Healthcare Homes (Spring) Limited

Alexandra Care Home

Inspection report

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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

About the service
Alexandra Care Home is a care home registered to provide accommodation and nursing care to up to 76 people. The service provides support to adults who require personal and/or nursing care, who may be living with physical disability, sensory impairment or dementia. At the time of our inspection there were 63 people were living at the service.

People's experience of using this service and what we found
People experienced delays in their care. There were insufficient staff deployed to meet the needs of people at key times. People, relatives, staff and visiting professionals shared concerns regarding the staffing level at the service, which our observations confirmed.

Risks to people were not consistently managed. Records regarding incidents, accidents and untoward events were not consistent in their completion or consistent with entries made in people's care records. We were not assured that all incidences of concern were investigated or reported to appropriate authorities, when needed. This included relevant statutory notifications to the Care Quality Commission (CQC).

Quality assurance processes failed to identify the impact of the staffing level on people. Actions required following audits, checks and reviews were included in the 'home development plan' however, some actions were marked as completed when issues remained.

Staff were recruited safely.Staff were aware of their responsibilities regarding safeguarding people and the concerns to raise, should they have any. Medicines were managed safely with robust infection prevention and control measures in place.

People, relatives and staff found the registered manager approachable and supportive. Relatives reported an improvement in communication with the service and receiving up-to-date information regarding their family member's care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 29 April 2022).

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

The provider told us the improvements required would be completed by 30 June 2022. This inspection was carried out before this date.

At this inspection we found the provider in breach of further regulations.

Why we inspected
We received concerns in relation to staffing and risks to people's health and wellbeing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained the same based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe section of this report.

You can see what action we have asked the provider to take at the end of this report.

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

Enforcement
We have identified breaches in relation to staffing, the management of risks and the submission of notifications at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Alexandra Care 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of three inspectors 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.

Service and service type
Alexandra Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Alexandra Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service and eight relatives about their experience of the care provided. We spoke with ten members of staff including the operations manager from the provider organisation, registered manager, deputy manager, nurses and care staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment.

A wide variety of records relating to the management of the service, including audits and monitoring records, feedback, the 'home development plan' and meeting minutes were also reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People, and their relatives, gave us mixed feedback regarding staffing levels. However, we were consistently told there was insufficient staff to meet the needs of people on one unit at the service. One person told us, "I can't use my buzzer because of my hands so I have to shout. They (staff) can't hear me and I have to wait. It makes me feel nervous and anxious." A relative told us, "You can't blame the staff here as they do what they can. I know there is a staffing issue." Another relative told us, "When I visit, they appear to be short staffed, mainly at weekend. Buzzers are ringing for a long time."

● Staff also told us of their concerns. One member of staff told us, "(We) need a balance of staff. I don't think there is enough staff. Lots of changes with the staff which has impacted on people's care." Another member of staff told us, "We have just finished personal care. It's 11:46. You can't rush them (people)." They went on to explain, "There are times where we will wait till the afternoon to help people with a shower. It is really busy and sometimes people have to wait."

● Professional feedback we received also expressed concerns regarding staffing levels. One professional told us, "There are issues with the staffing level, people are not getting out of bed." Another visiting professional stated, "Staffing levels aren't appropriate for the needs of the residents currently in the home, on each unit many residents require double up care from staff. Feedback from residents to us included waiting for personal care sometimes up until lunchtime and the afternoon, due to lack of staff. Residents have told us that staff are caring but don't have the time they need to spend more time with them."

● We observed people's care and the lunchtime meal being served on all units at the service. On one unit we observed staff were stretched and the demands on them were high. There were insufficient numbers of staff to serve people promptly or to assist people with eating their meals, where this was needed.

● Prior to our inspection, we reviewed call bell data after receiving concerns that people were experiencing delays in receiving responses from staff after pressing their call bell. We found that between February and April 2022, there were a significant number of occasions where people had waited over five minutes to receive a response from staff, and multiple occasions where people had waited over 20 minutes. We discussed this with the registered manager who explained they had requested an engineer attend the service due to faults within the call bell system. Whilst this explained some of the discrepancies noted in the data, the registered manager took action and discussed the concerns within staff meetings and requested action to be taken by staff to improve the timeliness of their responses. At this inspection we saw an improvement in the call bell data and analysis, however people continued to experience delays.

● The provider and registered manager continued to use a dependency tool to calculate the required staffing numbers based on their assessment of people's support needs. Staffing levels were consistent with the outcome of the tool but our observations and the feedback we received at this inspection confirmed

there were insufficient staff deployed at key times which resulted in a delay in people's needs being met.

Whilst we saw no evidence of harm to people, there were insufficient numbers of staff deployed to meet the needs of people living at the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. The provider completed a range of pre-employment checks such as obtaining references and Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Recording related to risk management varied. Staff were not consistently recording people's food and fluid intake or personal care within designated care records. We raised a number of queries relating to records with the registered manager who was able to provide a response. However, it was not clear if this was a recording issue or if staff hadn't attended to people's needs.
● The risks people faced were assessed and staff understood how to reduce those risks. However, action identified as needed was not always completed. For example, we found one person at risk of pressure injury whose pressure relieving equipment was incorrectly set for their weight. Staff on duty had recorded this equipment had been checked on the day of our visit but had failed to identify the incorrect setting. The registered manager took action and addressed this concern with staff on duty. Another person, who required a modified diet due to risks, was being supported by a relative to eat their meals. Staff had not identified that the relative was not following the guidance in place from health professionals and in accordance with their risk assessment. The registered manager escalated this concern to partner agencies.
● Accident and incidents at the service were reported. Report forms and care records were not always consistent with the action taken in response. For example, we noted one person had bruising to their face. Staff told us that the person had not experience a fall and the injury had been reported to the GP. The incident reporting form made no reference to the GP review and stated, 'body map updated.' This record had not been updated. In addition, there was no known cause for this bruising and no referral to partner agencies had been made.
● The registered manager completed a monthly analysis of any accidents, incidents or untoward events. The analysis consistent of a summary of each incident and there was no evidence of a review for themes and trends. We noted a significant increase in falls had occurred in March 2022 and found no exploration completed as to the potential reasons for this.

Risks to people's health, safety and well-being were not consistently managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The registered manager maintained a log of all safeguarding concerns and the action taken in response. However, we were not assured that all concerns had been included or reported to appropriate partner agencies. For example, via staff meeting minutes we identified a concern regarding staff performance which had been identified by the registered manager during a night check. This was not included on the safeguarding log or reported to appropriate authorities.
● Staff had training about safeguarding people from abuse. They understood the types of concerns to raise and knew how to report this.
● People and their relatives told us that, in the main, they felt they or their family member were safe. One

person told us, "I'm ok, they (staff) seems to be doing it ok." A relative told us, "I feel the home is secure and safe."

Using medicines safely

● People received their medicines as prescribed, with all medicines stored appropriately and securely. Records seen were fully completed, with routine audits and stocks checks completed.

● Where medicines were prescribed as and when needed, protocols that guided staff as to when to administer the medicine and how to monitor its effectiveness were in place. However, one person's medicine protocol had conflicting information regarding medication strength versus number of tablets that could be given in a 24-hour period. The registered manager ensured this protocol was replaced when we drew the discrepancy to their attention.

● Staff who administered medicines were trained and assessed as competent to do so.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● Visits to the service were being facilitated safely. We could not be assured that, following the withdrawal of government guidance on 01 April 2022, all restrictions to visits had been removed prior to our inspection visit. Staff and relatives described a booking system for visits and one member of staff told us that that visits were limited to a duration of 30 minutes. The registered manager confirmed this was incorrect and visitors were not restricted. They assured us this would be communicated with all staff and relatives.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Requires Improvement

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At our last inspection the provider had failed to ensure systems and processes for governance and quality assurance were effective and had failed to monitor and improve the quality of care being provided to people living at the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection and told us the improvements required would be completed by 30 June 2022. This inspection was carried out before this date. Therefore, the provider remains in breach of regulation 17.

- Since our last inspection a new registered manager had been appointed.
- The providers quality assurance system continued to be used by the registered manager with audits, reviews and checks being completed. However, they continued to fail in identifying the impact on people's care caused by insufficient staffing.
- The registered manager maintained a 'home development plan' which they updated following audits, checks and when any concerns or issues were identified to them. The plan noted a number of actions as completed which we found not to be the case. This included actions with regards to maintaining a safe environment and the mealtime experience for people.
- Relatives felt there had been a recent improvement in being engaged with the service. They confirmed receipt of regular communication from staff and newsletters. They told us that they found the registered manager approachable and supportive.
- A feedback survey had recently been sent to people and their relatives at the time of our inspection. The registered manager was awaiting responses from this. In the interim, they had implemented feedback forms for any visitors to the service to enable ongoing feedback.
- Regular staff meetings were held. Minutes reviewed showed a wide range of topics were discussed but did not evidence staff interaction or opportunity for discussion. However, staff told us that they could speak to

the registered manager and felt comfortable raising any concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider understood the duty of candour and their responsibility to be open and honest when something went wrong.

● As described in the safe domain, from the records reviewed we were not assured that all accidents, incidents or untoward events were fully recorded and investigated.

● The safeguarding log identified six incidences of concern where notifications had not been submitted to CQC as required.

The failure to submit the required notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to submit statutory notifications as required. Regulation 18 (1)

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 Risks to people's health, safety and well-being were not consistently managed. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of staff were deployed to meet the needs of people living at the service. Regulation 18 (1)