Burlington Care Homes Limited

Alexandra Court Care Centre

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 Court Care Centre is a residential care home providing personal and nursing care. The care home accommodates 72 people across three separate areas. The ground floor has 32 bedrooms for people with residential care needs. The first floor has 20 bedrooms for people who need nursing care and a separate wing with 20 bedrooms to care for people living with dementia. At the time of the inspection, there were 68 people living at the care home, 30 people receiving personal care, 18 receiving nursing care and 20 people living with dementia.

People's experience of using this service and what we found
Medicines were not always safely managed. We could not be assured people had received their medicines as prescribed due to missing signatures on medicine administration records (MAR) and lack of stock. Some medicines and topical creams did not have the appropriate MAR in place to ensure people were receiving their medicines as prescribed.

Staffing levels were not always sufficient. People using the service, staff, relatives and professionals all raised concerns about the staffing levels and the risks to people using the service.

Risks to people were not appropriately managed, people did not always receive the appropriate support with skin care and pressure relief. We have made a recommendation about tissue viability

The service was not well-led. Leadership was poor and ineffective; staff lacked support and guidance. The provider's quality assurance systems were not always effective in identifying and addressing issues.

Staff ensured people lived in a clean and tidy environment. Infection prevention and control (IPC) practices had been updated to follow government guidance.

Staff were trained in safeguarding and appropriate referrals had been made to the local authority.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 4 March 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection sustained improvement had not been made and the provider was again in breach of the

regulation found at the previous inspection and another breach was found.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection. This service has been rated requires improvement for the last two consecutive inspections and the inspection prior to these the service was rated inadequate.

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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicine management, staffing and good governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 Court Care Centre

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 Care Act 2014.

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 was carried out by three inspectors on both days. An Expert by Experience supported the inspection on the first day. 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 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced on the first day and announced on the second day.

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 including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service and eight relatives about their experience of the care provided. We spoke with 18 members of staff including the registered manager, administrator, nurses, senior care worker, care workers, activities coordinators and the chef.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who regularly visit the service.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

At our last inspection the provider had failed to ensure the safe and consistent management of medicines, as not everyone received their medicines as prescribed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not managed safely.
- There were regular missing signatures on medication administration records. This meant we could not be assured people's medicines had been administered as prescribed. For example, we found several people's medicine administration records (MAR) had gaps in recordings and no explanation provided why medicines were not given.
- Records relating to the administration of prescribed creams were not always completed. The omissions in records has placed service users at risk of increased risk of skin breakdown and infection.
- The correct amount of medication was not always in stock. Records showed medicines had not been ordered in a timely manner, some people did not have their medicines for several days.
- Audits had not been used effectively to help monitor and make sure medicines were managed safely. Where an issue was picked up by the completion of audit there was not always any information to support any actions had been taken. For example, an external auditor identified gaps on MAR sheets, but no actions were identified following this.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Safe recruitment procedures were mostly followed. Two members of staff's files showed gaps in employment. The records did not identify if these were followed up.
- Checks relating to the competency of agency staff used at the service were not robust. For example, staff told us that an agency worker had little experience in caring and they did not have the basic communication needs required to support staff and people using the service. This was discussed with the registered

manager who told us they would address these issues with the agencies they contracted with.
● People's basic care and support needs were not always being met due to insufficient staffing numbers. The provider calculated how many staff they needed via a dependency tool. But feedback about staffing levels from staff, relatives or people was not used as part of their assessment.
● A relative told us, "I think they could do with an extra person in the lounge. There should always be someone in there. Things have happened when staff have been absent." A person using the service told us, "There are times I think they need more staff. They seem to be rushing around and sometimes there are only three staff on the ground floor, and it is too much for them." Staff also told us they often struggled to support people appropriately.
● Staff were not always deployed in a way that ensured they were available to supervise areas of the service. People in communal areas were often left unattended. For example, people's care plans indicated they required support at lunch time. Our observations were that people were left unsupported for periods of time.

Failure to ensure appropriate staffing levels which put people at risk was additional evidence of the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● People's risks of sustaining skin damage were poorly managed. One person was observed sat in a wheelchair for long periods of time.
● Pressure relieving mattresses were observed to have faults indicated on them which had not been responded to.
● People did not always receive effective and timely support with repositioning, which placed them at risk of skin damage.
● Areas of the environment were found to have risks. For example, fire extinguishers were not attached to the wall and a toilet was not working correctly. We raised these issues with the management team who responded immediately.

We recommend the provider reviews their processes for maintaining the environment and equipment and updates their practices accordingly.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
● There were systems and processes in place to protect people from the risk of abuse.
● Staff had received safeguarding training and felt confident to report safeguarding issues. The registered manager followed appropriate safeguarding procedures, to report any concerns to the local authority safeguarding team for investigation.
● The registered manager investigated accidents and incidents to prevent reoccurrence and there was a policy and procedure in place to support this.

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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 the last inspection this key question was rated as Requires Improvement at this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well-led. The registered manager failed to provide effective leadership, direction and support to the staff team.
- Governance systems were not robust. They had failed to identify the areas found at inspection and improve the quality and safety of the service. For example, audits had identified gaps in medicine records and the provider had invited external agencies into the service to audit the management of medicines. However, planned actions to address this had not been effective.
- There was a lack of oversight of staff practice when the registered manager was not in the service. Staff did not always maintain up to date care records.
- There was a lack of oversight regarding the employment of agency staff members. Not all agency staff members had appropriate communication skills or experience to ensure they could care for people safely.
- Staff did not feel supported within their roles and staff morale was low. All the staff we spoke with told us the registered manager was not approachable and did not listen to them.
- People did not always receive person-centred care due to the poor staffing levels and deployment of staff. Staff were under increased pressure due to the concerns identified in this report and therefore were not always able to deliver the care they wanted to.

There was ineffective leadership at the service. Processes and effective systems were not in place to test the quality of the service and respond to concerns. There was a lack of oversight about the standard of care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and their relatives were not fully engaged in the service. They did not feel they were being asked in a meaningful way about their views of individuals' care. A relative told us, "I don't think [Name of person] gets much choice about getting up. When I have spoken to the carers, they say we get [Name of person] out of bed, we dress them. It is in the staff's routine not theirs." A person using the service told us, "We are supposed to have meetings, but they get cancelled. Nothing seems to change."
- Another relative told us, "Communication is not good at all. When I have complained they don't phone

back." Other comments included, "They are lacking in communication skills. We are so reliant on the staff giving us information, but they don't phone back."

● Some professionals we spoke with told us that communication was poor. They said the registered manager did not always return calls or was not available to them.

● Staff did not always follow advice given by professionals. For example, dieticians had requested information to be recorded and care plans to be updated. We found that staff did not always document concerns or report them in a timely manner as requested.

Failure to actively seek feedback to drive improvements in the quality and safety of the service was additional evidence of the breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Continuous learning and improving care

● The registered manager listened to our concerns and feedback of the service.

● The registered manager had appropriately notified agencies of all incidents.

● Accidents and incidents were monitored and analysed to look for patterns and trends, to learn from them.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure, medicines were managed safely and appropriate staffing levels were in place, to ensure the safety and well being of people using the service. 12, (1) (2) (f) (g),

The enforcement action we took:

We issued a warning notice against the provider and registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service, mitigate risks relating to the health and safety of others, maintain accurate, complete and contemporaneous records and ensure systems were in place to involve people and their relatives in the running of the service. 17, (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We issued a warning notice against the provider and registered manager