Cuerden Developments Ltd

Cuerden Developments Limited - Alexandra Grange

Inspection report

Alexandra Grange
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Alexandra Grange on 17 May 2017. We last inspected the service on 29 March 2016 when we found three breaches of regulations. These were in relation to person-centred care, safe care and treatment and good governance.

The service sent us an action plan identifying the actions they intended to take to address the breaches of regulations identified. At this inspection we found improvements had been made and the service was now meeting all regulatory requirements.

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

People who used the service, their relatives and professionals we contacted, told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise highlighted risks. Safeguarding policies were in place and staff had an understanding of the types of abuse and procedures for reporting concerns..

The environment was effective for people living with dementia and provided stimulation. There was signage to aid people's orientation and help them to be as independent as possible.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of DoLS and the MCA, the importance of consent to care and treatment and how to act in peoples best interests.

People who used the service and their relatives told us the staff were caring and kind. We observed care in the home throughout the day. Staff interacted with people who used the service in a kind and considerate manner, ensuring people's dignity and privacy were respected.. Relationships between people who used the service and staff members were warm. Conversations were of a friendly nature and staff's attitude to people was polite and respectful using their chosen names, to which people responded positively.

There was an appropriate complaints procedure in place. Complaints were followed up appropriately and people who used the service and their relatives knew how to make a complaint.

A number of audits were carried out by the service, issues were identified and action plans put into place. Medication policies were appropriate and medicines were administered, stored, ordered and disposed of safely.

People's care plans showed evidence of effective partnership working and we saw information in peoples

care files that showed the involvement of relatives where appropriate.

People's nutrition and hydration needs were met appropriately and they were given choices with regard to food and drinks. Care plans included appropriate personal and health information and were up to date.

We observed the lunchtime meal. There was a relaxed unrushed atmosphere and we saw that staff interacted with people in a respectful and dignified manner, recognising people as individuals' and encouraging their engagement. There was a four week, seasonal menu cycle in use which was nutritionally balanced and offered a varied selection.

The home had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose, which is a document that includes a specific set of information about a service.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates.

There was evidence of multi-disciplinary team reviews in people's care files and evidence of best-interest decisions and discussions.

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s).

People's spiritual needs were met through the provision of regular visits from different faith groups.

There was a 'key worker' system in operation for both day and night shifts. There was a person centred care policy in place. We saw that information about personal preferences, social interests and hobbies was recorded in people's care files. The service produced a monthly newsletter for people and their relatives. We found that resident's surveys were also undertaken.

The home employed an activities coordinator. A wide variety of information and photographs of previous activities was displayed throughout the home.

Staff supervisions were undertaken regularly and we saw these were used to discuss issues appropriately on a one to one basis. The manager carried out a registered nurse competency check under the home's competency framework.

There was a business continuity management plan in place that identified actions to be taken in the event of an unforeseen event.

Throughout the course of the inspection we saw the registered manager walking around the home observing and supporting staff.

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 we spoke with and their relatives told us they felt safe.

There were robust systems in place for the safe management of medicines.

There was evidence of robust recruitment procedures in place.

The home was adequately maintained, including the servicing and maintenance of equipment used within the home.

Is the service effective?

Good

The service was effective.

People's care plans showed evidence of effective partnership working and the involvement of relatives where appropriate.

Staff provided assistance to people who required it as identified in their care plan.

There was a four week, seasonal menu cycle in use which was nutritionally balanced and offered a good range of choices.

There were adaptations to the environment which made it dementia friendly.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were caring.

Relationships between people who used the service and staff members were very warm and staff demonstrated a good understanding of the people they supported.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates.

Is the service responsive?

Good

The service was responsive.

There was evidence of multi-disciplinary team reviews in people's care files.

There were regular visits by different supporting professionals such as chiropodists and opticians.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post which is a condition of Alexandra Grange's registration with CQC.

People we spoke with and their relatives told us they thought the service was well-led.

There was a range of monthly audits in place.

Cuerden Developments Limited - Alexandra Grange

Detailed findings

Background to this inspection

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

This inspection took place on 17 May 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Wigan Local Authority who monitor the service.

We spoke with six people who used the service, five staff members, one visiting relative, the team leader, the senior carer and the registered manager.

We also looked at records held by the service, including six care files, eight medications administration records (MAR) and five staff personnel files.

As part of this inspection we 'case tracked' records of two people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and well-being were being appropriately managed by the service.

We observed care within the home throughout the day including a medicines round and the lunchtime meal.

Good

Is the service safe?

Our findings

We asked people living at the home if they had any safety concerns regarding the home. One person told us, "I feel safe. They are there when you need." A second person said, "It's alright here. I'm safe." A third person told us, "I'm safe here. No concerns."

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. Care staff demonstrated an awareness of the potential signs of abuse or neglect and knew how to report any safeguarding concerns appropriately. Staff told us they had contact numbers for the local authority safeguarding team, the care quality commission (CQC) and the police, should they need them. One member of staff said, "Signs of abuse could be recognised if a person was low in mood, had bruising, behaviour changed. I'd report any concerns to the registered manager. If they didn't do anything, I'd whistle blow to social services or CQC." A second staff member said, "Safeguarding matters could be physical, mental, financial, and sexual. I'd report concerns to my senior. I could go to the owner or CQC f nothing being done about it." A third staff member said, "If a member of staff rushed a person or treated them what I perceived as rough. I'd report that to safeguarding."

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns and included contact details for the local authority and CQC.

We spoke with a local authority professional who told us the home manager had followed local authority reporting procedures for any incidents that had occurred within the home. These included details of any actions taken.

We asked people living at the home for their views on staffing levels. A person told us, "I think there is enough staff, they always come quick when I need them." A second person said, "I feel there are enough staff."

A staff member told us, "There is enough staff. When people ring in sick and nobody wants to cover the shift, they cover with agency. Some days are busier than others, it depends on the day." A second staff member said, "Having four to five staff down here works fine. If people are settled, five sometimes feels too many. We are a team and we don't struggle to meet people's needs."

We saw the service used a dependency tool to determine staffing levels based on the needs of people who used the service. Staffing levels during the day on the ground floor unit comprised of one senior care assistant and four carers to support 25 people, whereas on the upstairs unit had one senior carer and three r care staff to support 27 people. These staff were further supported by the manager, housekeeping / domestic staff, an activities coordinator and kitchen staff.

There was a call bell system in place to enable people to call for assistance from staff. We asked people if staff responded timely when they called for assistance. One person told us, "They always answer the buzzer quickly when I've pressed it." A second person said, "They respond to alarm quickly but then I sometimes

have to wait for support."

We looked at five staff personnel files and saw evidence of robust recruitment procedures in place. The files included application forms, proof of identity and at least two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure an applicant's suitability to work with vulnerable people.

We saw people had risk assessments in their care plans in relation to areas such as falls, mobility and moving and handling. Each person had a personal emergency evacuation plan (PEEP) in their file which meant staff would have quick access to information regarding their support needs in the event of an evacuation.

Accidents and incidents were recorded correctly and there was an up to date accident and incident policy in place. We checked historical accident records and found they had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further reoccurrence.

We found the provider had safe arrangements in place for managing people's medicines. We looked at eight people's medication administration records (MAR) in total.

At the previous inspection the provider did not have appropriate arrangements in place to manage medicines safely and this was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines. The service sent us an action plan identifying the actions they intended to take to ensure medicines were being managed properly. At this inspection we found that remedial action had been taken and the provider was now meeting the requirements of this regulation.

We saw the treatment room was clean and both medication trolleys were organised. We saw the medicine fridge and treatment room temperatures had been consistently checked and remained within the required range to maintain the efficacy of the treatment stored.

We saw the home used a bio-dose system. We saw the medication administration records (MAR) were kept in a large folder. Accompanying the MAR were coloured photographs and details of each medicine contained within the bio-dose. This meant staff would be able to distinguish between medicines when providing support to people. Controlled drugs were in a locked safe which was attached to the wall and the administration book was current and complete. We saw all the MAR had been completed correctly and there were no omissions of staff signatures.

There was a laminated card with people's MAR indicating any allergies the person was known to have. There was also a laminated card in place to highlight the medication that was required earlier than the morning medicines. For example; alendronic acid, levothyroxine and gastric release medicines.

The home had when required medicines (PRN) protocols in place. These explained what the medicine was, the required dose and how often this could be administered, the time needed between doses, when the medicine was needed, what it was needed for and if the person was able to tell staff they needed the medicine. This ensured 'as required' medicines were being administered safely and appropriately.

We found there was clear information recorded to guide staff when and where to apply creams which ensured people would be given the correct treatment. We saw accurate records had been maintained which

demonstrated creams had been applied safely and when prescribed.

Only senior staff and the team leader administered medicines following the completion of medicines training. The team leader and registered manager also undertook regular competency assessments to ensure people's medicines were being handled safely. A staff member said, "I've had medicines training. I did a 12 week course and the manager and team leader do competency assessments."

We looked at how the service managed the control of infectious diseases. There was an infection control policy in place that had recently been reviewed and one staff member was the infection control 'champion.' Personal protective equipment (PPE) such as gloves and aprons were available and there was an adequate supply of hand soap and hand-gels throughout the home. Weekly and daily cleaning schedules were in place and the home was clean throughout and free from any odours. Toilets and bathrooms had information/instruction on effective hand washing techniques. Staff were aware of precautions to take to help prevent the spread of infection.

The home was adequately maintained and we saw documentary evidence regarding the servicing and maintenance of equipment used within the home to ensure it was safe and fit for purpose. to use. Up to date certification was in place for gas and electric, portable appliance testing, water supplies and water outlets, legionella, hoists and equipment, the lift and pest control. We undertook a tour of the building to ensure that it was safe for the people who lived there and found that it was secure.

Good

Is the service effective?

Our findings

People who lived at the home told us staff had the right knowledge and skills to provide effective care. One person said, "I think the staff seem well trained." A second person said, "I'd say the staff are well trained because they know what they are doing."

We looked at the induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. Staff we spoke with told us they thought access to training and opportunities for on-going development were good. One member of staff told us, "We get plenty of training. Every third or fourth Wednesday, we have a trainer in and complete face to training. I've also got my NVQ 2 and currently doing my NVQ 3." A second member of staff said, "It feels like we do training every week. We are always doing training and there's a lot of support to do the NVQ's. I feel very supported. I always chose subjects in my area of interest, mental health and dementia. " A third member of staff said, "I feel we have all the relevant training to support us. We have updates as things change. I've done so many; moving and handling, diet, pressure care, safeguarding and dementia. I have training with speech and language team soon." A fourth staff member said, "I've been in care a long time. Training has changed significantly. It used to be the basics; moving and handling, fire, health and safety. It's escalated and includes privacy and dignity, mental capacity, choice and consent. It makes staff think and widens there considerations of people's rights.

There was a staff training matrix in place which identified different job roles and the training they had attended or were scheduled to attend. Training planned for the future included speech and language therapy training, diabetes care, mental health training, risk assessments and health and safety. Training records we viewed showed all staff had completed training in safeguarding, moving and handling, health and safety, fire training, infection control, MCA/DoLS, food hygiene and dementia, with 80% having completed end of life care/advanced care planning training. All staff who administered medicines had received the correct training.

We saw the care certificate had been introduced. The staff we spoke with confirmed that new staff completed the care certificate as part of their induction. We were also told existing staff had been required to complete the care certificate. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control. A staff member told us, "We were all given three months to work through the training booklet to get the care certificate.

The staff we spoke with explained their roles well, had a good understanding of what was required of them and how to deliver care safely. Staff told us they felt supported and were provided with regular supervision and had an annual appraisal of their work performance. A staff member said, "We have a supervision meeting every two to three months. It's a supportive meeting." A second staff member said, "I've had two supervision meetings and an annual appraisal. I also discuss things with my NVQ assessor which is in addition to this." We checked records and confirmed these meetings had taken place.

At the previous inspection the service had not given adequate regards to people's well-being when meeting their nutritional and hydration needs and this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014, person-centred care. The service sent us an action plan identifying the actions they intended to take to ensure nutrition was managed properly. At this inspection we found that remedial action had been taken and the provider was now meeting the requirements of this regulation.

We looked at the meal time experience and also asked people living at the home for their views on the food. One person told us, "I enjoy the food. It's good quality. The porridge is delicious and we have a full English breakfast on offer every morning. We have soup, sandwiches and pasties for lunch. The evening meal is a full meal and we get two choices but if we don't like either of them, they'd make us something else." A second person said, "We get plenty of food and hot drinks." A third person said, "The food is alright. We get a good choice. I like it." A fourth person said, "The food is good. There are always options and we get a cooked breakfast every day." A fifth person said, "The food is nice. We get good meals. I take my time I enjoy them that much. The porridge is really good." A sixth person said, "I am fussy but I do enjoy the roast dinner."

There was a four week rolling pictorial menu on display in the dining room which would assist people to understand what was being offered. Special diets were catered for, food allergies were recorded and people had diet and nutrition care plans in place.

We observed one person being assisted at breakfast who had a sight impairment. The staff member guided the persons hand to the edge of the bowl and supported them to guide the spoon. There was good verbal communication throughout the process and the staff member constantly checked with the person that they were happy with what was happening. The staff member then discretely checked on the person several times afterwards to ensure they were eating safely. The person managed as independently as possible and ate independently with the initial support and discrete observation maintained

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was complying with the conditions applied to the authorisations. Where applications had not yet been authorised, peoples' care plans contained restrictive practice screening tools, which
ensured that the least restrictive practice was being followed. We saw people had mental capacity assessments in their care plans, which were up to date.

A member of staff said, "Some people are living with vascular dementia. This can affect their mental health and decisions. They may neglect themselves, forget to dress or put too many clothes on which means they need some care." A second staff member said, "MCA relates to people's capacity to make decisions. We apply for DoLS if a person hasn't got capacity to consent to living in the home. People's families are involved in best interest meetings when the person hasn't got capacity." The senior staff member we spoke with and team leader were able to name people subject to DoLS and had a good knowledge of each individual.

We saw there had been 13 applications for DoLS made to the supervisory body in the 12 months prior to the date of the inspection. The registered manager showed us records that demonstrated they had followed-up the status of the outstanding DoLS applications and there was a DoLS tracker sheet in place. Where DoLS were being renewed the service applied for a renewal one month before the existing expiry date.

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care. Staff told us they would ask people again at a later time if they had initially refused care. Care files contained a consent form identifying that people and their relatives had consented to care and treatment. Where people had a lasting power of attorney acting on their behalf this was recorded correctly.

A person who used the service told us, "The staff always ask me first before they do anything."
A staff member said, "There are signed consent forms for things but you ask people as you are doing things and obtain verbal consent too." A second staff member said, "I always tell people what I am doing and show them as sometimes they may not understand what you are saying."

We asked people what they thought of their environment and the home. A person told us, "It's homely as can be, it's nice. I'm very happy here." We saw there were some adaptions to the environment, which included pictorial signs on doors, such as bathrooms, which would assist people living with a dementia to orientate around the home. Since the date of the last inspection additional adaptations and signage had been obtained. We found people's bedroom doors had been painted in a colour of their own choice which would help them to find their own room and more dementia specific signage was in place in addition to a number of tactile and reminiscence items. Bedroom doors also contained a picture of the person along with their name.

Good

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One person told us, "I enjoy it here. It's friendly and I've got to know the people. It's a busy home but quiet. The staff are lovely and I have a really good laugh with them." A second person said, "The staff are nice." A third person said, "The carers are champion and treat me well." A fourth person said, "Most of the staff are pleasant and polite." A fifth person said, "I couldn't ask for any better; they are really nice." A sixth person said, "The staff are proper soft with us; it's nice."

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke to people in a respectful manner. For example at the lunch time meal we saw staff gently encouraging people to eat their food.

People told us they were treated with dignity, respect and were given privacy at the times they needed it. One person said, "The staff always cover me with a towel. Make sure I've got my dressing gown. They make sure the water is a good temperature. They constantly check I'm okay. When I need privacy, I come to my room and they respect that." A second person said, "Doors are always locked, curtains shut and they keep me covered up."

We observed one staff member had noticed a gentleman's jumper was rolled up exposing his boxer shorts. They discretely rolled it back down and rubbed the person's back in a friendly and reassuring manner.

We asked staff members how they ensured people they supported were treated with dignity and respect. One told us, "I always knock on people's doors before entering their bedroom. I say 'good morning' and tell them what I'm there to support with. If it's personal care, I close the curtains and shut the door. If it's the toilet, I cover their legs with a towel. Some people want to be left when they use the toilet; other people want you to stay with them so I ask them and don't just assume." A second member of staff said, "I always knock on doors. Close doors. When people have bed rest in the afternoon, close curtains so they can have a restful sleep and open them again once they are up and dressed." A third member of staff said, "I keep people covered up when providing personal care. I wouldn't want them to feel exposed."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "People are individuals. They like different things and things done in line with their preference. I explain what want them to do and then ask them how they want to do it." A second staff member said, "People have had different lifestyles, previous employment which can influence when they get up, go to bed now. People are different and we get to know them and do things their own way."

We observed care staff knocking on people's bedroom doors and waiting for a response before entering. On one person's bedroom there was a notice that stated, 'I have requested that my bedroom door be locked at night; staff have the keys so they can do my regular check.' A sign on another bedroom door stated, 'Wednesday, please do not get me up I'm having an occupational therapy assessment/observation.' We asked staff about this and they told us that the occupational therapist regularly visited to assess people and provided an update to staff on any change in needs following their visits. This showed us that people's individual wishes had been taken into account and communicated to the wider staff team.

We looked to see how staff promoted people's independence. A person told us, "I do the things I can for myself. I have a daily wash myself. They help me with the bath but I lather myself." A second person said, "The staff pass me my clothes but I get dressed myself."

We asked people if they were offered choices regarding their care and support. One person told us, "It's my choice, everything I do. To be honest, I'm not that bothered what I wear but they still hold things up and will say skirt or trousers. They show me things and then I pick them."

A staff member told us, "We always give people choices. Lift things out, show people different options and encourage them to choose for themselves." A second member said, "Care has changed so much for the better. Having choices and meeting individual needs is a fundamental right."

We observed throughout the inspection people's relatives visiting without restriction as there were no prescriptive visiting times at the home. A relative told us, "I visit at different times and another relative visits quite late and it's never a problem."

Throughout the course of the inspection we heard lots of chatter between staff and people and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people. We saw that people living at the home were well groomed and nicely presented.

People were able to personalise their own room and were encouraged to bring personal family photographs and items relevant to the individual. People could use their own bedding if requested. We saw that rooms were personalised and all were clean and fresh. One person told, "I get the option of a bath or a shower and I get them as often as I would like."

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and visitors to the service confirmed this was the case. At the time of the inspection no person was in receipt of end of life care although each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

We looked at records of residents and relatives meetings, which were held regularly. Records were kept of each meeting and notes were given to people and their relatives. Discussions from previous meetings included food, activities and outings, laundry, staff uniforms and the environment. We saw that one person had requested more sweets and nibbles be provided and as a result the service had introduced a 'candy trolley' which contained various items of this nature and was available to each person every day if they wished to purchase anything of their own choice.

A wide range of information was on display throughout the home, for example in the entrance area a notice board held information on safeguarding, dignity, DoLS, advocacy, advanced care planning, end of life care and the Hospice in Your Care Home team. The service had previously undertaken training and received guidance and support from this team as part of a local initiative.

The most recent newsletter was also on display in addition to a précis of feedback comments previously received from people who used the service and their relatives. Comments included, 'Very good staff and manager,' and 'The girls are very nice and treat everyone with dignity and respect', and 'Looked after my wife like no-one else could – superb,' and 'My auntie came for respite and loved it.'

Good

Is the service responsive?

Our findings

We asked people living at the home whether they received care that was responsive to their needs. One person told us, "I'd say they are responsive to my needs. When I wasn't well, the staff helped me to bed after my lunch." A second person said, "I go to bed and get up when I want." A third person said, "Getting a bath or a shower is a given whenever you want one." A fourth person said, "I go to my room when I want, I watch television and go to bed when I want." A fifth person said, "There good to us, we're all treated the same. I go to bed, get up and do what I want."

We looked at the care and support plans of five people who used the service. Since the date of the last inspection the manager had re-formatted the care file information and in each plan we found information was now easy to read and the quality of documentation and recording was of a consistently good standard. All care plans contained a pre-admission assessment which identified people's support needs for different situations such as bathing or eating. Risk assessments associated with these were all reviewed each month.

People's care plans contained good quality person-centred information for example, people's likes, dislikes, personal preferences, life and social history were recorded. Care plans also demonstrated how people who used the service, their family or lawful representatives had been involved in planning and agreeing care.

There was a 'key worker' system in operation under which each care staff member had specific responsibility for a defined number of people during the day. There was a list of staff 'champions' which identified the names of staff members who had agreed to champion a certain area of care provision such as infection control, MCA/DoLS, dementia, falls, dignity and palliative care. People could go to these staff for additional information and it was the responsibility of these champions to raise the profile of their chosen area to ensure care was provided appropriately.

Risk assessments and support plans were precise and up to date. People's care plans identified individual, personalised goals that were attainable and measurable. There was a quick reference page with all the information required to mitigate risks. One person was diabetic and been nursed in bed for a long time, which increased the risk of developing pressure sores. We saw this had been recognised and the tissue viability nurse had been involved in providing advice and guidance on how to manage this situation and the correct pressure relieving equipment was in place.

As part of our inspection, we checked to see how people were supported with interests and social activities. There was an activities coordinator in post who knew people who used the service well. We saw a wide range of activities were offered which included group activities as well as more personalised one-to-one sessions. Activities were displayed on notice boards throughout the home and included a craft afternoon, cards/dominos/jenga, gentle exercise, ball/parachute games, Wii games, film afternoon, bingo, cards and invited entertainers.

The service had recently received a small grant from the local authority Innovation Fund and the manager told us that it was their intention to purchase more Wii consoles and IPads which would be Skype enabled

to allow people to communicate electronically with their family members and to increase people's general IT skills. Additionally one bathroom was being decommissioned and the plan was for this room to be converted into a sensory room where people would be able relax and enjoy aromatherapy/gentle music or one-to-one activities with the activities coordinator.

During the inspection we saw the activities coordinator encouraging people to take part in activities and also respecting people's choice if this wasn't what they wanted to do. One person said to us, "When the weather is nice, we go outside. We have trips out and we went on a barge trip up the canal the other week. I really enjoyed that. We had an open air concert and the singer that comes in is very good. I sometimes go upstairs to bingo. It's my choice." A second person said, "The barge trip was really good. I would like more trips out." A third person said, "There's all sorts going on. I feel there is enough." A fourth person said, "I'm not in to the games but I really rate the singer. The singer is brilliant." A relative said, "There is lots going on and the activities coordinator always asks [my relative] but they don't engage."

A staff member said, "I feel there are enough activities. The coordinator is up here twice a day doing things with people. They are always planning outings and went on a barge trip two weeks ago." A second staff member said, "Not everybody participates in activities but there is always something going on. The activities coordinator schedules things during the week and staff do movies and music at weekends."

A person who used the service told us they had previously enjoyed attending a concert at the home and on the day of the inspection they were going out into the community, with staff support, to buy some more music to play on their CD player which had also recently been purchased. They also told us they enjoyed doing jigsaws and regularly completed three or four different ones every week, which staff provided for them.

We looked at how the service managed complaints and found the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use which was up to date. Details of how to make a complaint were identified in several areas of the home and included details on the complaints process and contact numbers for the home, the local authority and the Commission. We observed the compliments and complaints file and saw issues had been responded to in a timely manner. People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required.

We asked people about making complaints. One person told us, "I made a complaint once about a resident hanging around my door. They sorted it out though." A second person said, "I've not had any complaints." A third person said, "I've not made a complaint and I've no concerns." A staff member said, "We don't get a lot of complaints. Things tend to be easily resolved."

Good

Is the service well-led?

Our findings

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

People living at the home felt the home was well-led. One person told us, "The manager is visible and I can go to her. I like her." A second person said, "The manager is good." A relative said, "The manager is very nice. I get on well with her."

A staff member told us, "I like working here. I feel valued and the manager is approachable." A second staff member said, "I think the home is well-led. We have an excellent team leader, a good registered manager and the people living here are happy." A third member of staff said, "We all get on well with each other. I've been here for many years. It's a really nice place to work." A fourth said, "We relate to each other. We are not frightened to challenge if don't agree with something. We are shown respect for our opinions and there are no grudges if we don't agree."

At the previous inspection audits had not always been successful in identifying deficits in care practice and this was a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the systems and process being used did not effectively improve the quality of the services being provided in carrying on the regulated activity.

The service sent us an action plan identifying the actions they intended to take to address the breach of regulation identified. At this inspection we found the service had taken remedial action to rectify the issues we found and was now meeting the requirements of this regulation.

There were a range of monthly audits and checks in place, including a monthly falls audit and tracking form; a falls register and falls analysis form used to identify people who frequently fall, including the action taken to minimise the potential for a reoccurrence; monthly accident and incident audits; regularly reviewed risk assessments for all areas of the home such as lounges and bedrooms; fire system audits and risk assessments; workplace audits for areas such as safety signs/notices, storage facilities and tools; audits of people's care plans including a tracking form identifying which care plans had or needed to be audited.

Other audits included an environmental work place inspection, care file audits, monthly nurse-call system response monitoring, audits of people's weights, audits of medicines, audits of hospital/GP visits and admissions, pressure sores, a catheter audit and a recent risk assessment for a new type of soap dispenser.

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, health and safety and infection control. These could be viewed by staff if they ever needed to seek advice or guidance in a particular area.

Staff understood their role in sending notifications to CQC and had sent us notifications as required by the regulations. People's care records were kept securely and confidentially, and in accordance with legislative requirements.

We saw evidence of regular staff meetings being undertaken. A member of staff said, "We have senior meetings and a full staff meeting bi-monthly. The manager asks us for our opinion and encourages us to go to them." A second member of staff, "We have regular meetings. The manager will ask us directly if we have any questions or want to raise things. We can go to them anytime as well."

There was a service user guide and statement of purpose in place. A statement of purpose is a document which includes a required set of information about a service. When people were given a copy of the service user guide they were also given a copy of the complaints policy, a satisfaction questionnaire and terms of residence.

We found residents' surveys were also undertaken regularly. We looked at a recent survey and comments included, '[My relative] says everyone is lovely,' and 'The home is lovely and I enjoy it here; I have made some good friends and we always laugh,' and 'Very clean and always very nice,' and 'Staff always knock on my door and ask if I'm okay,' and 'I was feeling lonely so my keyworker sat with me,' and 'Everything is run efficiently, always helpful', and Staff explained everything to me in great detail.'

The service had a business continuity plan. This included details of the actions to be taken in the event of an unexpected event such as the loss of utility supplies, fire, loss of IT, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support for people using the service in a safe and coordinated manner.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. The service has also achieved Investors in People status. Investors in People is the standard for people management, offering accreditation to organisations that adhere to the Investors in People Standard.

We saw that the registered manager was very visible within the home and actively involved in the provision of care and support to people living at Alexandra Grange. Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included opticians, chiropodists, dieticians, speech and language therapists, district nurses, social workers, NHS health workers and doctors.