Bondcare (London) Limited

Alexander Court Care Centre

Inspection report

320 Rainham Road South
Dagenham
Essex
RM10 7UU

Tel: 02087090080

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our last comprehensive inspection of this service on 27 February and 6 March 2018, breaches of legal requirements were found in relation to the safe care and treatment of people and the overall management of the service by the provider. We rated the service as 'Requires Improvement'. We sent the provider a Warning Notice for them to be compliant with legal requirements by June 2018. After the comprehensive inspection, the provider wrote to us to say what they would do to meet these legal requirements.

We undertook this unannounced focused inspection on 1 and 2 November 2018, to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to those requirements. At this inspection, we found these requirements were met.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Alexander Court Care Centre 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.

Alexander Court Care Centre is registered to accommodate up to 82 people across five separate units, each of which have separate adapted facilities. There are three units for people living with dementia and one unit for young people with physical disabilities. There is also a residential unit for older people. At the time of our inspection, 78 people were living in the home.

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

The registered manager was committed to improving the service and had demonstrated the work they had carried out since the last inspection. We saw that improvements had been made in ensuring people were safer.

Medicines were being managed safely. Nursing staff and trained senior care staff administered medicines to people. They signed medicines administration record (MAR) charts to evidence that medicines were given as prescribed and at the correct times. All staff received medicines administration training and were assessed as competent before being allowed to administer medicines.

Risks to people were assessed and guidance was in place for staff to follow to help minimise these risks.

The provider's quality assurance systems and processes had improved to assess, monitor and improve the quality and safety of people in the home.

However, further time and work was needed to ensure these changes were fully embedded and that the home was well managed and safe. For example care plan audits had not identified that some had not been updated and the recording of prescribed creams for people was not always effective.

Staff were recruited appropriately and the necessary background checks were undertaken to ensure they were persons of good character and suitable to support people. There were enough staff in the home across each of the units.

People were protected from abuse and staff understood safeguarding procedures.

The premises was safe and equipment was serviced and checked according to the manufacturer guidelines.

Infection control procedures were followed to protect people from contamination.

Staff ensured there was learning from accidents and incidents to prevent reoccurrence.

The registered manager ensured feedback was received from people and relatives to check they were satisfied with the home.

Staff told us they were supported by the management team and could approach them with any concerns.

We were assured that the registered manager and provider would be able to achieve a level of consistency in achieving high standards going forward and over a period of time. We will check this at our next comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We have improved the rating for Safe from Inadequate to Requires Improvement. To improve the rating further requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

There were improvements in medicines management. People received their medicines safely when required and staff received training on how to do this.

Risks to people were identified and assessed to ensure the were managed when providing care.

There were enough staff in the home across each of the units and staff were recruited safely.

The environment and premises was safe and infection control procedures were followed.

Staff understood safeguarding procedures to protect people from abuse and had received training.

Is the service well-led?

Requires Improvement

We could not improve the rating for Well Led from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

There was a quality assurance system in place. However, this did not always identify shortfalls such as the issues we found during our inspection.

Staff received support and guidance from the management team.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

Alexander Court Care Centre

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 was 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.

We undertook an unannounced focused inspection of Alexander Court Care Centre on 1 and 2 November 2018. The inspection was unannounced on both days.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 27 February 2018 and 6 March 2018 had been made. The team inspected the service against two of the five questions we ask about services: 'is the service well led' and 'is the service safe?' This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection team consisted of one inspector and two specialist pharmacy inspectors on day one. Day two of the inspection was carried out by one specialist pharmacy inspector.

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

During the inspection, we spoke with the registered manager, the deputy manager, a regional manager, five nursing staff, three care staff, a visiting GP, the head of maintenance and an activity coordinator. We spoke with four people who used the service and one relative.

We looked at twelve people's care records and other records relating to the management of the service. This included six staff recruitment records, training documents, rotas, accident and incident records, complaints, health and safety information, quality monitoring and medicine records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 27 February 2018 and 6 March 2018, we found that people were not provided with safe care and treatment and as a result, the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the home as 'Inadequate' under the Safe question because medicines were not managed and administered safely, placing people at risk of harm. People did not always receive their medicines as prescribed and when needed. Risks to people were not always adequately assessed or identified to ensure they remained safe. This meant that the provider did not always assess, monitor and mitigate risks associated with the service to ensure people received safe care.

At this inspection, we found that these issues had been addressed. We looked specifically at medicine management, which included how they were stored, managed, ordered, administered and recorded. We found that improvements had been made and the home's medicine procedures were more robust. We checked medicines in all five units in the home. Each unit had a secure medicine room for the storage and preparation of medicines. Medicines were stored in locked medicines trolleys within these rooms. They were attached to the walls when not in use. People were receiving their medicines on time and did not go without them for prolonged periods, which was the case at our last inspection.

The provider had medicines policies and procedures in place. Staff knew where to find them and signed forms to confirm they had read them. All staff had received training and competency assessments before being involved with administering or handling medicines. Medicines were administered by nurses and senior care staff. In most cases, medicines administration record (MAR) charts were generated electronically and supplied by the local community pharmacy. In other cases, MAR charts were completed on paper by trained members of staff, where they had to be transferred to the electronic system. Staff had a process to check the new MAR charts against the old MAR charts when they arrived each month from the pharmacy to ensure the details were accurate. Any discrepancies found by staff were dealt with by contacting the pharmacy or the GP.

We saw that for topical medicines, such as creams and ointments, electronic records were kept when these were applied by care staff. However, the electronic system used did not enable staff to keep accurate and complete records. For example, it only stated 'cream' and staff were unable to specify the name of the cream or the number of times a day the prescriber wanted it to be used. This was highlighted to staff on the day of our inspection. The registered manager told us they would discuss the issue with the provider and revert to using paper records to ensure completeness and accuracy with recording.

Trained staff signed MAR charts to show that medicines were given as prescribed. We saw MAR charts had been checked by two members of staff. Each person had a photo on the front of their MAR chart to assist staff in identification. This was useful for staff as some people were not able to communicate verbally. Allergies to medicines were listed on MAR sheets for each person. Staff told us they had access to this information prior to the administration of medicines.

Staff conducted daily stock counts of medicines that were not dispensed in blister packs. This enabled them

to identify when medicine supplies were running low. We found that all medicines that were required for people, were available in the home. Controlled drugs, which are medicines that have a risk of being misused, were stored securely. Staff told us that if there were any concerns with controlled drugs, they would carry out an investigation and follow procedures to alert the management team. Medicine errors were investigated by the registered manager when required. Senior staff ensured that learning from medicines incidents was shared in meetings to ensure staff followed the correct procedures. People told us they received their medicines on time and were assisted by staff. One person said, "Yes I get my medication when I need it." Another person told us, "Yes they come round with them [medicines] everyday."

At our last inspection, we found risks to people who received care and support were not adequately identified during assessments of their needs. Risk assessments did not contain suitable guidance for staff on how to reduce risks. Following our last inspection, the registered manager took steps to ensure risks assessments were completed and at this inspection, we saw that improvements had been made. Records showed risk assessments included the risk and control measures to minimise these risks. Assessments had been completed for people at risk of incontinence, choking, diabetes, falls, pressure sores and inflicting self-injury. For example, for one person at risk of harming themselves, staff were to ensure "their finger nails were regularly trimmed, the person was regularly checked and to keep any scratched areas clean and free from infection."

At our last inspection, some people with diabetes did not have a risk assessment in place. At this inspection, we saw they now had a risk assessment and staff could monitor each person to minimise symptoms such as hyperglycaemia (high blood sugar levels) or hypoglycaemia (low blood sugar levels). Blood sugar monitoring was completed in accordance with care plans and risk assessments for people with diabetes. This showed that risks to people were assessed and monitored.

People and relatives told us the home was safe. One person said, "I feel very safe." Another person told us, "It is safe. I am looked after well. The staff take care of me and they know me." A comment from a relative was, "I think it is a safe home for [family member]."

We viewed accident and incident records such as falls and injuries. The registered manager and staff were learning from incidents. This ensured there was continuous improvement and people using the service remained safe. We saw that after an accident was recorded, action was taken to minimise the risk of reoccurrence. For example, people were monitored by staff more closely after a fall or a trip and equipment was checked so that it was safe to use.

All units within the home were clear of hazards. Regular cleaning and maintenance took place. Checks had been carried out to ensure the premises were safe. We spoke with the head of maintenance in the home and they told us regular fire tests and drills were carried out. All fire extinguishers were serviced and were easily accessible throughout the home. We saw records of fire alarm tests and maintenance records. Each person had a personal emergency evacuation plan so that they could be assisted in the event of an emergency.

Care equipment was maintained and had been serviced so that staff could assist people safely. We observed staff using safe moving and handling techniques where a person required assistance.

Infection control procedures were in place. Staff were knowledgeable of the procedures and wore protective clothing when providing personal care such as hand gels, gloves and aprons. Staff told us they washed their hands thoroughly before and after providing care to people. We saw that staff had access to a number of tablet crushers and these were used safely to ensure tablet or medicine residue was cleared after each use. This prevented any cross contamination. However, we noted that a sharps bin used for the disposal of sharp

objects, such as needles and syringes, was not labelled with the start and end dates for collection and disposal of the box. We addressed this with the management team so that procedures for sharps bins could be checked. They told us they would check all sharps bins in the home and review the procedures where necessary.

There was a safeguarding policy to protect people from abuse. We spoke with staff who were able to describe types of abuse and how they would report it. Safeguarding alerts were completed when required and we saw that the process was followed.

There were sufficient numbers of staff in the service. We checked staff rotas for each unit and saw that they were covered by nursing staff and care staff. We also checked rotas for domestic and night staff. The numbers of staff required depended on the number of people in each unit. We noted that this was planned and worked out in advance so that where additional cover was required on some days, this was provisioned and cover was arranged.
Some people required one to one care and we saw staff provide this. A member of staff told us, "We provide one to one care on this unit but we are never stretched, we have enough staff on the floor. We take breaks in turns so there is always staff available." One person said, "Yes I think there is enough staff here. I always see them. They come when I call them."

Staff were recruited safely to ensure people were supported by qualified staff. We looked at records for any new staff that had been recruited since our last inspection. Application forms contained the applicant's employment history, education and qualifications. Nursing staff were registered with the NMC (Nursing and Midwifery Council). Pre-employment checks such as obtaining two references, proof of identification and criminal background checks with the Disclosure and Barring Service (DBS) were undertaken.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, there were shortfalls in the way the home was managed. The provider was failing to ensure there was an effective system in place to assess, monitor and mitigate the risks to people's health and safety. Conditions to the provider's registration (for a monthly report to be sent to us that we attached before our last inspection), were therefore not removed and are still place. There was a lack of robust quality assurance, which left people at risk of harm. Complete and accurate records of people were not maintained to ensure all their needs could be sufficiently met.

At this inspection, we found a number of improvements had been made. The provider had complied with the requirements of our Warning Notice relating to good governance. The registered manager was newly appointed at our last inspection and over the last eight months had put in place systems to ensure the running of the home was more effective. They had identified where further work was required and action plans were developed with senior staff to check the progress of these improvements. For example, any issues relating to the maintenance of the home, the kitchen, concerns raised by care staff, activities, medicines and personal care.

However, there were some shortfalls which we identified during our return inspection. Care plan audits were carried out by the registered manager and deputy manager and this work was still in progress at the time of our inspection. The management team checked care plans to ensure they were up to date and accurate, such as risk assessments and best interest assessments. However, where actions had been completed, these were not always signed off and dated as required. For example, we saw two care plans that had been audited but we found each action under the audit had not been signed and dated by the auditor. We discussed this with the registered manager and they agreed to check all actions were signed off. Paper copies of care plans were divided into numbered sections such as mobility, hygiene, communication, behaviour, capacity, medicines, skin integrity and incontinence. However, the numbered sections were not easily accessible within the care plan. We recommended to the registered manager that these sections were separated by a divider with the corresponding number for ease of use so that they were quicker to find. The registered manager told us they would consider this.

We noted that one person that used a PEG tube (percutaneous endoscopic gastrostomy) which is a medical procedure in which a tube is passed into a person's stomach to help them with feeding, required their PEG to be cleaned monthly. Records showed that their PEG cleaning maintenance record had not been updated since September 2018. Another person required their body map to be reviewed monthly but the last entry was in August 2018, meaning that it had not been reviewed in September and October 2018. We addressed these issues for the registered manager to look into to ensure people's care was being monitored and maintained. They told us they would check that staff had update these records when required.

These findings showed that further improvement was required. However, we were assured that the provider and registered manager would continue to make improvements as they had demonstrated progress had been made in the home since our last inspection. We viewed an internal quality assurance compliance audit completed after our last inspection. It showed that all targets were 85% complete, according to the

provider's own recommendations. This meant the provider had identified where improvements were required and was nearing completion of its targets to improve the service.

The registered manager was supported by a regional support manager, who we met during our inspection. The registered manager said, "We have worked hard and improved. We are all working well as a team and I have support from the regional manager and my deputy manager. I do daily checks on each unit, walk rounds, monthly audits and spot checks. We also have daily flash meetings where we discuss any developments or concerns with the nurses." We saw records of 'daily flash' meetings, which were used to cascade information to all staff.

We saw that there was now stronger oversight of the home following the findings of our previous inspection. For example, at our last inspection, we found there was a lack of communication between senior staff and the management team, which led to some people not receiving their medicines for over five days. At this inspection, we saw improvements had been made and staff were proactive in informing the registered manager of any serious issues, such as missed medicines or supply shortages. The registered manager received alerts or information about any changes to medicine regulations from the provider's head office, the local authority, the Medicines and Healthcare Products Regulatory Agency and NHS England. This information was communicated to relevant staff. We also saw weekly and monthly medicines audits that highlighted areas for improvement in medicines management. This meant there was a more robust quality assurance system in place.

People's care records were improved with details about their care needs. People had signed their consent to care. At our last inspection, we found staff and managers did not have an awareness of the use of bedrails and obtaining consent from people because they placed restrictions on their liberty. At this inspection, where people had bedrails in place to keep them safe, records showed they had consented to them. Where people were unable to give their consent, assessments were undertaken to determine it was in their best interest. This showed that the provider was taking steps to ensure accurate and contemporary records were kept of people's care.

People, relatives and staff spoke positively about the registered manager. One person told us, "The manager is very good." Another person said, "I think [registered manager] is doing a nice job. The service is good." Staff told us they had confidence in the registered manager, there was an 'open-door' policy and a positive culture. One staff member said, "[Registered manager] is excellent and is very approachable. We are all fully supported." The deputy manager who was appointed shortly after our last inspection said, "I am really enjoying working with [registered manager]. We work well together and listen to each other. The home has improved and we have made changes such as new carpets and curtains. Staff seem more happy now. We are working on all the improvements we need to make."

The provider had introduced new technology to help staff in their day to day work. They had piloted an electronic system of documenting the care given to people. Staff used smartphones to update care records, for example after administering medicines or carrying out personal care. People's care needs were uploaded to a system which was updated by staff on a daily basis. This meant staff had access to up to date information on their phones. Staff told us it helped them in their roles. One staff member said, "It is very good. There is no paperwork, it is much easier. We were all trained to use it and it is quite straightforward."

Staff attended team meetings, where the management team discussed any concerns and shared information. Other topics included documentation, respecting the workplace, team working and caring for people. Staff told us they found staff meetings useful and encouraged them to perform well.

People and relatives completed questionnaires and feedback forms, which helped to ensure people were satisfied with the care and support that was delivered. We noted that feedback from people and relatives was positive. Feedback was collated and analysed by the management team to help drive further improvements in the service. Records showed people in the home took part in monthly meetings or forums and discussed items such as laundry, housekeeping, meals, choices, staffing, management, activities and the home environment. Where people made suggestions for improvements, we saw these were taken on board by staff, for example further activities or appointments for particular treatments.