Health and Home (Essex) Limited

Alexander House Private Nursing Home

Inspection report

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Essex
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Tel: 01702346465

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04 June 2019

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Alexander House Private Nursing Home is registered to provide accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury for up to a maximum of 25 people. At this inspection 16 people were living there, some of whom were living with dementia.

People's experience of using this service:
The service was not safe. People's identified needs were not always managed safely. Staff did not always know what people's identified needs were.

Medicines were not always stored in line with best practice. Staff did not administer time specific medications on time, and times administered were not accurately documented in records.
The environment was not safe and where risks were present they were not always identified and mitigated.

Poor governance systems were in place to manage the quality of the service provided and the registered provider had not identified failings found at this inspection.

The service had not carried out daily quality checks or observations of staff practice, and those related to the care provided to people.

The registered provider and registered manager had a poor understanding of what constituted good quality care. They had failed to implement changes needed in a timely way to improve the service provided.

Rating at last inspection and Update: The service was previously inspected on 18 December 2018 and placed into special measures with an overall rating of Inadequate with breaches of regulation. The report for this inspection was published on 8 February 2019.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected: This was a focussed follow up inspection based on the previous rating to review whether those domains rated as inadequate had sufficiently improved.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: The service remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alexander House Private Nursing Home on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below	**Inadequate**

Alexander House Private Nursing Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of two inspectors.

Service and service type:
Alexander House Private Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At this inspection 16 people were living at Alexandra House.

The service had a manager registered with the Care Quality Commission. This means that they and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection took place on the 4 June 2019 and was unannounced.

What we did:
Before the inspection we reviewed information, we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to

send us by law.

We asked the local authority and commissioning teams for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities, together with other agencies, may have responsibility for funding people who used the service and monitoring its quality.

During the inspection we spoke with four people living at the service, one relative, the registered manager (who is also the company director), deputy manager, three care staff workers, one nurse, the cook, domestic staff and the provider. We also reviewed a range of records such as quality audits, provider policies and procedures and future plans for improvement.

We reviewed in detail three people's care needs and reviewed the safety of medication administration.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider had addressed the issues raised regarding internal fire safety concerns following the inspection on the 18 December 2018 and engagement with the fire department. However, we found that on the people residing on the first floor had fire escape doors from bedrooms to a balcony area.
● The registered manager confirmed these doors were fire escapes, but they remained open for ventilation. All three doors were wide open onto a balcony area. This had not been assessed for risk of people exiting unsupervised and the potential for falls and posed a poor security risk.
●It had been heavily raining and the outside floor tiles were very wet. The registered manager told us that the tiles on the balcony were non-slip, so people would not slip should they go out. However, this had not been appropriately assessed. They had not considered the height of barriers which only were at a person's waist height, and the potential for people to climb over the barriers and fall.
● As three bedrooms all had fire escapes open onto the balcony, people could potentially access other's bedrooms without being noticed by staff.
● Assessments did not adequately address the risk of people exiting these doors without staff supervision. One person whose bedroom had an accessible fire door and who had previously been described as "bedbound," was now able to walk with a frame. They also had a diagnosis of confusion due to dementia. We noted a risk assessment had been completed about the door, but inappropriately highlighted the person as still "bedbound" so they would not get out. This was not up to date information.
● People who had been identified as having high risk of pressure ulcers did not have adequate care plans in place to address the risk. One person was nursed in bed all day. A tissue viability assessment completed in 2016 stated they should be turned every 3 hours. More recent care plans and risk assessments highlighted the person at being at high risk of developing pressure ulcers on their heels and care plans stated they should be turned regularly. It did not say how often or where staff should record the repositioning. All three staff we spoke to did not know the person needed to be repositioned. They told us the person could reposition themselves. Assessments we reviewed did not indicate they could reposition themselves.
● The provider's policy for managing pressure risk stated that repositioning should be recorded in people's notes, but staff did not record how often the person was turned and repositioned. The registered manager told us the person did not currently have pressure ulcers, however, as the service lacked records of how the person's care was managed we could not be assured this was the case. The person had previously had pressure ulcers on their heels and staff were instructed that they should use special heel protectors. We observed immediately following care that these were not positioned correctly on the persons left heel.
● The deputy manager, registered manager and care staff told us one person had a grade two pressure ulcer. However, records demonstrated this was actually a grade three pressure ulcer, confirmed by the tissue viability nurse. The most recent assessment by staff identified that the area was deteriorating and had enlarged in size. However, staff had not followed best practice in the management of this wound which had been ongoing for over six months. One photo had been taken, identifying the size of the wound, however no

date was recorded on the photo which had been taken on a staff mobile phone. There were no additional photos to demonstrate monitoring of the wound and there was no consideration or assessment in place advising staff about the rules regarding not using their private phone to take photographs.

● Other people had risk assessments in place that highlighted risk of developing pressure ulcers and the need to be repositioned regularly. However, they did not tell staff how often nor where to record this. This included the person who had a grade three pressure ulcer and was unable to mobilise independently.

●People were not always taken to the toilet when they requested support. One person was observed to wait half an hour and during the wait had become incontinent. Staff told us, "They don't really need to go to the toilet they just want to move around and they can't independently."

● One person's care plan documented that they needed cream applied to them due to dry skin and potential risk of pressure ulcers. Care plans also stated that the cream should be dated when opened. However, care plans did not document what creams should be used, how often and where staff should administer the creams. There were no body maps to tell staff where to apply the cream. Staff did not document in care notes that any creams had been applied and where. Medication records did identify the cream used but only that it was for external use. We found the cream in a person's top drawer without an opening date. The provider felt this was not a concern as staff knew people very well and did not need this instruction. Staff told us they just applied the cream all over the person's body. The person did not verbally express themselves and could not give permission for this to happen. The person's needs had not been sufficiently identified and there had been no consideration given to the persons privacy and dignity.

● Staff were unable to tell us which people at the service were at risk of choking or who needed a textured diet. We observed a communal jug of orange drink that had been heavily thickened. One member of staff had to ask another which people received a thickened drink. There was no choice of drink. The person had care plans in place to state they required stage one thickened fluids. Stage one fluids are slightly thickened however these fluids were the consistency of wall paper paste, which was more indicative of stage three.

● Another person had been identified as high risk of aspiration (inhaling fluids) and we found ambulance records of when the person had been found choking after eating porridge. Whilst an ambulance was called staff did not record this as an incident and care plans had not been reviewed.

● Staff did not record routine checks of people who were cared for in bed. The deputy manager told us that staff did check people when they needed personal care, for example to change an incontinence pad, but it was not clear how often or the quality of the interaction given. This included whether fluids were offered or engagement with an activity.

●We asked staff how many people were cared for in bed but received inconsistent answers. One member of staff said two people, another said four.

● The provider had been using a health and safety bedrails assessment, however this was used as a tick box and did not demonstrate that the checks had been carried out appropriately. This included using the least restrictive options before using bedrails to manage the risk of falls from bed. The assessments ticked said "yes" but there was no evidence for what alternatives had been considered.

●We found that one person requiring bedrails did not have a bedrail bumper. We found the bumper under a chair covered in a thick layer of dust. The deputy manager told us that contrary to the care plan this bumper had not been used for some time as it was very worn. It had not been replaced or disposed of. Instead staff were using a type of mattress on the floor next to the bed in case the person fell. We observed the mattress was dirty and soiled with an unknown substance. There was no information in the person's care plan about the floor mattress although it had been in place for some time. Staff could not tell us how often it had been cleaned. We observed a number of these mattresses under people's beds.

Using medicines safely

● Medicines were not administered safely or in line with people's preferences. Care plans for people's medication did not include person centred information about how they preferred to take their medicines.

We observed staff administering people's medicines all on a spoon with whatever liquid they could find to hand.

● One person who had time specified medications to manage their Parkinson's symptoms had a medication sheet that specific times for their medicines. We asked the deputy manager when the person was due for their next dose. They told us a different time than that recorded. They said, "We give them at different times depending if the person is awake." However, they had not recorded what times the medicines had actually been given. They had not understood why the person needed medicines at certain times. This was despite the person's care notes recording that this has a negative effect on the person and their condition, including hallucinations and distressed behaviour.

Preventing and controlling infection

● The provider had made improvements to the infection control issues found at the previous inspection in relation to disposal of waste and a locked sluice room. However, we still observed a number of poor infection control practices.

● One member of staff had a very chesty cough and was supporting a person to eat. They kept turning away and coughing into their hand, the same hand that was used to give the person food from a spoon. This increased the risk of spread of infection.

● Nursing staff were observed to not use gloves for taking blood sugar readings. This is contrary to best practice guidance which states that gloves "must be worn in an activity that might lead to contact with blood or body fluids, or with sharps or contaminated instruments." National Institute of Health and Care Excellence (NICE 2017). This demonstrated a lack of understanding of infection control and sharp injury risk as well as lack of understanding how the nurse's own skin could affect blood sugar readings.

● Staff did not store or keep clean some equipment used to maintain people's personal care needs. We found razors heavily caked in dry foam and old hair. If used this would increase the risk of cutting a person and spreading infection.

● Oral hygiene equipment for people's mouth care, such as toothbrushes, toothpaste and mouth wash were not readily available. Poor oral hygiene and mouth care can lead to risk of infection.

● We found that some equipment used such as crash mats and bedrail bumpers were stored inappropriately and heavily worn.

● Staff were observed transferring sandwiches to trays without the use of gloves.

Systems and processes to safeguard people from the risk of abuse

● Staff did not always understand events or incidents that might indicate safeguarding concerns. There were significant language barriers to discussing safeguarding concerns. One member of staff said, "What is safeguarding?" and, "Abuse is when you want to do something, and they refuse, and you continue this is abuse. I don't know who I would raise this with the person in charge." and, "Punch or no punch?" However, two staff members did tell us they would report any concerns to managers.

● We observed staff engagement with people at the service to be poor. This in part was due to a language barrier, but we also observed that staff did not always talk people through care interventions, such as hoisting and supporting people to eat and drink. This lack of communication resulted in care activities that were impersonal and undignified. We observed one member of staff to say to a person after supporting them to eat, "Look at me," before then wiping their mouth without permission, or supporting the person to wipe their mouth independently.

● One person had been losing weight over some months. Whilst medical advice had been sought, staff would still feed the person without promoting independence. The person appeared capable of feeding themselves, but staff told us they fed them to "Make sure they eat." We did not see any capacity assessments or best interest decisions about why staff should remove this independent activity, nor did we see any reviews of whether they had considered other reasons for poor intake of food, other than physical cause, although the person had a significant history of mental health difficulties.

This was a breach of Regulation 12 of the Health and Social Care Act, 2014; Safe Care and Treatment

Staffing and recruitment
- We did not explore this question during our visit.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate:□There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider and registered manager had not ensured that there were appropriate daily quality checks at the service. This would include observations of staff, environmental checks and people were receiving care in care plans, such as recording specific interventions for high risk needs like pressure area care and adequate fluid intake.

● The registered manager told us that they were in the process of developing a walk round checklist, but this was still not implemented six months following the previous inspection.

● The provider and registered manager had failed to accept previous identified failings. They told us, "CQC keep moving the goal posts." They had not considered reviewing or seeking help from other external services to understand what person centred and high-quality care looked like.

● The provider had previously failed to assess the quality of people's experiences and we found that they had not put in place measures to improve this. One area previously highlighted was the meal time experience. This remained poor. People remained seated around the outside of a room, with a table in front of them. Staff had not considered the need for moving people from the chairs, socialisation or impact of noise from two televisions on different channels competing. The provider had not considered how to make the experience more enjoyable and dementia friendly.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

● The registered manager told us that they were working on new governance procedures and care plan format. However, none of these things were in place or being used. Some audit drafts still failed to give appropriate instruction to staff. This included where a person might need their fluid intake monitored due to risk of dehydration or needed repositioning due to pressure area breakdown risk. New checks did not identify how the information would be used. We gave feedback on the drafts the provider showed us and discussed the inclusion of this information.

● The registered manager told us that they and the provider were in the process of developing clear job roles for staff, along with checklists for their identified responsibilities. However, these were yet to be put in place.

● The registered manager told us they had employed a registered nurse to review care plans across the organisation and take over some of the administration duties in the head office. They had known this person for over 20 years as they had previously worked for them.

● However, this was the same person observed using poor practice for blood sugar monitoring and told us they felt care plans used by the organisation were very person centred and could not understand the need for review. We could not see how the provider had assured themselves that this person had the competencies to support improvements.

● We found that care plans, risk assessments and daily entries completed by one qualified nurse were illegible. When we spoke with the provider they told us, "I know about this and I have told them many times, I will have another go at them." They had failed to adequately address these concerns to ensure that staff had access to clearly written information about how to care for people.

● The audit identified that one of the processes to be carried out was to observe and assess staff practices to make sure they were kind and compassionate in response. However, no observations were recorded. Instead a few people living at the service were asked questions about whether they were happy with care. A number of these people were living with dementia or unable to verbalise.

● Audits contained space to document evidence to back up that quality questions had been reviewed. These were not always completed or completed with information to demonstrate what the evidence was. One person's care notes identified that they required specialist equipment. this was ticked yes but did not identify what the equipment was. Evidence of specialist input and recommendations was ticked No, but it was unclear if specialist input had been needed.

This was a breach of Regulation 17 of the Health and Social Care Act, 2014; Good Governance

● The registered manager did carry out audits at the service, but they did not identify the failings we found. In a safe care and treatment audit dated the 14 April 2019 the registered manager reviewed three peoples care files and wrote that all risks were addressed adequately. However, this did not agree with our findings as discussed in the safe domain.

Working in partnership with others

● The provider had recently engaged with the commission on a teaching day designed to support the staff across the organisation to understand what good care looks like. This was a positive engagement with the commission.

● However, they did not agree with concerns found during this inspection and consequently we were not confident that they would take appropriate action to ensure that these concerns were managed appropriately.

● The registered manager and provider's understanding of what quality care should look like was poor. They lacked the skills, knowledge and competence to ensure that the service was adequately monitored, and care provided was in line with best practice guidance and met people's needs.

● Relationships with the local authority had also deteriorated and they had stopped commissioning beds at the service due to the providers failing to address concerns found at local authority quality visits.

● When external advice had been sought about how to manage people's identified risks, as discussed in the safe domain, this advice did not always transfer to care plans or staff care activities. The provider and registered manager did not understand that this posed a risk to people's physical and mental wellbeing. They believed that staff knew people well enough to know what to do, however, as discussed in the safe domain, care staff were not providing care in line with risks identified.

● Despite the failings found across all four services held by the provider, they had remained isolated in their approach to care provision and had not explored additional networking and training available to providers and care staff that might support them to improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Previously we had found that people were not involved in the running of the service. During this inspection, we did find that there had been regularly monthly resident meetings and that people had fed back what they would like for activities and food on the menu. Actions were not recorded, and we could not be confident that suggestions had been followed up.

● The service was in the process of developing a new care plan template, however the provider had not used this opportunity to truly engage with people and staff to develop this. Instead staff had spent time transferring over information from the current care plans into the new care plans at head office.

This was a breach of Regulation 9 of the Health and Social Care Act, 2014; Person Centred Care

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons lacked the skills and knowledge to ensure that people had access to person centred care. They did not include people or seek external advice from professionals with the appropriate skills and knowledge, about how to improve failings found at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality and Governance checks at the service were inadequate and had not identified the failings found at this inspection, including the risk of harm to people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not taken appropriate measures to mitigate and manage peoples known risks.

The enforcement action we took:

We issued a notice of decision to impose positive conditions on the service to ensure that someone identified as competent reviewed all care needs of those living at the service, and that care staff had the correct information to mitigate and manage these risks.