Sir Josiah Mason's Care Charity

Alexandra House

Inspection report

Hillbourgh Road
Acocks Green
Birmingham
West Midlands
B27 6PF

Tel: 01212451081
Website: www.sjmt.org.uk

Date of inspection visit:
06 October 2016

Date of publication:
04 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 this inspection on 6 October 2016 and it was unannounced.

Alexandra House provides care for up to 36 older people in Solihull. At the time of our inspection there were 35 people living at the home. Some people were living with dementia.

A registered manager was in post and had been in the role for almost two years. This person was absent on the day of our visit. 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 could not be sure people who used the service were safe. Risks to people's safety had been identified by staff, however ways to manage and reduce these risks were not always documented to ensure a consistent and effective approach was taken.

Care records contained information for staff to help them provide personalised care, however some information that staff needed was conflicting or missing about people and how they should receive their care.

There were enough staff to care for the people they supported however some concerns were raised about staffing levels at night. Checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service. New staff received an induction into the organisation, and they completed training to support them in meeting people's health and care needs.

Staff had a good understanding of what constituted abuse and knew what actions to take if they had any concerns.

People and relatives told us staff were caring and had the right skills and experience to provide the care required. People were supported with dignity and respect and people were given a choice in relation to how they spent their time. Staff encouraged people to be independent.

People received medicines from staff who were trained however medicines were not always administered correctly. For medicine taken 'as required' (PRN), guidelines were not always recorded to tell staff when people needed this.

Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making, which included arranging further support when this was required.

People had enough to eat and drink during the day, were offered choices, and enjoyed the meals provided.

Special dietary needs were catered for.

People were assisted to manage their health needs. Referrals to other health professionals were made when this was required.

Some people had enough to do to keep them occupied. There were limited activities arranged for people living with dementia.

People were given the opportunity to feed back about the service they received through surveys. Meetings for people and relatives were held.

People knew how to complain if they wished to, however told us they had no complaints. The provider was aware of their responsibilities in relation to managing complaints received about the service.

The provider did not have effective systems in place to identify areas that required improvement and to assure themselves that people received a quality service.

Staff had mixed views about the management of the home. Some staff did not always feel they could raise concerns or that these would be listened to. There were some formal opportunities for staff to feedback any issues or concerns at team meetings and in one to one meetings.

Checks of the environment were undertaken and staff knew the correct procedures to take in an emergency.

We had received the required notifications to enable us to monitor the service. The provider was able to tell us which notification we were required to receive such as safeguarding referrals and of serious injuries.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

People received support from staff who understood the risks related to their care, however these were not always documented so staff could consistently manage and reduce risks. People received their medicines from trained staff. However, medicines were not always administered correctly. We could not be sure that people who needed PRN medicine would receive this consistently. Staff had a good understanding of what constituted abuse and knew what to do if they had any concerns. There was a thorough staff recruitment process and enough experienced staff available to provide the support people required during the daytime.

Is the service effective?

Good

The service was effective.

Staff were trained to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making. People were supported with their nutritional needs. Staff referred people to other professionals if additional support was required to support their health or social care needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Relatives told us staff were caring and respected people's dignity and privacy. People were encouraged by staff to be as independent as possible and were given choices about how they spent their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received a service tailored to their personal preferences.

Care records contained information about people's likes, dislikes and routines, however other information was missing or conflicting. People enjoyed some activities; however there were limited activities for people living with dementia. People knew how to complain if they wished to, however had no complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff had mixed views on whether they felt able to raise concerns with the management team. Effective systems to review the quality and safety of service provided were not in place to identify issues and improve the service. People and their relatives told us managers were approachable. There were opportunities for staff to discuss any issues or concerns at meetings. People were given opportunities to feedback any issues of concerns by completing surveys and attending meetings.

Alexandra House

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 6 October 2016 and was unannounced. The inspection was conducted by two inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of care service.

Before our visit we reviewed information we had received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We looked at information received from relatives and visitors.

We spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They had no further information about the home.

Some of the people living at the home were not able to share their experiences of the care and support provided as they were living with dementia. We spent time observing the interactions between them and the staff who provided their care in the communal areas.

During our visit we spoke with 15 people and seven relatives. We also spoke with 13 staff including five care staff, two team leaders, a deputy team leader, the cook and two laundry assistants. We also spoke with the sheltered housing and care services manager and a supporting manager from another service.

We reviewed four people's care records to see how their care and support was planned and delivered. We checked two staff files to see whether staff had been recruited safely and were trained to effectively deliver the care and support people required. We looked at other records related to people's care and how the service operated, including safety records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed and found they were not always administered correctly. Medicated creams were kept in people's rooms and where they were able, they applied these themselves. Of four creams we checked, one was out of date and two had not been applied as prescribed. Another person had a cream to use 'as required', known as PRN. These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. There was no guidance for staff to tell them how often or where the cream needed to be applied. We discussed this with a team leader who told a protocol was in place for this medicine. We checked records and a protocol was not in place, however protocols were in place for some other medicines.

One staff member told us previously medicine administration records (MAR) for creams had been kept in people's bedrooms. This had been effective because staff signed the charts when they applied the creams or as people did so themselves. These had included body maps to show where the creams needed to be applied. These records had been removed by the management team and were now kept in a different area. One senior staff member told us they were unhappy signing records for creams if they were not sure these had been applied correctly and they recognised that not having MAR charts in people's bedrooms was not as effective as before.

Some people had PRN medicine for when they were in pain. Although PRN protocols were not always in place, staff could tell us signs that indicated people required medicine. A staff member said, "[Person] can't always tell me if they are in pain, I know if they are because they might look pale and their body language will indicate this. They will hold their hands tightly clenched." For another person staff knew they would cry out if they felt in pain, however this was not documented on their care records so we could not be sure the person would receive this medicine consistently.

Medicine should be stored within specific temperature ranges, so it remains safe to use. We were unable to see the room temperature recorded, however staff were able to tell us what this should be for safe storage. We raised this with the sheltered housing and care services manager who told us they would address this.

Senior staff administered medicines and team leaders told us they checked this was done correctly. A pharmacy visited the service monthly to support them. Weekly audits had been carried out for medicines that required special storage. However, we were unable to see medicine audits had been completed for other medicines to identify the issues we found during our visit. Staff had received training in administering medicines, however no competency checks were carried out by managers to ensure staff remained safe to do this. The sheltered housing and care services manager told us they would review this now to make improvements.

People told us they had no concerns in relation to how they received their medicines. One person told us, "I do my medicine myself, my inhaler, I have some in the morning and at night." Another person told us that they received their medicines on time.

Staff wore tabards to show others when they were administering medicine and to stop them from being distracted while doing this. We observed staff giving medicine to people and seeking their consent while explaining what it was for. Staff gently encouraged people to take their medicine.

Staff understood the potential risks associated with providing people's care and told us how they supported people safely. However, we found these had not always been documented consistently to identify the ways risks could be minimised to keep people safe.

A risk assessment tool assessed people as red, orange or green. This helped staff to identify at a glance who may be at higher levels of risk. We were told risk assessments were updated by senior staff monthly, however we found these were not always correct.

For one person their health risk assessment had been updated in September 2016 which identified a 'high' risk. It was unclear why. A staff member explained to us the person was at the 'end stage' of a serious health condition. This information had not been recorded in their care records.

Mobility risks had been updated for one person in January 2016. Their record stated they were at 'High risk of falls, uses a frame to mobilise. Staff to encourage them to use their walking frame.' The person had fallen in October 2016, however this information had not been reviewed to see if risks could be reduced further.

One person was at risk as they could not call for staff to help them. Their record contained conflicting information. It stated, 'Unable to use call bell to summon assistance therefore check every 2 hours throughout the night.' It then stated 'staff were to ensure they had their call bell to hand to summon assistance.' We raised this with the management team who agreed this was confusing and told us they would review the information immediately.

A nutritional risk assessment for one person stated they were 'obese'. We saw this person and they were slim. We asked the team leader about this person and they told us this information was incorrect, and had not been updated.

Other risk assessments had been updated and were correct. The mobility risk assessment for one person assessed them as high risk of falls in September 2016. To reduce the risk of them falling, staff needed to walk by their side and offer them encouragement to use their frame, and we saw staff did this. A relative told us how their family member had fallen out of bed and how the staff had taken steps to address this, such as their bed being lowered down and a padded safety mat provided to protect them if they fell again.

People told us they felt safe and were happy with the care they received. One person said, "The staff are very good, they look after me." One relative told us their family member had to be moved using a hoist by two staff. They told us they felt safe when this was carried out because staff always 'talked them through' what was happening.

The provider's recruitment procedures minimised the risk to people's safety. Prior to staff starting work at the home, the provider checked their suitability to work with people who lived there. Background checks were obtained and references were sought. Comments from staff included, "I had a DBS check when I started a couple of years ago. I had to wait for clearance before I could start work," and "I provided two references to check that I was the right sort of person to work in care." The disclosure barring service completes background checks to ensure as far as possible that staff are of suitable character to work with people. We checked two staff files and saw these had been completed.

Most people told us there were enough staff available to meet their needs. One person told us, "We don't have to wait for staff, they are quite quick." Staff comments included, "We usually have enough staff. Team work is good, we all work together to cover shifts if need be." "There are more staff now. We can supervise people better, keep a close eye on them to make sure they are safe." "There is always enough staff, shifts are covered."

Some staff had mixed views about whether there were enough staff available at night. A staff member told us, "I felt more concerned with staffing, when I did a night shift." One relative told us, "The need more staff at night, there is only two for 36 people."

There were no staff vacancies currently and agency staff were rarely used. To supplement the permanent staff team 'bank staff' were employed. These staff members provided occasional cover for shortfalls in staffing levels and staff absences. The sheltered housing and care services manager told us, "Because we have bank and floating staff we can flex the hours if needed and add people in." A 'floating' staff member worked to support staff each day. Staff covered any extra shifts themselves and told us they preferred to do this as they knew the people well and they could be consistently supported.

Staff understood the importance of keeping people safe and their responsibilities to report any concerns. Comments included, "Abuse is neglect, hurting people or stealing their money or belongings," and "If I suspected abuse such as physical I would inform a manger immediately. It is my job to keep people safe."

Staff had received training around safeguarding and told us, "Safeguarding training is really good. We have it each year, it is face to face. I learned about types of abuse and my responsibilities to protect people" and "Safeguarding training is really important. We have to be vigilant." They told us they noticed a bruise on someone's arm a few weeks ago and had told their manager.

Staff were aware of what 'whistleblowing' meant (raising concerns about other staff at the home) and how to report concerns. One staff member told us, "We have a whistle blowing policy. I would speak up if I witnessed any poor care, it's my duty" and "We have safeguarding guidance. I would write down any concerns about people and tell the managers. If they did not do anything I would ring care standards or CQC." A phone number was displayed for staff to call if they were concerned about possible abuse.

Staff were aware of the procedures to take in an emergency and if the home required evacuation. One staff member told us, "We have a fire test every Monday. I know what I need to do if there was a fire." Personal emergency evacuation plans were documented for each person and advised staff how to support someone safely and effectively during an emergency. We saw some had been recently updated, others were not dated so we were unclear if the information was current. This meant the person may not be supported correctly in an emergency. Fire safety checks and fire drills had been completed. A business continuity plan documented how people could be supported safely in the event of any issues such as flooding or disruption to services occurred.

Accidents and incidents were documented for each person and had been analysed to identify any trends or themes which might prevent these from reoccurring. A monthly falls audit had been completed. We identified one fall which had not been recorded and this was amended by the management team.

Two maintenance people were employed. Safety checks of the environment were completed such as gas safety, electrical and call bell checks. Equipment had been serviced regularly to ensure it remained safe to use. We saw found one fire extinguisher which required servicing and raised this with the sheltered housing and care services manager who told us this would be arranged.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received and staff had the skills and knowledge to meet their needs. One person described staff as 'top notch'. One relative told us, "The staff have been golden, they are well trained and know [name], they have put weight on since they have been here." Staff told us, "Standards of care are high, we all sing from the same hymn sheet and work together to provide good care to people," and "People deserve good care, I think they always get it here."

Staff received an induction when they first started working at the home. One staff member told us, "I came to meet people, was shown around and completed some training." Another staff member told us, "I had a 12 week induction. At the end I was offered a permanent job." Staff were given a handbook when commencing employment and this detailed the provider's policies and procedures. An induction checklist was completed for all staff and covered areas such as health and safety.

Staff received training suitable to support people with their health and social care needs. Comments from staff included, "We always have training, it's quite good, we are encouraged to ask questions." "We have training in first aid and fire safety it's quite good." "I have learnt a lot from the training. I learnt how to hoist someone safely and I think we all have high standards here." Training had been completed in areas such as moving people safely, first aid, dementia care and health and safety. A schedule was kept by the management team to enable them to monitor training completed by staff and when this was due. Several staff were completing health and social care qualifications to increase their knowledge. One team leader had the additional role as a mentor for an apprentice at the home.

New staff completed the Care Certificate. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment.

A 'handover' meeting was held twice each day as the staff changed. Information was shared by staff about people's health or well-being, so people could be supported consistently. One staff member told us, "We always have a handover, it's really useful especially if people are poorly or if I haven't been at work for a few days." We observed a handover meeting and important information was shared about people. For example, one person had not slept well the previous night and staff were made aware of this.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 (DoLS) were

being met. We found three of the people living at the home were having their liberty restricted. Decisions had been correctly taken to submit applications to a 'Supervisory Body'. At the time of our visit the applications had been submitted or authorised.

Staff had an understanding about the principles of mental capacity and had received training in this area. Most people at the home could make some day to day decisions. Staff comments included, "Capacity is about people making choices. I don't assume people can't make decisions," and "Some people lack capacity. I always explain to them what I am doing." One team leader told us, "People have the capacity to make their own decisions. If they do not, you need to consider what is in their best interests." On one person's care record it stated correctly that what might be deemed as 'unwise choices' of one person should be respected by staff, as this person had capacity to make these decisions.

Staff gained consent from people before supporting them with care. One staff member told us, "If someone refuses my help, I know that I have to respect people." Consent forms had been completed by people where they were able to consent. We observed people being supported by staff for example, with their medicine, and consent was obtained. We saw a fact sheet about DoLS was displayed to aid staff understanding.

Do not resuscitate forms (DNA CPR) were completed and kept with people's care records. We saw these had been completed correctly and people had been involved in making these decisions.

People's nutritional needs were met with support from staff. One person told us, "The food is good and plentiful, we get two choices but if I don't like something the cook will make me something else." People told us they could choose where to eat their meals. One person asked for a small portion and this was provided. People told us they could have extra food if they wanted it. A four weekly menu was available.

We observed lunch time and overall this was a positive experience for people. People told us the meals were hot and they looked appetising. Tables were laid and there were some positive interactions between people who were chatting to each other. However, some people sitting at the same table were served at different times, so some people had finished their meal before the person next to them had begun to eat. We saw staff encouraging people to eat their meals. One person ate from a bowl instead of a plate because they had poor vision and eating from the bowl meant they did not spill their food.

Some people who were living with dementia were not shown plated choices of the meals and it was not clear they understood what the options were. There were no picture menus. Staff told us people were asked after each meal what they would like for their next meal.

People were only offered one choice of drinks at lunchtime, however, one person asked for a cup of tea and this was provided. Comments included, "They know I don't like plain water, so always give me squash," and, "They know I don't have sugar in my tea, there are plenty of drinks." We saw drinks were available for people throughout the day.

People who had special dietary needs were supported. People had 'nutritional profiles' and this information was communicated to the cook when people moved in. The cook was able to tell us about people and how they supported them. For example, they made low sugar puddings for people with diabetes and fortified foods if people were under weight. The cook told us about one person, "They have a small appetite; we encourage small fortified portions to maintain their weight. I make fortified milkshakes with double cream and whole milk. We offer a fortified yogurt each morning and they contain 249 calories so it's a good way to ensure their calorie intake is sufficient."

Allergens in food were displayed so people were aware of the ingredients of their meals. Some people had special dietary requirements in relation to their cultural needs and the cook was aware of this.

People were supported to manage their health conditions and had access to health professionals when required. One person told us, "If I feel unwell, the doctor is sent for quickly." They explained they had recently had an infection. Another person told us the district nurses visited regularly to help with their sore legs and they were quite happy with the care they received. One staff member told us, "If I saw someone had red skin I would tell a manager. They phone the district nurses who would come and check the person's skin." Another person frequently had chest infections. They told us the GP was called quickly and the staff administered medicines and inhalers as soon as they are prescribed.

One person had been referred to an occupational therapist because they needed a piece of equipment. An occupational therapist helps people to carry out everyday activities which are essential for health and well-being. Some people had been referred to a dietician around managing their weight. A chiropodist visited every six weeks. People told us they saw the dentist when needed and opticians visited the home when necessary.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. Typical comments included, "I am very happy here." "The staff are ever so nice." "They look after me and I look after them, we are all mates together." Comments from relatives included, "[Person] is looked after really well, the staff are respectful." One relative explained that when their family member had been taken to hospital. The next day they were tired and staff encouraged them to have a lie in and a late breakfast, which they felt demonstrated kindness.

Staff told us what caring meant to them, "Being kind and patient" "Listening to people, giving them time." "Some people really enjoy a hug, hugs are plentiful here." One staff member told us, "I feel proud of the care I provide." This was because they had enough time to sit and talk to people and they did not rush people. A staff member told us, "Its busier in the mornings, sometimes it can be a bit rushed, afternoons are better. Its quieter and we can spend more time with people."

We observed staff supporting people with kindness during our visit, being respectful and encouraging to people. We observed good relationships between staff and people. Some people walked arm in arm with staff. One person had found it difficult to communicate using speech. Staff had identified that by singing with them, this helped them to express themselves and their speech had slowly improved. We saw them singing with staff and enjoying this.

One staff member told us that if someone needed some personal shopping, they would get this for them. For one person who had been very unwell, they had asked for rice pudding to eat and as it was not being delivered for a few days, the staff member went out to get this for them so they could have it straight away.

Staff supported people with privacy and dignity. One person told us, "They always knock on my door before entering." One relative told us, "My husband always looks co-ordinated with his clothes, which is important to him." A family member explained when their relative had started to use incontinence aids this had been discussed discreetly and respectfully with them by staff.

On the day of our visit we saw all the bedroom doors were open. The team leader told us people preferred this and this enabled staff to check on them. A relative also told us this was as staff liked to keep an eye on people. However, on the day of our visit, we were aware some people were unwell and this did not afford them privacy during this time. We raised this with the sheltered housing and care services manager who told us that some people did prefer this however understood our concern.

People made choices about how they spent their day. Some people liked to socialise with others whilst other people preferred their own company. One person smoked cigarettes and their relative told us they were happy that they were able to have a cigarette when they chose to.

People were encouraged to be independent where possible. One person used a spoon instead of a fork to eat their meals. This was because they could scoop their food easier as they did not have enough strength in their fingers to push food onto their fork. Some days another person could not grip a cup and preferred to

use a beaker and this was provided to maintain their independence.

People's rooms were individualised, contained their own personal items and people were encouraged to make these comfortable to suit their needs and preferences. None of the bedrooms had en-suite facilities; people had commodes in their rooms and shared bathrooms.

People were encouraged to keep in touch with their families and friends and there were no restrictions on visiting times. On relative told us, "If I telephone the home, the phone is answered quickly and if I ask for my [family member] to be ready to go out at a certain time, they are always ready." This person also went to stay with their family at the weekend. Another relative visited the home to play music and entertain people. Some people used a computer to keep in touch with their relatives. Another person had a relative living close to the home so regularly went over to see them.

Requires Improvement

Is the service responsive?

Our findings

People were positive about the care they received and staff knew the people they supported well. One person told us, "The staff are good, they understand my needs."

People were assessed prior to them living at the home to ensure that their care and support needs could be met safely. Pre - admission assessments were completed and information was obtained about people's life histories, likes and dislikes from people and their families. People were involved in writing their care plan with their relatives. Care records contained information about routines and preferences. We saw information about what was important to people and significant life events.

Although care records were, overall 'person centred' and contained information which enabled staff to get to know people better, some care records we reviewed did not detail the level of support people required or detail how staff were to provide this support. Some information was missing, contradictory or required updating. For example, one person's care record around their mobility was dated June 2015. Other information for personal care was dated April 2014 and we were unable to see whether this had been reviewed. Some other information was not dated, so we were unsure if this was correct. Some records contained conflicting information about people's needs. For one person's ability to communicate, their record stated, 'Unable to make wants and choices known to staff.' However, it later stated that staff were to 'give the person time to make their choices known.' We asked staff about this and they told us this person could make some choices for themselves.

One person was prone to infections and this caused them to be confused at these times. This had been documented in September 2016, but there was no information to guide staff on how to support this person or what they needed to do if they were confused. In the care record for another person it stated that 'staff needed to encourage them to wear glasses.' We saw this person was not wearing glasses. We discussed this with a team leader who told us the person had never worn glasses and this information was incorrect.

Staff told us about people's care records, "We should read them, but I know people really well" and "People have a care plan, but they are out of date now." The sheltered housing and care services manager told us, "We had picked up the issue about care plans before." People's care records had not been reviewed regularly and were in the process of being updated by a team leader. They told us these should be updated usually every four weeks or if people's needs changed. It had been documented in a management meeting that three care records were to be reviewed monthly, however it was not clear if this action had taken place. One care plan we checked had been audited in October 2015. The team leader told us these were done annually and were due now.

Some care records were correct and had been updated. One person had been referred to a dietician as they had a small appetite and were at risk of losing weight. To support them to maintain a healthy weight, a fortified diet had been recommended and this was being provided. The person's weight was recorded and was stable.

Staff knew people who lived at the home well. Staff explained to us in detail about one person's morning routine and preferences. As the person did not always want to be supported with care, staff encouraged them by telling them what they were doing and in what order. They told us, "When [name] says, "That's enough; I know they don't want any more help, so I will stop what I am doing. I will leave them alone for a few minutes and then come back. Usually they will let me carry on helping them to get dressed." They told us they could tell if the person felt anxious and they knew how to speak to them in a way which reassured them.

Staff worked in teams and were allocated to support people so they had consistent staff who they knew well. Keyworkers were allocated to people and these staff ensured people were supported with individual needs such as purchasing clothing and toiletries. A staff photo board was displayed so people knew who the staff were.

Care review meetings were held annually or more frequently if required. One relative explained to us their family member had a review meeting after they had lived at the home for approximately five months. Another relative told us their review had been more formal with a social worker involved. Relatives told us they were involved in planning care and were notified of any changes when this was appropriate.

There were some social activities to keep people occupied. For example, quizzes and exercise to music classes took place. Music nights and film nights were held. A hairdresser visited weekly. Activities were arranged by care staff. Some staff felt this could be improved comments included, "There are some activities, I think we could do more to keep people occupied," and "We try and provide activities." The sheltered housing and care services manager told us, "We are looking to develop an activities co-ordinator."

Some people due to their health conditions were cared for in bed. We asked staff what one to one activities were available to these people to keep them occupied. One staff member said they would mainly 'sit and chat' with people. Trips out had been arranged in the past, however the uptake of these had not always been popular. We asked one person about this and they told us they did not want to go on any trips.

Individual activities records were completed to show what people had joined in with and what they had enjoyed doing. However, we were unsure how this information was used to review activities. Records for one person cared for in bed had not been completed since March 2016.

During our visit we saw one person who lived at the home calling the bingo numbers and it was obviously they enjoying doing this. This person later told us how they enjoyed drawing and gardening. They had their own greenhouse and a raised garden bed where they grew their own plants and food, some of which was eaten by people living at the home. A computer had been available for people to use but had not been used widely so hand held tablet computer was now being purchased so people could use the internet if they wished. A loop system supported people to watch television who were hard of hearing.

Staff had received some training to support people living with dementia but they were unable to explain the content or what they had learned. One comment included, "I treat people as individuals." However they could not expand on this information. A member of staff told us people could take part in a game of 'Play your cards right.' There were some 'old time' photographs displayed on the walls of the home but we were unable to see other dementia friendly activities. Corridors were painted different colours, but staff did not think this was to help orientate people living with dementia. One staff member told us said, "The manager just chose different coloured paint."

We looked at how complaints were managed by the provider. No one had made any complaints in the last

12 months at the time of our visit. However, people told us they felt confident to complain if they needed to, and would speak to the manager or senior care staff. One relative told us, "I spoke to [sheltered housing and care services manager] the other day, they were very helpful." A copy of the complaints procedure was displayed. It stated, 'Tell us about anything that has caused you to be unhappy about the service we provide,' and contact details for the registered manager, the provider's head office and the care quality commission were included.

Compliments had been recorded and thank you cards were displayed. Comments included, 'Thank you for looking after Mum so well, your kindness was very much appreciated.' 'Thank you for everything, dad really appreciated everything that you did for him,' and 'Many thanks to all of the wonderful staff.' The home had one review from a care website submitted by a relative in September 2016 and this stated.' Mother was very comfortable during her stay, staff were very attentive and help was never too far away."

Requires Improvement

Is the service well-led?

Our findings

We received mixed views form staff about the management of the home. Some staff told us they did not always feel able to raise concerns as they would not be listened to. One comment included, "I don't think I can suggest things here. It is if your face fits. I come in and do my job, I should be able to go to [manager], I don't think I can."

Systems were not always being operated effectively to assess, monitor and improve the quality and safety of the service provided to benefit the people who lived at the home. Care records were not always accurate and contained conflicting, inaccurate or out of date information which posed a risk people could receive the incorrect care. Some care records had not been reviewed in-line with the provider's procedures and staff told us information was out of date. Risk assessments had not always been updated, so it was not clear how staff could manage and reduce the risks to people's care and keep them safe. Medicines were not always administered correctly and were not being audited to ensure they were being given safely. Checks to ensure staff remained competent to administer medicines were not being completed to ensure they remained safe to do so. Checks that had been completed had not identified the issues we found during our visit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

People and relatives told us they were happy at the home. One person told us, "Personally I would not change anything. I love it here." One relative told us, "I've got to know [registered manager] quite a bit, they are approachable and available." Another relative told us, "It was by far the best home I've seen, you get that feeling as soon as the door was opened."

Other staff felt supported by the management team and enjoyed their jobs. One staff member told us, "It's a nice place to work, I am happy here." Another staff member told us, "I feel supported. The team leaders are really good. They get stuck in and help out." One staff member told us they felt able to talk with the sheltered housing and care services manager. They told us, "[Person] is quite approachable, I could raise things."

The provider's management team consisted of the registered manager, the sheltered housing and care services manager and team leaders. They were supported by deputy team leaders and care staff. The registered manager was not at the service on the day of our visit due to an unplanned absence and had been away for around five weeks.

The team leaders were covering the manager's role in their absence and staff were positive about this. One staff member told us, "I trust the team leaders, they do a good job here in the absence of the manager." Other comments included, "The team leaders are approachable, they are doing a good job supporting the staff and caring for the residents." "The team leaders are lovely, so helpful, always around."

Staff had formal opportunities to meet at team meetings and in one to one supervision meetings. This was

an opportunity for staff to raise any concerns or issues they had with their managers. Staff comments included, "We have team meetings, we are encouraged to raise our concerns. We had one two weeks ago, a lot of staff attended and I feel my views were welcomed." "I have supervisions with my team leader, we can talk about how I am feeling and my performance at work." At the last staff meeting in September 2016 staff had discussed activities for people, the role of the keyworker and whether further training was required. Team leaders had supervisions with the registered manager each month and these meetings took place for other staff every three months.

Staff were also observed by managers whilst carrying out their duties and were given feedback. One team leader told us, "I observe practice of staff and I will put any concerns across."

Appraisal meetings gave staff the opportunity to reflect on their practice. The registered manager was supported by the sheltered housing and care services manager.

People at the home had an opportunity to feed back any issues or concerns they had. Resident and relatives meetings were held. Questionnaires had been sent out in 2015 to obtain feedback about the service and 13 responses had been received. Positive comments included, 'I feel safe and secure' and 'staff are attentive'. Some people said they would like a private bathroom and to go out on trips more. Overall people were happy with the care. A further survey had been sent out in 2016 and the provider was awaiting these responses.

A newsletter was produced every three months and featured news stories about people using the provider's services. An open day had taken place in August 2016 and people told us they had enjoyed this.

Further developments were being planned at the home to improve the environment for people. For example, new furniture and flooring was going to be purchased. Some new equipment had also being purchased to help staff care for people safely.

An external audit had been completed by the clinical commissioning group in August 2015. Overall this was positive with some suggestions for improvements to hand washing facilities and flooring.

The sheltered housing and care services manager told us about some challenges for them at the home. These included the increasingly high level needs of people and managing these as people's health changed. They told us they were proud of how the staff had worked hard since the manager had been away and 'pulled together'. They told us they felt the home had a good reputation and a lot of the referrals were through 'word of mouth'. They had a very low turnover of staff and had received no complaints. The sheltered housing and care services manager told us as they had several facilities for care nearby, often people stayed within the group if their needs changed.

The provider understood their responsibilities and the requirements of their registration. They were able to tell us what notifications they were required to send us, such as changes in management, safeguarding and serious injuries.

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively. The quality and safety of the service was not always monitored to mitigate the risks relating to the health, safety and welfare of service users. An accurate and complete record of each service user, their care and treatment was not maintained.