get a choice. I look forward to my dinner every day."

People were offered choices of meals. The choice was varied. For example, on the day of our inspection people had a choice of breaded chicken or home-made corned beef hash and a choice of two puddings. We saw from previous menus that people always had a choice of meals. We saw the cook asking people what they wanted for lunch. Meals were prepared according to people's choices but people were able to change their mind if they wanted. The cook was aware of people's dietary needs and food preferences. People had choices of what to have at breakfast and tea time. Most people liked to have a cooked `English breakfast' on a Saturday morning. People told us that was something they looked forward to.

During the meal time we saw that people enjoyed their meals. Staff helped make the meal a social occasion by joining in conversations that people initiated. People made complimentary comments about the meal to the cook.

People's food and fluid intake was monitored. People were weighed monthly to check that they were either maintaining their weight or reducing or increasing their weight if health specialists advised they needed to do that.

People were supported with their health needs. People's care plans included a section about their medical history and how care workers should support people with their health needs. We saw care plans with guidance for staff about how to care for people with their oral health, personal hygiene and sensitive skin. Staff we spoke with were knowledgeable about the content of people's care plans.

Care plans also contained a `grab sheet' containing essential information that paramedics or ambulance crew needed to know in the event they were called out to the service. People were supported to attend healthcare appointments and they received visits from healthcare professionals.

Staff kept each other informed about people's health and demeanour. We sat in on a `hand over' meeting when staff who arrived for work for a shift were given information about people and the support they required by staff who worked the earlier shift.

People using the service could be confident that the provider had effective arrangements in place to ensure as far as possible that people's health needs were met.

Good

Is the service caring?

Our findings

People using the service told us staff were caring. A person told us, "This [Alexandra House] to me is home, its perfect here." Another person told us, "I like all the staff, they are so kind."

In August 2015 we received feedback from a family stating, `Amazing staff, concern for residents & their family's needs. So professional at all times.'

Staff did things that helped people feel they mattered. We saw and heard staff asking people if they were comfortable and whether there was anything they wanted staff to do for them. Staff offered people blankets whilst they were seated in a lounge. After a person received support a care worker asked them, "Can I get you anything else?" Staff gave people verbal encouragement to people when they supported them to walk to different areas of Alexandra House. We staff say "Well done, keep going"" and "You are doing really well" when they supported people. Staff referred to people by their preferred names when they spoke with them. A person using the service told us, "We [people using the service and staff] get on ever so well together. The staff are kind, they keep me laughing." A person told us they liked their room and that was important to them.

Staff told us they developed caring relationships by getting to know the people they supported. This included reading people's care plans and talking with people about things they liked and about their lives. Staff we spoke with knew about what professions people had when they worked. They used that knowledge when they supported people with activities, for example when having `reminiscence' activities with people. A person using the service told us, "The staff know what I like." They told us they liked the smell of cooking. When we mentioned this to the manager they told us they knew that and that people were asked if they wanted to sit closer to the kitchen when meals were being cooked. That reflected good practice. This was something recommended in research about therapeutic support for people living with dementia. It also showed that staff cared about people and what they liked.

We tried to speak with people using the service about whether they were involved in decisions about their care and support. However, we couldn't tell from their responses whether they were involved. We saw that their care plans included information that was provided by them or their relatives. To that extent people were involved in decisions about their care and support and how they wanted to be supported. We observed during our inspection that when staff supported people they involved them in making decisions about how they wanted to be supported.

Staff respected people's privacy. We saw care workers offer support discreetly so they could not be overheard by other people using the service. For example, a care worker asked a person if they needed support to which the person replied "Of course I do", and the care worker replied quietly, "But we don't want to tell everybody that do we?" and proceeded to discreetly assist the person to where they needed to go.

The provider's most recent satisfaction survey of people using the service showed that all people felt that staff always respected their privacy.

Care workers did not intrude on people when they spent time in a `quiet lounge'; though they made discreet observations to see if people required support. A person told us, "I like to be on my own." This showed that people had choices and options about which part of Alexandra House they wanted to spend time in.

People's relatives were able to visit them without undue restriction. We saw from the visitor's signing-in book that relatives visited at a variety of times. A relative told us, "I can visit at any time I want."

People's care plans and records were securely kept in the registered manager's office. This meant that only staff authorised to see the plans and records had access to them. People using the service or their representatives could see their care plans if they wanted to.

Good

Is the service responsive?

Our findings

We saw from care plans we looked at that people using the service or their representatives contributed to discussions and decisions about their care. Care plans included information about people's specific individual needs. When we asked people what they thought about the care they received they responded positively. A person told us, "It is all about what we want to do." Another person told us, ""They look after me very well."

Staff we spoke with told us they developed their knowledge of people's needs, likes and preferences through reading their care records and speaking with them. Staff told us what people liked and what they preferred. Records we saw confirmed that what staff told us was correct. A care worker told us, "I look at care plans. I find them helpful. I also talk with people. I get to know the people."

Care plans we looked included information about how people should be supported with the whole range of their needs, for example personal care, hygiene and their mobility. A person using the service told us, "They've (staff) have taught me to walk again." This showed that a person had been helped to achieve what was an important goal to them. We saw staff support and communicate with people in ways that met their communication needs. Staff adapted how they spoke and supported people depending on who they supported. For example, we saw staff supporting two people to walk to other areas of Alexandra House in two very different ways. This was an illustration of how care was person centred.

When we spoke with people we were able to confirm they received the care and support that was detailed in their care plans. For example, support with washing and dressing. A person told us, "They (staff) listen to me when I ask them do things for me." Care records completed by staff during the day recorded the support people received. A person who visited Alexandra House often told us "The care [person] receives is pretty good."

People with hobbies and interests were supported to follow them. A person with interest in football was told when football matches were televised. Staff knew about the interest and talked about it with the person.

Some of the people using the service had faith needs. The provider supported those people to attend faith services at Alexandra House that had been organised with representatives of different churches. Visitors from church groups also visited the home to socialise with people. These visitors and the friendships people had with others using the service and no undue restrictions on visiting times meant people were protected people from social isolation.

People's care plans were reviewed regularly, usually at monthly intervals, by the registered manager or manager, though we saw two care plans where not every section of the plan was reviewed when it ought to have been, for example fall risks assessments were not reviewed after people had falls.

The service had an activities coordinator. They used information about people's life history and interests to plan and provide one to one `reminiscence' activities when they talked to people about their past lives.

They used `memory boxes' and photograph albums when they supported people with `reminiscence' activities. Some people helped staff to clear tables after lunch. We were told that some people participated in baking biscuits. This was a good practice that is recommended by organisations specialising in support for people living with dementia. We saw photographic evidence that people participated in activities at Alexandra House. A person visiting someone who used the service told us, "I've seen people here play games and do drawings, but I think they could do with more entertainment." We shared that with the activities coordinator who told us that people were entertained by local choirs who visited Alexandra House. The manager told us they would find out what kinds of entertainment people would like.

We saw people reading newspapers of their choice. Several people engaged in conversations. A person using the service told us that people at Alexandra House preferred to do that rather than watch television. We saw that to be the case. People were told what television programs were available but they chose not to watch television. A person told us, "We get on ever so well together." Another person told us, "We spend our time the way we like." Throughout our inspection we saw people spending time together in small groups. People chose which communal areas they wanted to be in and staff supported them to those areas.

People using the service and relatives had access to the provider's complaints procedure. The people we spoke with told us they had no concerns. A person told us, "There is nothing to grumble about. If there is anything wrong they put it right." The provider's most recent satisfaction survey showed that all people felt that staff were friendly and approachable and that communication with staff was good. Our observations of how staff interacted with people was consistent with the results of the survey.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with didn't say anything about whether they were involved in developing the service. However, those we spoke with knew about the building development work at Alexandra House and a planned refurbishment of the existing premises. The manager told us people were going to be asked for their ideas about colour schemes and décor.

The provider sought feedback from people using the service and their relatives using a survey. Feedback from the latest survey was mainly positive but some people said they were unaware of activities and that the quality of activities was `average'. There responses were still under review at the time of our inspection.

Staff we spoke with felt involved in decisions about the service. They told us they had opportunities to make suggestions at staff meetings or at any time by talking with the registered manager or manager. We saw from records of staff meetings that ideas were discussed and some changes were made, for example to the design of forms for recording information about training.

The registered manager was not present during our inspection, but an experienced person took charge of the running of the service. Their job title was `manager'. People using the service, relatives and staff we spoke with told us they were confident they could raise any concerns with the registered manager or manager. A care worker told us "The managers [registered manager and person in charge] are brilliant."

On the day of our inspection the manager (person in charge) was busy assisting care workers with supporting people because a care worker had not reported for work. This meant we had only limited time to speak with them. They had an awareness of the responsibilities of a registered manger. They had, for example, ensured that all reportable incidents and events at Alexandra House were notified to the Care Quality Commission. They were aware of fundamental standards of quality and safety set out in regulations.

The registered manager and manager carried out a series of checks, for example checks of care plans, medications administration, and how staff supported people with personal care and nutritional and healthcare needs. The registered manager or manager also reviewed people's risk assessments. We identified that two people who were assessed as being at risk of falls had risk assessments, but these had not been reviewed after those people had falls. The people had not had further falls but the previous risk assessments should have been reviewed to reassess whether measures in places were adequate to minimise the risk of falls.

The monitoring activity that was taking place enabled the provider to make an informed view about the quality of care and support people experienced. Feedback was used to identify areas of the service that could be improved.

Action to implement improvements was not always taken promptly. For example, not all recommendations from a food hygiene inspection carried out by a local authority under the Food Safety Act 1968 in April 2015 had been implemented. The non-implemented recommendations concerned two pieces of equipment, one

rusty another missing a part and an area tiling near a food preparation surface that required re-grouting.

We found that the provider's quality assurance procedures monitored the quality of the service and to identify improvements, but improvements were not always made without undue delay. The quality assurance procedures were based the Care Quality Commission's `essential standards of quality and safety' which were replaced by the `fundamental standards' on 1 April 2015. The provider was in the process of updating their procedures.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Providers are required by regulation to return a PIR, but they did not do so. We took this into account when we made the judgements in this report.