Larchwood Care Homes (South) Limited

Alexander Court

Inspection report

Raymond Street
Thetford
Norfolk
IP24 2EA

Tel: 01842753466

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 24 January 2017 and was unannounced.

Alexander Court provides accommodation and support for a maximum of 47 older people, some of whom may be living with dementia. The ground floor is divided into two 'wings'. People living with dementia are predominantly accommodated on the first floor. Each floor has their own communal areas. There is a secure garden area outside the main entrance. At the time of our inspection there were 44 people living in the home.

There was a registered manager in place who has been at the home since 2012. 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. The provider of the service has changed their name since the last time we inspected.

At our last inspection, in November 2015, there was a breach of regulations for the safety of systems for managing people's medicines. At this inspection, we found that action had been taken to improve. People's medicines were stored and administered safely and as the prescriber intended. The management team had improved the way that they checked the way medicines were managed and that staff were competent to support people in this area.

There were enough staff working in the home to promote people's safety. Where there were unexpected shortages due to staff sickness, staff cooperated well, with support from the deputy manager, to ensure people's needs were met in a timely way. Staff were recruited in a way that ensured proper checks were made and helped protect people from the employment of staff who may not be suitable to work in care services. Staff were aware of the importance of reporting any concerns or suspicions that people were at risk of harm or abuse and the registered manager understood their role in addressing any issues.

There were some gaps in the way that risks to people's safety were recorded and reviewed, and in producing written guidance for staff about managing these. This included risks of developing pressure ulcers. However, staff were clear about their role in addressing risks and working with health professionals to promote people's welfare and safety. Staff took prompt action to seek professional advice and to act upon it where there were concerns about people's health and wellbeing.

People had a choice of food and drink although this was not always as well promoted as it could be. There was a lack of consistent guidance for staff to promote people's welfare when people lost weight or did not drink enough. The provider's recent audit of service quality also identified that plans of care to support people effectively in this area, needed to improve.

Staff were trained and competent to meet people's needs. There was a core of long-standing staff members

who understood people's backgrounds and preferences and could support newer staff to work with people effectively. They responded flexibly to people's needs, preferred routines and interests. However, supervision, to monitor staff performance and development needs, was not always being used effectively, particularly to monitor new staff properly during their probationary period.

Staff understood the importance of helping people to make choices about their care and seeking consent from people to provide support. Staff were aware of the importance of acting in people's best interests to protect their rights if they could not make some decisions. The registered manager had taken action to ensure the rights of people who did not understand risks to their safety and welfare were protected.

Staff had developed warm and compassionate relationships with people and treated them with respect for their privacy and dignity. They acted promptly to offer reassurance when people became distressed and to intervene if any conflicts may develop as a result of people becoming anxious. They were successful in creating a homely atmosphere for people and had a good understanding of their roles.

Systems for monitoring quality and safety and for driving continuous improvement within the service were inconsistent. Internal monitoring and auditing processes had not always been sustained robustly. This included informal systems for consulting with people and acting on their views. The findings of formal consultation through questionnaires, had not led to an action plan to address areas of concern or improvement highlighted in the results. However, we noted that the provider's quality audit had identified areas for improvement, including for the management of risk, that were consistent with concerns we found. There was an action plan in place as a result of the audit. The operations manager was monitoring progress towards achieving this.

You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were managed safely and they received them as the prescriber intended.

Although risks to people's safety were not always clearly assessed, staff understood the action they needed to take to promote people's safety.

There were enough staff to support people safely and recruitment processes contributed to protecting people from staff who may not be suitable to work in care.

Staff understood the importance of reporting any concerns that people were at risk of harm or abuse and people felt safe in the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to eat and drink, but staff did not always have clear guidance about the action they needed to take to manage risks for people were not eating and drinking well.

People were supported by staff who were trained and competent to meet their needs, but the performance of staff was not always consistently monitored.

Staff sought people's consent to deliver care and acted in people's best interests if their capacity to consent was in doubt.

People were supported to maintain their health and staff acted promptly to seek advice if people became unwell.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and promoted people's

privacy and dignity.

People were confident that they, with support from their family if they wanted, could make choices about their care.

Is the service responsive?

Good

The service was responsive.

Although people's care records were not always up to date, work was underway to address this. Staff had a sound knowledge of people's needs and preferences and how to meet them and responded to people's needs promptly.

People were confident that any complaints they raised would be listened to and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People living and working in the service, and visitors, were formally asked for their views but there was no action plan to respond to suggestions.

The provider's quality audit had identified the need for improvement. However, systems within the home had not done this effectively.

Staff were well motivated, enthusiastic and committed to ensuring people received good quality care.

Alexander Court

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.

The inspection took place on 24 January 2017 and was unannounced. It was completed by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection, the provider completed 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. The registered manager completed this and returned it when they needed to. We reviewed the content of this.

We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or registered manager must tell us about by law. We received feedback from three health professionals who supplied regular support and advice regarding the care of people living at the home.

During our inspection visit, we observed how people were being supported and how staff interacted with them. We used our 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 five people living in the home four visitors. We spoke with the registered manager, deputy manager and six members of staff including the activities coordinator. We also spoke with three visiting health professionals.

We looked at assessments and plans of care for six people and checked how they were supported through their care and treatment. We reviewed records associated with the employment of three staff, staff meeting minutes and staff training records. We also looked at the arrangements for storing, administering and auditing medicines and a sample of other records associated with the quality and safety of the service.

After our inspection, we contacted the operations manager for the service to seek some additional information and clarification and requested a further piece of information from the registered manager. They supplied the information we requested promptly.

Good

Is the service safe?

Our findings

At our last inspection of this service on 25 November 2015, we identified concerns for the safety of medicines management. Medicines were not always stored safely when the trolley was in use, some medicines were out of stock and auditing processes were not robust in identifying concerns or anomalies. The registered manager told us how they were going to make improvements. At this inspection, we found that they had taken action so that people's medicines were stored, administered and managed in a safe way.

People and their visitors were satisfied with the way that staff supported them with their medicines. For example, one person told us they received their medicine regularly and, "Staff always ask if I need anything for a headache." A visitor said that staff stayed with their family member to make sure they had swallowed their medicine properly.

Staff responsible for administering medicines gave us clear accounts of the process and the checks that they made. They also confirmed that a member of the management team assessed their competence to administer medicines safely. This supported what the registered manager told us within their action plan after the last inspection and the additional information they sent to us. We saw that a staff member administering medicines did so safely. They ensured each person had a drink with their medicines and offered people their prescribed pain relief if they needed it. Staff retained keys in their possession to ensure medicines were stored safely.

We saw that regular audits of medicines management took place to ensure that records were complete and to account for medicines kept in the home. This confirmed what the registered manager told us in the Provider Information Return sent to us before our inspection. We checked a sample of medicines administration records (MAR) against balances of medicines held and these were accurate.

Two people whose medicines records we checked had medicines that staff should not give on the same day, because of adverse effects. We found that the previous month's MAR charts, and one of the new ones, were annotated clearly to show when each of the two medicines were due to minimise risks they would be given together. We noted that, for one of these people, the new chart introduced two days before our inspection was not annotated so clearly. A staff member had signed for the administration of both medicines but we found this to be an error in recording what staff had given to the person. We raised this with the management team to ensure that they updated the new chart clearly for future doses.

There was guidance for staff about medicines prescribed for occasional use when people needed them (PRN). We noted that one person had this guidance for only one of the two PRN medicines prescribed for them. However, there was additional information on the person's MAR chart explaining the purpose of the second medicine and clearly indicating that it was for occasional use.

We found that medicines storage rooms, referred to as treatment rooms within the home, were well organised with minor exceptions. The ground floor treatment room had a schedule showing that senior staff were responsible for cleaning it every Thursday. Staff had last signed this to show completion of cleaning on

24 November 2016 and some surfaces were dusty. The cupboard under the sink was dirty and contained dressings that had exceeded their expiry dates or had damaged packaging. This meant that they were not necessarily sterile and safe for use if needed to dress a minor injury. A staff member confirmed that these dressings were not in use and the deputy manager had already discussed with them the need to dispose of the old ones.

Staff understood the risks to which people were exposed and took action to minimise them. However, there were gaps in the recorded assessments of risks and guidance for staff about this. The provider's internal audit from 3 and 4 January 2016, three weeks before our inspection, also identified shortfalls and the action the registered manager needed to take to improve processes for promoting safe care and treatment. The registered manager had taken urgent action in response to their report and was working on an action plan to improve in other areas.

The provider's audit of the service identified that bedrails were in use for some people and the risks associated with their use were not properly assessed and mitigated. The audit confirmed that the registered manager had implemented action straight away to improve people's safety in this area. The operations manager for the service was working with the management team to ensure further improvements were incorporated into a development plan for the service.

The provider's audit also identified concerns for the way risks to people's skin integrity were assessed, recorded and kept under review. This concurred with our findings. We noted that one person's risk of developing pressure ulcers was assessed as low risk in August 2016. Staff continued reviewing the risks regularly and by the time of our inspection, the risk had increased to medium, bordering on high risk. There was no up to date care plan for the person to guide staff about the interventions or checks needed to manage the increased risk. Another person admitted to the service without any pressure area problems, had developed a grade 2 pressure ulcer. Again, there was no guidance within their records of the monitoring or checks that staff needed to make to promote the person's skin integrity.

We found that predominantly this was an issue of a lack of guidance within records because staff could tell us how they supported people. This included the checks they made and the importance of repositioning people although they acknowledged that for the people we had concerns about, the information was not in their care plans. A visitor told us how staff had taken action to ensure their family member had a proper bed and mattress when their condition deteriorated. They told us that, "The carers reposition [person] regularly. Nothing is too much trouble." They went on to say, "The pressure area care is very good." One visiting health professional told us that they had found pressure area screening to be up to date. They were satisfied with the support that people received to promote their skin integrity. One visiting health professional told us that the management team and staff gave people's safety a high priority within the service.

We noted that staff made referrals to the district nursing team promptly when people's skin condition deteriorated. We also noted that one person, experiencing a high level of falls, was referred for specialist advice promptly. One person told us that their health had deteriorated and although they had not fallen, they had felt unsafe. The management team had helped them to get a motorised wheelchair, which they were very happy with and told us they felt safer as a result.

There were arrangements to maintain and service equipment used within the home, to ensure that it was safe to use. This included equipment for detecting and extinguishing fires. The registered manager was expected to make routine checks on health and safety matters and the provider's representatives monitored this. Action needed to improve the safety of the home or equipment in use was incorporated into an action plan with timescales for addressing shortfalls based on priorities.

The home had systems and processes to help protect people from the risk of harm and abuse, and people said they felt safe living in the home. One person commented to us, "It's fine here. It feels like home." Another said, "The staff look after us really well." A visitor said, "I know [person] is safe and looked after." Another visitor told us they had witnessed one incident that had made their family member anxious but that was over a year ago. They had not seen the staff member since and was confident that, if they saw anything concerning, they could raise it straight away.

Staff were aware of the importance of protecting people from the risk of harm or abuse and clear about their obligations to report any concerns or suspicions. They confirmed that they had training to support them in this and would have no qualms about reporting anything that bothered them. There was guidance displayed containing information about how to contact to local authority safeguarding team if they needed to. We were aware from the history of the service that the registered manager had cooperated with the safeguarding team when they needed to. No suspicions of harm or abuse had been raised by the service since January 2016 and none had been raised with us for a similar period.

There were enough staff to meet people's needs safely. One person told us, "If I need help, they're there for me." Another said, "Staff come as quickly as they can." A visitor to the home said that staff answered call bells promptly and came quickly when people asked for assistance.

On the day of our inspection visit, one staff member had reported sick so that the ground floor of the home was one staff member short. We noted that the deputy manager, who was not rostered for care shifts on the day of our inspection visit, assisted staff when they needed it. We saw that the remaining staff on duty were very busy but worked very well in cooperation together to ensure they were able to support people promptly. People's requests for assistance using the call bell were responded to very promptly and staff were successful in maintaining a calm atmosphere for people. The deputy manager was available to help staff when they needed assistance. Staff confirmed that the management team would, "… lend us a hand…" if necessary.

The registered manager explained to us that they had increased the numbers of staff on night duty in response to changed needs and demands overnight. This enabled people to be supported promptly if they wished to get up early.

The deputy manager arranged for an additional staff member to cover for the sickness during the afternoon of our inspection visit. Staff said that their colleagues were good at picking up additional shifts when necessary. They told us that it was only when there was sickness at short notice that shifts might run short but staffing did not fall to a level which presented a risk to people's safety.

Recruitment processes contributed to protecting people from the appointment of staff who were not suitable to work in care. Records we reviewed showed that applicants provided full employment histories and proof of their identity. They provided written declarations about their health to ensure they were fit for the work they were to perform. The skills and aptitudes of prospective staff were discussed at interview and their responses were recorded to help ensure the recruitment process was fairly applied.

References were obtained, as were enhanced vetting and barring (DBS) disclosures. This helped to ensure that staff appointed had nothing in their backgrounds that raised concerns about their suitability to work in care services. The checklists we reviewed showed that the service obtained this information before staff took up their appointments.

The provider's audit of the service identified that enhanced DBS checks were not renewed every three years

as they expected. This was incorporated into the development plan for the service and work had started to review records for existing staff so that checks were updated. This represented good practice in ensuring that staff remained suitable to work in care services.

Requires Improvement

Is the service effective?

Our findings

We observed that staff offered people drinks regularly and provided people with support to eat their meals. One visitor was concerned that their family member had lost weight. They acknowledged that staff fortified food or drink to ensure it contained extra calories and provided assistance and encouragement. Another visitor told us that their family member had lost weight when they were first admitted but that they were gaining it again now. They said that staff offered the person supplements to increase their calorific intake and confirmed how staff assisted and encouraged the person.

However, we identified some concerns in people's records about a lack of clarity about how risks associated with not eating and drinking enough were assessed and mitigated. The provider's audit also identified concerns in this area. For example, the audit report showed that one person was assessed as at low risk for poor nutrition. However, that person had lost 11.5kg between October 2016 and the date the audit was completed on 4 January 2017. The provider's representatives considered that the actions listed in the person's care plan were not sufficient to mitigate further weight loss. The weight loss was significant and rapid and so indicated an increased risk that was not recognised within their care records. They were not being weighed weekly in line with their assessment of risk and there was no monitoring of the person's food and drink intake in place. However, staff had been successful in stabilising the person's weight.

For another person, the provider's audit found that their fluid intake was well below the recommended daily amount for three successive days but no actions to improve the person's intake and prevent dehydration were recorded.

We found that one person had an assessment of their risk of not drinking enough in place, with a target amount for what they should be drinking. However, on 23 January 2017, the day before our inspection visit, their record contained only one entry about refusing supper at 8.30pm. There was no reference to their intake of drink or of other food throughout the day.

We checked another person's information about eating and drinking in detail. We found that there was conflicting information within the person's care records about their risk of choking, particularly when they were drinking. One piece of information in their main care file said they had normal fluids and finger foods. More recent guidance showed that they needed pureed food. There was also conflicting information about their speech and language therapy (SALT) assessment for the risk of the person choking on drinks. Information within the care file in their room referring to SALT advice, said that they took normal fluids. Another annotation marked on their 'weekly records' indicated that drinks should be thickened.

We raised the conflicting information with the management team as a potential risk to the person's safety. If staff followed out of date information this would increase the risk of aspiration (inhaling fluid into the lungs), which could potentially be fatal. However, care staff were clear that the person's drinks needed thickening. They told us that they always followed the guidance on the can of thickener prescribed for them and we saw this product was available.

We noted that staff were monitoring what food and drink the person was accepting, and the target amount of drink staff should aim to support the person to achieve. Their target intake for drink was 1500mls of fluid. We found that, on the day before our inspection visit they had only drunk 500mls, a litre below the target. On the day of our inspection visit, we found that they had only managed 300mls of fluid by the end of lunchtime. The remainder of their lunchtime drink was left on their bedside cabinet and the cup was almost full.

We asked staff about the person because their records showed that their intake of food and drink for the last two days was poor. Staff told us that the person had days where they did not eat and drink well but that they supported the person to, "…make up for it..." when they were more willing to eat and drink. There was nothing in their daily records to prompt staff to encourage them further with food and drink because of their poor intake during previous shifts.

We found that the person was weighed regularly during the first half of 2016. Staff had then recorded that this was no longer possible because the person's health had deteriorated. There were repeated entries saying that staff could not weigh the person. However, staff continued to record their weight as the same as it had been when they were able to use the scales. Staff had not taken the recommended action to use an alternative measurement to monitor any weight loss, such as measuring the circumference of the middle of the person's upper arm. The person's assessments for the risk of poor nutrition and for developing pressure ulcers continued to show that their appetite was good. However, their daily records did not support this and they were not eating well.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People expressed variable views about the food on offer. For example, one person said, "I have nothing to complain about. Not everything is to my taste." When asked whether the person was offered an alternative if they did not like the options available, they told us, "Not always, you can take it or leave it." Another commented, "The food is not always to my taste." A visitor said that their family member would eat most things but that there was a lot of mince on the menu.

We observed that there were some conflicting practices in the way that people were offered choices about what they ate and drank. For example, at lunchtime we saw that one person asked if they could have a yoghurt for their dessert. However, staff responded, "There are none at the moment; they'll send them up at tea time." When staff served mid-morning drinks in one part of the home, they did not offer people a choice of hot or cold drinks but served tea. At the same time, staff handed biscuits to people who wanted them from the biscuit box without offering a choice. One person did ask, "Can I have one of those other ones please?" Up to that point, staff had not offered the person a choice but handed them biscuits on a plate.

In the same part of the home at lunchtime, one person did not eat their meal. The registered manager brought them some sandwiches. However, they did not explain what was in them or offer a choice about fillings. We also noted that some staff were loud in their approach and that there was a lot of noise from banging doors and lids on the meal trolley. This did not provide a calm and conducive atmosphere for people to eat their meals.

At lunchtime in another part of the home, we saw that staff asked people if they would like a cup of tea after they had served people their meals. No one was offered coffee as an alternative, although this was displayed as an option on the menu board. However, staff did discuss the lunchtime food on offer and reminded people what they had chosen from the menu. They also offered people the vegetables that accompanied

the meal, asking if they would like broccoli and/or sweetcorn.

We saw that staff asked one person's permission to help them with an apron, "…because you have a nice jumper on and it would be a shame to spoil it." The person agreed to the apron and when they continued to struggle to eat their meal, staff offered assistance to cut it. Staff asked another person if they would like some help and, when they agreed, positioned themselves next to the person to provide the assistance they needed.

People received support from staff who were competent to meet their needs. The manager was aware of and monitoring the completion of staff training so that they could encourage staff to renew any time limited training promptly. The provider's representatives also monitored compliance with expected training to ensure any shortfalls were followed up.

A visiting health professional told us, "Care staff at all levels are receptive to learning, taking advice and instruction." They went on to describe the manager as, "…very supportive in diabetes management, with training, advice, support and assessment of competencies as delivered by the community nurse." We also found that the staff we spoke with were knowledgeable about the people they supported and about their welfare. This confirmed the findings of the provider's audit.

Staff told us that they had access to good training to enable them to meet people's needs. They said that much of this was electronic using the computer but it was relevant to the work they did. A staff member who worked with people who were living with dementia explained that they had also completed training in dementia awareness. They explained how they had a particular interest in this area of work. They felt that the training had helped them to understand how the condition affected people and the way they reacted.

Care staff had access to qualifications in care to support them in their roles. The registered manager confirmed in their Provider Information Return (PIR) that there were 33 care staff with permanent contracts; 17 of them had obtained additional qualifications in care. The PIR also indicated that there were plans for team leaders to complete specific training towards a qualification specifically for their role. This showed a commitment to developing the skills and competence of staff.

Staff felt supported by the management team although this was largely an informal approach and not formal supervision. Supervision is a way of giving staff the opportunity to discuss their performance at work and any training or development needs. We found that new staff were subject to a three-month probationary period. This helped to ensure their performance and progress was satisfactory to become a permanent member of the staff team. However, for one staff member appointed in March 2016, their records contained evidence of only one formal supervision and that was six months after their appointment. This compromised the ability of the management team to take action during the probationary period to address any gaps in performance or capability.

Two staff confirmed that they had recently received supervision by a member of the management team. Another member of staff told us that staff should have supervision every two months but in reality, it was normally six months before it took place. The registered manager told us that staff supervision should take place every two months. The provider's audit confirmed that staff did not receive supervision with the expected frequency. The registered manager told us that there was a recovery plan to address shortfalls and that more than half of the staff had received supervision in the previous month. They had plans to complete the remainder but needed so sustain this to ensure proper support and monitoring.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes is 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 aware of the importance of encouraging people to make decisions about their care and of seeking consent before they delivered care. We observed that this happened during our inspection visit. We noted that a staff member asked someone's permission if they could assist them with their meal. We also heard a staff member explaining to people what their medicines were for when they were assisting people with these.

Staff knew that sometimes people's willingness to accept care would vary and that they needed to be flexible in returning to offer care at a different way or to see if people would accept support from a colleague.

People's care records contained assessments of people's capacity to make informed decisions about specific aspects of their care. This included understanding the importance of personal care, oral care or foot care for example. Where individuals were assessed as unable to understand the importance of these aspects of care to their health and wellbeing, their best interests were taken into account so that their rights were protected under the MCA.

One person told us that they had not felt confident to go into the town alone and so a staff member went with them. They added that they did not feel restricted and, "I have a key to come and go as I please."

The registered manager told us that they had recently reviewed the way that people were supported and any restrictions on their freedom of movement for reasons of safety. The provider's audit had highlighted this as an area needing attention. The registered manager confirmed that they had made applications under the DoLS to ensure people's rights were protected. They were awaiting the outcome of most of these applications but told us one had recently been granted and the circumstances in which it was needed.

Staff ensured that they sought advice promptly about people's health if they became unwell. However, two visitors expressed a concern that their family members had lost their dentures. Staff provided them with a soft diet that they could chew and swallow without their dentures but their visitors were not aware whether staff had followed this up with the dentist. Another visitor told us that their family member had lost their glasses. However, they told us the person had seen the optician although their replacement spectacles had not yet arrived. A third visitor commented that their family member needed their eye bathing each day and they could tell this did not always happen. However, they visited regularly and said that staff were always happy to do this for the person when they were reminded.

One person did not recall being unwell but confirmed that they saw their GP when they needed to. Another person told us how the staff had contacted their doctor promptly for them when they became unwell. A third person explained that they had been a bit concerned about their health, "… but the staff look after me and will call the doctor if I or my daughter asks them." People confirmed that they had support from health professionals such as the district nursing team.

A district nurse confirmed that they worked closely with the service. They said that nursing referrals were always appropriate and timely when the service needed advice about a person's welfare. They told us that staff acted promptly if there were concerns about people's health. They said that staff demonstrated a good knowledge of the condition for people referred to them and could provide the information they needed in order to offer advice and treatment. One professional also commented that staff responded well and promptly when someone living with dementia became unwell very quickly.

Another health professional told us that the home worked well with them. They felt that staff communicated well with their team and always provided time to discuss people's needs. They explained, "Staff and management are able to take on board the advice, implement any actions and evaluate these with the team."

Good

Is the service caring?

Our findings

People received support from staff who had developed warm and caring relationships with them. People told us that staff were kind, considerate and supportive. For example, one person said, "The carers are very kind. I get on well with them, and they're nice people." Another person commented to us, "The staff are fantastic. They've got a lovely sense of humour."

Relatives were also satisfied with the approach of staff and the relationships they had built up with their family members. For example, one said, "The staff are wonderful; when I leave I have peace of mind that they look after [person] well." Another described staff as compassionate and "Generally they're all very obliging, and happy to help us. They know the residents and understand when something is worrying them. They're very supportive and the residents respond to them." One visitor said that their family member could sometimes become anxious and panicky, but staff spent time talking with them and offering reassurance.

Health professionals in regular contact with the service also told us that they felt staff were caring and kind in their approaches. One told us that they had seen staff speaking to residents in a reassuring friendly manner and, "The residents respond warmly to the staff which is always a good sign." Another health professional told us that they were happy with the way their family members had been supported by the service. "They were always cared for with such respect, kindness and understanding, and that care ranged from the cleaner to the manager of the home." They went on to say, "They [staff] convey kindness and understanding to those they are caring for. They have a particular strength and passion around both palliative and end of life care, where there is a strong sense of compassion. They also positively support residents and their families ... and have evidenced that they can readily meet [end of life] needs with the support of the community nursing team."

We observed that staff interactions with people were largely positive. We noted that one staff member called across a lounge area to someone who was hard of hearing, rather than approaching the person directly. However, this was an isolated incident. Staff took prompt interaction to intervene when two people argued about seating arrangements at lunchtime. They were skilled in resolving this, gentle and sympathetic, calming one person respectfully and offering reassurance. Our observations at lunchtime showed that three people interacted regularly with staff and the people we observed were calm.

We saw that one staff member arriving for work in the afternoon, crouched down to a person's level and asked how they were. The person was not able to answer but smiled and held the staff member's hand while the staff member spoke gently with them.

People told us that they were comfortable making decisions and choices about their care. One person told us they had not been involved in developing or reviewing their care plan, but said, "My daughter speaks to them and looks after that side of things." Another person told us, "The staff are very respectful and I make my own decisions" They went on to say they were happy to talk with staff regarding their care. A visitor told us how they had another family member living nearby who visited the person frequently and was kept informed about any changes and more involved in the person's care.

Staff understood the importance of promoting people's privacy and dignity. People and their visitors told us that staff respected people's privacy and dignity. They also helped people to maintain or develop some independence. For example, one person said that they had confidence in the staff and, "They sort me out when I'm not able to dress myself, or when I get frustrated." A visitor described how staff had worked hard with one person to understand and help them manage their continence as they had difficulties with this when they first moved to the home. They went on to explain how staff had persevered with supporting the person and told us, "They've got it sorted."

A visitor to the home explained that their family member was sometimes anxious about receiving personal care, such as having fingernails trimmed. The visitor told us, "Staff always close the door. They're discreet and reassure [person], and tell [person] what they're doing." They went on to say that when they returned to their family member's room after staff left, their family member looked relaxed and was clean and tidy. Another visitor told us how staff recognised that their family member became distressed by their continence difficulties and they had spoken to staff about that. They explained to us that the person's privacy and dignity was maintained because, "They moved [person] to this room. There's no carpet to ruin so there's no smell." They also felt that the new room was in a quieter area and that the person had benefited from not being disturbed by other people who might call out.

We observed that staff knocked on people's doors before entering their rooms. We saw that one staff member asked a person if they needed anything while their door was open, and then discreetly asked the person if they would like assistance to empty their catheter bag. The person agreed and, after collecting what they needed, the staff returned and ensured the person's bedroom door was shut while they provided support.

Good

Is the service responsive?

Our findings

The provider's audit showed that people with capacity to be involved in their care did not always sign or otherwise show how they were involved in reviewing their care plan. We also found that there was not always evidence in people's files of how they were involved in assessments and planning the care that they needed. However, people told us that they could discuss their care, or their relatives could be involved if they wished them to be.

We, and the provider's audit, identified that some reviews of documentation about people's care were significantly overdue. We concurred with the provider's audit findings about this and that much of the information was overdue for review. For example, we found that parts of one person's care plan and assessments had not been reviewed since June 2016. The registered manager explained that action was underway to address this. One staff member was currently allocated administrative time to ensure all care plans were reviewed, updated and transferred onto the provider's chosen format.

People told us that they felt the care they received took into account their individual needs and preferences. One person told us, "I go to bed when I want and get up when I want." Another said that they could decide when they got up. They explained that some people went to bed early but said, "I can sit in the lounge and watch films with other residents." Another person commented that a few people enjoyed sitting in the lounge watching films together during the evening.

On the day of our inspection visit, one person told us they felt unwell and had asked to remain in their room. They explained that staff had ensured they had meals and drinks in their room and said, "Staff have popped in to make sure I'm all right." The person added that, "They know I like to have the door open all the time." We heard staff asking another person about this, who had their door closed when the staff member knocked to go in. They asked the person about their door being shut, because they normally liked to have it left open, and checking about their preference.

A visitor to the home told us that staff responded promptly to their concerns about changes in their family member's wellbeing. They told us how the person, "…became muddled and tripped." The visit asked that staff find out whether the person had an infection. Staff acted on their concerns.

Staff were knowledgeable about people's histories and preferences and recognised that as a means to engage people in conversations that they would enjoy. A staff member commented to us that they generally had a good idea about people's needs and preferences before they came to the service. They said this was because the registered manager or deputy manager completed full assessments of people's needs before they moved in.

A visiting professional told us that they felt the registered manager took careful account of the needs of people they referred to the service. They described the process as considering carefully whether the service could meet the person's individual needs. They told us that the management team also considered the support needs of other people within the home in deciding if a placement was appropriate. They felt that

this enabled the management team to better balance the needs of people. They told us that the management team would decline admissions if it was appropriate and they could not meet the needs of the person.

People had the opportunity to engage in both organised and informal activities if they wished. During the morning on both floors, people joined in a word game. We observed that, on the first floor where some people were living with dementia, the game was not clearly explained to people. One person said they did not know what was going on. However, others were very engaged with the game and staff offered support and prompts to join in. People living on the ground floor joined in the same game enthusiastically just before lunch.

One person had told us that, during the afternoon, they felt the television was often on channels they did not want to watch. However, others did not share this view. One person told us they enjoyed the planned activities, and spending evenings in the lounge watching television with other people. After lunch, we heard one person commenting to another, "Where are they [staff]? They said they'd come and put a film on for us." A staff member did arrive and spoke to people about what film they might like to watch. However, their ability to meet people's preferences was compromised because many of the DVD cases they offered to people were empty. They did eventually find something that a group of people agreed they would enjoy.

Others were offered the opportunity to go to another part of the home for "Nan's Pantry," to help in making sandwiches as a snack for the afternoon. One person told us that they liked cooking and joined in the baking sessions. They told us how they had enjoyed decorating three large Christmas cakes. One person told us how much they enjoyed the regular music sessions and, "I get up and jiggle with my frame." One person spoke enthusiastically about their outing with a group of other people, to have a Christmas meal in a local pub. They told us how much they had enjoyed it.

People were also able to join in with routine domestic tasks if they wished. For example, a housekeeper told us how some people liked to join her in the laundry and help fold towels. They told us, "They only stay for about ten minutes before they say they have had enough, but they feel helpful." A visitor told us how this was important to their family member. They described how the activities coordinator supported the person, "...to potter. [Person] assists her with the morning tea round. [Person] feels useful." They went on to explain, "[Person] likes to fix things, they gave [person] a work box for Christmas and try to keep him occupied."

Most relatives felt that there could be more stimulating things for people to do, including outings, but recognised that this was not always easy to achieve. The activities coordinator told us that they tried to offer activities that suited people. The layout of the home sometimes made it difficult to ensure people were supported with hobbies and interests across both floors. They told us that they did try to get to people who spent most of their time in their rooms. They said, "I talk to them, or give them a pampering session. I do their nails or play dominoes."

People told us that they could go to the manager if they had any complaints. Two people told us that they did not have any complaints. One commented that they frequently spoke with the manager, not to complain, "We just chat." The person confirmed they would have no reservation in discussing issues with the manager.

Visitors were also confident that they could raise any concerns or complaints they had affecting the welfare of their family members. One visitor told us that team leaders would help out if they had concerns or they could go to the registered manager. One visitor told us they had spoken to the registered manager as they were unhappy with their family member's room. They felt that the person was isolated and lonely because

of the location of the room and after they had an illness restricting their mobility and interaction. They told us that, when a room had become available, their family member was moved to a room, "…which is better as people pass often on they can pop in." Another relative said, "It's a lovely feeling, I can go and speak to the bosses about anything, not just about [person], they even help me."

The registered manager told us that they had received just two complaints in the last year, both in February 2016 and investigated. They told us there had been none since and no concerns were raised with us on behalf of people living in the home.

Requires Improvement

Is the service well-led?

Our findings

We noted that people using the service, their visitors and staff found that the manager was approachable and listened to their suggestions. However, some aspects of leadership within the service had deteriorated since our last inspection in November 2015. We spoke with the registered manager about slippages since our last inspection and that they had not sustained all the improvements they had previously made.

For example, at our last inspection, there were regular meetings for people living at the home and their families. The minutes of these showed that people received feedback about the action taken to improve and change in response to their suggestions. At this inspection, we found that they had not sustained this improvement. The last recorded "resident and relatives" meeting, was in February 2016, a month after our last inspection report was published. The registered manager told us that they thought there had been one such meeting since then but was not able to find records of the discussions.

We also found that, although there were night staff meetings taking place, meetings for day staff were infrequent. We discussed with the registered manager that these were important in cascading consistent information to staff about changes within the service. This included for example, the importance of ensuring staff understood changes in recording systems and why the provider of the service required these. The provider's audit also identified that staff had not been fully updated on new policies in place.

There was a formal system for surveying people, their visitors and staff for their views and comments about the service. The last questionnaires were completed in September 2016 and we reviewed the results of these. The majority of responses to the questionnaires were positive about the standard of the service. However, there were areas, particularly in staff responses, where improvements were required. The action plan to address these was not completed and, coupled with a lack of consistent meetings and follow up, did not show how shortfalls were being addressed. The operations manager for the service told us that they felt the lack of an action plan to improve, was an oversight.

On the ground floor, we found that there was a plan to audit a sample of care plans on a monthly basis, taped to the inside of the door where people's care plans were kept. This did not indicate that there had been any audit to ensure records were complete and accurate since June and July 2016. This compromised the ability of the management team to ensure there were always relevant plans of care in place based on people's assessment, and to ensure they were up to date. The management team had not identified the concerns we found, for example, in relation to conflicting information about one person's eating and drinking and a lack of appropriate recording in relation to weight monitoring. We also identified that written plans for managing increased risks were not always developed promptly as guidance for staff about mitigating those risks.

The provider's quality audit report was thorough and the concerns they found were consistent with those we identified. Their audit report was completed at visits on 3 and 4 January 2017, and highlighted shortfalls from expected standards. These included the way that records reflected people's risks and support needs and were overdue for update or review, and gaps in the assessment of risk. They also identified a lack of

clear follow up about accidents and serious injuries. We found that the management team monitored the frequency of falls for people to identify whether they needed to make referrals to the falls prevention clinic. However, we concurred with the provider's view that accidents were not always reviewed promptly to see if there was action needed to address specific, individual circumstances. For example, we found a report of an accident taking place almost two weeks before our inspection visit, which had not yet been reviewed by a member of the management team.

The registered manager acknowledged some difficulties arising from changes in processes. They told us that they were struggling with how they could best support staff to develop, review and update people's assessments and plans of care. Since our last inspection report was published, the provider had changed their name. They had developed new documentation to show this. The registered manager needed to transfer information onto new, headed documents and their expected templates. They explained that this was the third change in six years and did make things difficult to consolidate.

They also acknowledged their difficulties in supporting staff with developing care plans, which may had contributed to shortfalls in developing those from relevant assessments. The operations manager told us how they were trying to source additional training and support in this area. We noted that the operations manager was making weekly visits to the service to try to support the improvements across the service, which the provider expected. They had made two such monitoring visits since the provider's representatives completed their audit and before we started our inspection.

The registered manager had maintained improvements in their accessibility and availability to people, their visitors and staff. Staff spoken with demonstrated a high level of motivation and commitment to the people they supported. They had a clear understanding of their roles and what was expected of them. They were enthusiastic in the way they described their work and how much they enjoyed it. They described teamwork as good and the management team as supportive in encouraging them.

The management team and staff were successful in ensuring Alexander Court was a homely place to live and people were satisfied with their care. One person told us, "It was difficult at first, but I'm happy that I'm settled. I've made some good friends." Another told us, "Look around, it's genuinely a good place." Their views were shared by visitors we spoke with. One told us they would recommend the home and, "I'd give it 9 out of 10." Another visitor said, "More than anything, it's just the right size. Any bigger and they're just numbers." A third visitor was very satisfied with the quality of the service and told us they would have no hesitation in recommending it. They said, "It's absolutely superb, there's a lovely atmosphere here."

Three visiting health professionals also assured us that they would be happy for one of their family members to be cared for at Alexander Court and one said they would use it themselves.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons did not ensure that the risks of people not eating and drinking enough were consistently assessed and managed to ensure people's nutritional and hydration needs were met. Regulation 14(1), (2), (4), (4)(a)