The Princess Alexandra Home

Princess Alexandra Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Outstanding**

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

The Princess Alexandra Home is a care home that provides accommodation and personal care for 72 older people of the Jewish faith. It is divided into two units, one of which also provides nursing care. Some of the people in the home have dementia.

This was an unannounced inspection. The service was last inspected in December 2013, and was found to be meeting the regulations we inspected.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run

The registered manager and staff understood and were aware of how to safeguard people they supported from abuse. Managers and staff received training on safeguarding adults, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The registered manager and staff understood and had a good working knowledge of MCA code of practice and DoLS.

The service ensured people's needs were met by staff who had the right skills, qualifications and attitudes. People and their relatives described the service as good.

People and their relatives were positive about the caring attitude of staff. We saw staff treated people with respect and dignity.

We saw from people's care records that families were involved in people's care. People received care that was planned to meet their individual needs. They were involved in the identification of their needs, choices and preferences and how these would be met.

The registered manager and deputy manager demonstrated an understanding of their role and responsibilities, and staff told us they felt well supported. There were systems in place to monitor the safety and quality of the service provided. The service had a positive culture that was person centred, open, inclusive and empowering.

Summary of findings

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 and their relatives described the service as safe. Staff could recognise abuse and knew what action to take when responding to allegations or incidents of abuse.

The recruitment system was robust. Appropriate checks were undertaken to ensure the right staff were recruited to keep people safe.

The provider had effective systems to manage risks to people without restricting their activities. The service was meeting the requirements of the MCA code of practice and DoLS.

Is the service effective?

Good

The service was effective. People were involved in their care and were asked about their preferences and choices. Relatives felt involved in the care planning process.

People were supported to maintain good health and they had access to external healthcare services when required.

We asked people if they were supported to have food and drink that met their assessed needs and preferences.

Is the service caring?

Good

The service was caring. People and their relatives gave us positive feedback about the attitude of staff. They told us staff treated them with kindness, dignity and respect.

People's privacy was respected. Staff knocked on people's doors and waited to be invited in before entering.

Staff understood people's likes, preferences and needs, which ensured they were able to respond to people's cultural, religious and dietary requirements.

Is the service responsive?

Good

The service was responsive. Prior to using the service, people's health and social care needs were assessed.

The care plans described what staff needed to do to ensure people's needs were met. Care plan reviews were undertaken regularly. This ensured people's changing needs were promptly identified and kept under regular review.

The complaints policy and procedure provided people with details about how to make a complaint. Relatives said they felt able to raise concerns or complaints with staff and were confident they would be acted upon

Summary of findings

Is the service well-led?

The service was well-led. Staff told us the manager was approachable and were confident that any issues they raised would be addressed appropriately. People were involved in developing the service. Regular meetings were held with them so they could express their views about the service provided.

There were systems in place to monitor the quality of the service. This included audits on accidents and incidents, medicines, infection control, nutrition, infection prevention and control, and care plans.

Outstanding 

Princess Alexandra Home

Detailed findings

Background to this inspection

We inspected the service on 15 August 2014. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service, including a Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight staff members and three members of the provider's management team and people's relatives. We observed how staff interacted with the people who used the service. We spoke with eight people who used the service. We looked at eight people's care records to see how their care was planned, seven staff personnel files and records relating to the management of the service including quality audits.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I don't have any concerns." A relative told us, "The service is sound, secure and safe" and another said, "The staff are excellent and fantastic."

There was a policy for the prevention of abuse and safeguarding of adults. All staff had completed training in safeguarding adults. They could recognise signs of abuse and were aware of what action to take when responding to allegations or incidents of abuse. Staff told us they would report allegations of abuse to their manager. They were aware of when to use the whistleblowing procedure and stated they would report allegations to the local authority safeguarding team and the Care Quality Commission (CQC) if action was not taken in response to safeguarding information.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). DoLS provide a process of determining whether individuals can be lawfully deprived of their liberty to keep them safe. Staff had received training on when an application for DoLS should be made. This process was explained to us by the manager. At this inspection one application had been submitted for authorisation in response to the Supreme Court ruling that widened the scope of this legislation.

The registered manager and staff understood and had a good working knowledge of Mental Capacity Act 2005 code of practice. We saw that capacity assessments were carried out for people who were unable to make decisions for themselves to ensure that any decisions were made in their best interests. In each case the provider, person's family and other relevant professionals had met to decide what would be in the person's best interests. For example, capacity assessments had been carried out in relation to "Do Not Attempt Resuscitation" (DNAR) forms. These were signed by people's relatives and their GP. For day to day decisions we saw that staff used visual aids and prompting to facilitate choice and support people to make decisions for themselves.

The recruitment systems were robust to ensure that suitable staff were employed. Appropriate checks were undertaken before staff commenced work with the service. Staff personnel records contained a list of checks, including two references, criminal record checks, proof of identity and address, along with documents confirming the right of staff to work in the United Kingdom. The same recruitment checks were also completed for volunteers who worked for the organisation.

The provider had enough staff available to meet people's needs. The manager explained to us that staffing levels were informed by people's dependency levels. We looked at the staffing rotas and we saw that shifts were sufficiently covered as scheduled. When extra support was required we saw that the registered manager and the deputy manager were available to support staff.

Assessments were undertaken to identify risks to people who used the service. When risks were identified appropriate action was taken to manage these. For example, we saw that preventative measures were in place for people at risk of developing pressure ulcers. We saw that these measures were informed by current guidance, including the National Institute of Health and Care Excellence (NICE): Pressure ulcers: prevention and management of pressure ulcers. In another example, we saw that appropriate action was taken following incidents to ensure people's safety. We saw plans to reduce risks of falls following audits.

The service had a fire safety risk assessment and an evacuation plan for staff and people who used the service to follow in the event of a fire. The fire alarm and doors were regularly checked and fire drills were completed once every month. Staff had completed health and safety training. Information about risk was shared in staff meetings, review meetings and staff handovers. We observed staff were aware of risks people faced.

Good

Is the service effective?

Our findings

People told us that staff understood their needs. Their comments included, "I love it here. I am very happy here. I can't grumble", "The food is good, and appetising" and "The home is pretty good and care is very good." Equally, the feedback from relatives was complimentary and included a comment, "The staff are excellent and fantastic."

People were supported by staff who had the knowledge and skills they needed to carry out their role. We noted that 48 out of 60 staff had completed an induction based on the Skills for Care common induction standards. These standards provide a structured start for workers in the first 12 weeks of employment, to ensure that they are then equipped to support people safely. A new staff member who had recently completed their induction programme told us the induction process ensured they were confident to carry out their role effectively. Plans were in place for the remaining new staff to receive their induction.

Support for staff was provided through training. We saw that staff were up to date in their skills and training. Staff were also supported to gain vocational qualifications in health and social care and 30 out of 60 permanent staff had achieved such qualifications. There were plans in place to ensure staff received training to equip them with the skills and knowledge to meet people's needs. Training plans were in place and detailed the training scheduled for 2015. The 70 volunteers who supported the service also had access to the same training as permanent staff. The provider had a volunteer department, which was responsible for training and supporting volunteers who visited the home so that they understood the needs of the people they supported.

Staff were supported in their roles through regular supervision sessions, staff meetings and annual appraisals. Staff records contained evidence of regular formal staff supervision and appraisals. Regular staff meetings had been organised and the minutes were available. These showed that staff had been provided with guidance regarding people's care and updates regarding the management of the home.

The service presented awards to individual staff members and teams who demonstrated the Jewish Care Values. These values were 'excellence, compassion, integrity, kindness, creativity and enabling'. For example, the 'I made a difference award' recognised individual staff members positive behaviour. All staff we spoke with during the inspection felt supported by their line manager.

We asked people if they were supported to have food and drink that met their assessed needs and preferences. One person told us, "The food is good and is appetising enough" and one relative said, "The food is very good, and if [my relative] doesn't like it they can have sandwiches or an omelette." We saw that care records detailed people's likes and dislikes in relation to food. People and their relatives spoke positively about food, mealtimes and choices that were available. People were actively involved and were able to feedback on a regular basis. We saw staff supporting people to comment about the quality of food after meals.

We observed staff ensuring that people's food choices and preferences were met. People were given a menu and were able to choose what they wanted to eat prior to mealtimes. We observed a staff member making suggestions about what a person might like for lunch, and they were patient when the person could not make up their mind. In another example, we observed a staff member who was evidently concerned about a person who was not eating their lunch enquiring, "What's wrong. How come you are not eating? Do you want to try something else?" Eventually, the staff member went to discuss her concerns with a deputy manager who then supported the person to choose an alternative meal. Staff were able to tell us about people's dietary needs.

Staff used pictures or read to people in order to facilitate choice. The menu was displayed prominently in numerous areas, and was printed in large legible print so that it was easy to read. We saw a 'menu comments book', which people used to write their feedback after meals. Those who were unable to write fed back to staff, who recorded their feedback. People also attended food forums, which were held on a quarterly basis, 'residents' meetings' and relatives meetings. The manager explained that these ensured people were able to contribute to their care by sharing how they felt.

People with complex needs, including those at risk of poor nutrition, dehydration, risk of choking and other medical

Good

Is the service effective?

conditions that affected their health were referred to appropriate professionals and regularly monitored. We saw that people's care plans were up to date and reflected their current needs.

People were supported to maintain good health and had access to external healthcare services. Referrals had been made to physiotherapists, a podiatrist, dietician, and tissue viability nurse for relevant investigations and support. People's health was monitored and care records confirmed this.

Good

Is the service caring?

Our findings

People were complimentary about the attitude of staff. They told us staff treated them with kindness, dignity and respect. Comments from people included, “Staff are very pleasant; very nice indeed” and “Staff are caring. The team leaders are very marvellous.” Another person singled out a member of staff, who they described as, “very helpful. She will go out of her way to be kind to you.” Three relatives we spoke with gave the home a score of 9 out of 10; 10 being excellent, with one stating, “We are always made to feel very welcome. I would come here.”

We observed staff treating people with dignity and respect. We noted people’s assessments and care records considered their need for privacy and dignity. For example, staff guidance was available about how to maintain people’s personal dignity whilst providing care. Staff knocked on people’s doors and waited to be invited in before entering. The service had eight dignity champions, who met on a quarterly basis or as necessary. The dignity champions worked with the registered manager to improve people’s experience of care.

When people were nearing the end of their life the home had arrangements to ensure they received compassionate and supportive care. The registered manager described the end of life care arrangements that were in place to ensure people had a comfortable and dignified death. This included the involvement of people’s families and a multi-disciplinary team. The provider was working towards accreditation with the Gold Standards Framework (GSF) in end of life care. GSF is an award that is given to organisations that are providing a gold standard of care for people nearing the end of life. Individual end of life wishes were documented in care plans and reviewed regularly by a multi-disciplinary team, including palliative care specialists. This ensured people who were nearing the end of life were supported with planning to help them live and die in the manner of their choosing.

Staff understood people’s likes, preferences and needs, which ensured they were able to respond to each person in a caring and compassionate way. All people receiving care were supported to observe the Sabbath. The home had a synagogue, where Sabbath services were held. We observed staff supporting people to attend a Sabbath service that was held during this inspection.

People’s dietary preferences and choices were met because staff understood kosher dietary requirements. The provider employed a Jewish chef who was trained to prepare Jewish meals. All food was supplied from kosher certified companies. We saw that the staff induction programme included a five day ‘Jewish way of life training’. This covered common Jewish practices, including kosher dietary requirements. We read minutes of ‘residents meetings’. In one, a person had commented, “The food is good. It’s kosher. This is important to me. There is always choice. The standard is good.”

People told us they were involved in making decisions about their care. They told us they were aware of their care plans and were involved in their reviews.

Good

Is the service responsive?

Our findings

We asked people if their needs were being met. One person told us, "I am satisfied" and a relative told us, "Staff listen." The relative proceeded to tell us about the assessment of needs that was undertaken before their family member was admitted at the home. The records we saw confirmed that people's individual needs were assessed before they were admitted to the service. The registered manager explained this was to ensure the service was in a position to meet their needs. We saw that people received care, treatment and support that met their needs, choices and preferences.

People had been involved in developing their care plans. The care plans described what staff needed to do to ensure people's needs were met. Care plan reviews were undertaken every six months or as necessary. This ensured people's changing needs were promptly identified and kept under regular review. We saw that care plans were tailored to the needs of the person, and included details about their choices and preferences. Staff were able to demonstrate that they were aware of the content of people's care plans.

People engaged in a range of activities that reflected their interests. There was a full programme of activities and outings. The home had several volunteers who were co-ordinated by an independent volunteer adviser, including a full time social care co-ordinator, who coordinated activities. At this inspection we observed quiz sessions and discussions. The coordinator was very proactive in engaging everyone in the discussions. The home had its own hairdressing salon, which offered a manicure service, which people made use of.

There were regular meetings with people to get their views on the service provided. Where people raised concerns, we saw this was recorded, along with suggestions for improvement, which the provider actioned. For example, the provider took action in response to people's concerns about food and laundry. In addition, the service collected formal feedback from relatives through annual satisfaction surveys. We saw the provider always took action in response to feedback.

We saw staff regularly asking people how they were. For example, during lunch time a staff member who was administering medicines smiled and engaged with the diners, asking "Did you enjoy your lunch?" This prompted responses of satisfaction from people using the service.

The complaints policy and procedure provided people with details about how to make a complaint. The procedure was displayed on the notice board with a reminder for visitors to make comments about the quality of the service. Relatives said they felt able to raise concerns or complaints with staff and were confident they would be acted upon. A relative told us, "Complaints are dealt with very professionally by the manager." At the time of this inspection there were no complaints recorded.

Outstanding ☆

Is the service well-led?

Our findings

The service had a registered manager in post and a deputy manager, who were both described by people in complimentary terms. One person told us, “The manager is good.” Staff told us the registered manager was approachable and said they were comfortable raising concerns and were confident issues would be addressed appropriately. Staff told us they received adequate support from their manager.

Staff were involved in decision making through different forums such as periodic staff meetings, dignity champion meetings, and through consultations in relevant projects. Staff were given the opportunity to raise any issues of concern and also to share ideas. People using the service, their relatives and health and social care professionals were also involved and asked for their feedback. We saw that these different groups were regularly involved with the service in a meaningful way. For example, the provider had implemented action plans taking into account of feedback from these meetings. This had included making changes to improve communication and extensions to the car park.

Staff were aware of the organisation’s vision and values. The registered manager told us the stated values such as compassion, respect, integrity and treating people with dignity ensured staff were able express the behaviours that enabled them to meet the needs of people. We saw that these values were considered during the staff recruitment process, staff induction and as a regular topic of discussion in staff meetings. For example, the provider employed a ‘value-based recruitment model’. This was based on the National Skills Academy for Social Care recommendations to recruit people with the right values and behaviours. We saw that the provider’s interview questionnaire was based on the organisation’s values. We saw that staff expressed these values in the way they treated people.

Staff contributions were valued through rewards and recognition. For example, individual staff members received awards, including an 'I made a difference award'. The registered manager told us the award rewarded individual staff members and was based on feedback from people receiving care, staff, volunteers and relatives. The registered manager shared this with us to demonstrate that the management and staff worked collaboratively to promote good practice.

There were systems in place to monitor the quality of the service. This included audits on accidents and incidents, medicines, infection control, nutrition, infection prevention and control, and care plans. We saw that the outcome of audits always led to service improvement. For example, in the case of falls, we saw interventions were put in place within a week of the audit results to reduce any future risk of falls. In another example, hand hygiene standards were included in the staff induction programme following an infection control audit.

The service worked with other organisations to support care provision, service development and joined-up care. The provider took an initiative to be involved in a Care Home Support Team pilot scheme. This is a multi-disciplinary team working in partnership with GPs and care homes to provide person centred care to people. This had resulted in improvements in areas such as communication with the multi-disciplinary team, training and reduced hospital admissions.

Other schemes that the provider was involved in included the Skills for Care’s National Minimum Dataset for Social Care, (NMDS-SC), which provided access to staff training, and other workforce development initiatives.

The service had received awards for the quality of care and support provided to people who used the service. This included the Investors in People Gold Award. This is given to organisations who can demonstrate excellence in developing and supporting their staff.