Health and Home (Essex) Limited

Alexander House Private Nursing Home

Inspection report

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10 November 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**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 and treatment of disease, disorder or injury for up to a maximum of 25 people. At this inspection 13 people were using the service, some of whom were living with dementia and had a mental health condition.

People's experience of using this service and what we found
Information relating to people's individual risks was not always recorded or did not provide enough assurance that people were safe. People were not consistently protected by the service's prevention and control of infection practices and procedures. We were not assured the provider was admitting people safely to the service and compliant with COVID-19 testing for people newly admitted to the service. Information relating to Personal Emergency Evacuation Plans [PEEPs] for people using the service were not accurate or up to date.

Not all staff employed at the service had up to date training or training that met the specialist needs of people using the service. Additional staff training information was submitted on 14 December 2021 and this demonstrated staff had received updated training following our inspection. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's needs were not assessed prior to their admission to the service. Relatives were not kept up to date about their family members needs and the outcome of health-related appointments.

The leadership, management and governance arrangements did not provide assurance that the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service. The lack of effective oversight of the service has resulted in continued breaches of regulatory requirements.

We have made a recommendation about staff training and environment.

There were sufficient numbers of staff available to support people living at the service. Most records relating to staff recruitment practices were in place and this had improved since our last inspection to the service in February 2021. People received their medicines as prescribed and staff met good practice standards when administering people's medicines. The provider told us staff received regular supervision and received good support. People received sufficient food and drink to meet their needs.

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

Rating at last inspection
The rating at our last inspection was Requires Improvement (published May 2021). There was one breach of regulation cited and this related to a breach of Regulation 17 [Good governance]. At this inspection enough improvement had not been made and the provider was still in breach of this regulation.

Why we inspected
The inspection was prompted in part due to concerns received about people being transferred from one of the provider's other locations to another service without appropriate processes being followed, including adequate consultation with people and the Local Authorities. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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.

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 the management of safeguarding, risk, consent and governance arrangements at this inspection.

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

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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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. 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 team consisted of three 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.

The service had two managers registered with the Care Quality Commission, one of whom was also the registered provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of inspection was unannounced. The second day of inspection was announced to enable the Care Quality Commission to speak with staff and obtain further information.

What we did before the inspection
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. We sought feedback from the Local Authority who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people about their experience of the care provided. We spoke with four members of staff throughout the inspection. We also spoke with the provider and the assistant to the provider. We arranged to formally speak with staff on duty on 2 November 2021, but staff would not consent to this. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at one staff file in relation to recruitment. We looked at some of the provider's auditing arrangements.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested information by email as not all information was made available during our visits. Unfortunately, this information was not received so a further letter was sent to the provider. Some information was then received from the provider. We reviewed training data and quality assurance records relating to infection, prevention and control. We spoke with three people's relatives and two independent advocates.

Inadequate

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 now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Not all risks to peoples' safety and wellbeing were assessed and recorded in sufficient detail to demonstrate the actions to be taken to mitigate risk. Concerns highlighted at our previous inspection in February 2021 relating to risk assessments had not been addressed and remained outstanding.
• For example, where a person had a stoma fitted and were living with the medical condition of diabetes, this had not been considered or recorded.
• Where people's care plans detailed, they could exhibit behaviours towards others when distressed, risk assessments were not completed detailing the actions to be taken by staff to mitigate the risk. The failure to provide staff with the information needed to understand how to support people safely, placed them and others at potential risk of harm.
• We were not provided with sufficient information to evidence people were moved safely from one service to another and that adequate risk assessments had been completed. For example, there was a lack of information regarding people's fitness to travel, appropriate transport and who had been consulted as part of that process.
• The fire risk assessment was last completed on 30 December 2019 and had not been updated. The purpose of this document is to identify potential fire hazards, people at risk, and evaluate the service's fire safety measures. The provider's assistant was not able to confirm if the risk assessment had been updated or if it had, where this was located. Following the inspection, the provider submitted an up to date fire risk assessment, dated August 2021.
• Information relating to Personal Emergency Evacuation Plans [PEEPs] for people using the service was not accurate or up to date. This is a bespoke plan for people who may have difficulties evacuating to a place of safety without support or assistance from others. PEEPs were still evident for five people who were no longer living at the service and the PEEP for two people referred to the wrong room number. Additionally, the information recorded for one person stated they could mobilise independently using a walking frame. This was incorrect as the person's needs had changed within the last week as reported by the senior member of staff in charge. Following the inspection, the provider submitted an up to date PEEP for this person.
• Hot water outlets were tested at regular intervals to ensure hot water emitted remained safe and within recommended guidelines. However, where cold-water outlets were not regularly used, frequent flushing is required to prevent the risk of legionella bacteria to multiply in the water system. We could not be assured this was happening as there were no records available. The service's testing of legionella was last completed on 3 October 2019.

Preventing and controlling infection

• We were not assured the provider was admitting people safely to the service. No evidence was available to demonstrate COVID-19 testing had been completed in line with the latest government guidance for people who had transferred from the provider's other locations or care homes to Alexander House Private Nursing Home.
• On the second day of inspection, staff [assistant director and registered manager] did not request proof of both inspector's negative test result for Polymerase Chain Reaction [PCR] or rapid lateral flow test, in order to minimise the risk of COVID-19 transmission. However, relatives told us they had been asked to complete a COVID-19 rapid lateral flow test prior to visiting.
• There was no designated 'donning' and 'doffing' area within the service. This is based on best practice guidance. Inconsistencies with staffs' practice relating to the wearing of appropriate Personal Protective Equipment [PPE], such as the wearing of face masks and aprons, was observed during the inspection. This demonstrated staff's practice was not fully compliant with COVID-19 PPE government guidance. The impact of this suggested staff were not following national guidance, may not have fully understood their responsibilities and were not protecting people by maintaining good infection control practices.
• We were not assured the provider's infection prevention and control policy was up to date. The senior in charge was unable to provide us with a copy of the document and stated this document was not available. We were not assured the provider understood the latest government guidance relating to visiting arrangements following an outbreak of COVID-19. The provider had stopped people's relatives from visiting even though no people using the service had tested positive for COVID-19.

Although no one was harmed, systems were either not in place or robust enough to manage and mitigate risk, including those related to the service's infection control practices and procedures. 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.

• The service's fire alarm and emergency lighting systems were regularly tested to ensure these were in good working order. Information showed weekly fire drills were conducted to make sure staff were prepared should a fire emergency happen.

Systems and processes to safeguard people from the risk of abuse
• We could not be assured staff understood and recognised the different types of abuse and actions to be taken if abuse was suspected as no staff consented to undertaking formal interviews.
• Staff training information demonstrated not all staff employed had attained up to date safeguarding training. Following the inspection, additional staff training information was submitted on 14 December 2021. This demonstrated staff had received updated safeguarding training.
• We were not able to determine if the service's safeguarding arrangements were satisfactory as information relating to safeguarding was kept at the provider's head office and was not made available when we inspected. Following the inspection we asked for this information to be provided but no information was received.
• The provider had not allowed the Local Authority timely access to the service to complete safeguarding investigations.
• Two safeguarding concerns were raised with the Local Authority relating to one person using the service. Concerns raised suggested the person's basic needs were not being fully upheld and there was a failure to recognise or respond to abuse.

Effective arrangements were not in place to protect people from abuse. This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment

• The deployment of staff during the inspection was appropriate and there were enough staff available to meet people's needs. Staff told us staffing levels were appropriate to meet existing numbers of people living at Alexander House Private Nursing Home.

• Improvements were required to the service's recruitment procedures to ensure these were safe. No Adult First Check or evidence of a Disclosure and Barring Service [DBS] Certificate was evident for the newest member of staff employed at the service.

Using medicines safely

• Suitable arrangements were in place to ensure the proper and safe use of medicines. The medication rounds were evenly spaced out throughout the day to ensure people did not receive their medication too close together or too late.

• We looked at seven out of 13 Medication Administration Records [MAR]. These showed people received their medication at the times they needed them, and records were maintained and kept in good order.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Though people's capacity to make decisions was recorded, people were not supported to have maximum choice and control of their lives.
• No information was available to demonstrate people using the service, their relatives or those acting on their behalf, including independent advocates, had been consulted or consented to the transfer from another of the provider's service's to Alexander House Private Nursing Home. An independent advocate ensures a 'person's voice' is heard and listened to and their rights are respected within the framework of the Mental Capacity Act 2005.
• Following the inspection, the provider wrote to us and confirmed people's relatives or their representative were consulted about the move from another of the provider's service's to Alexander House Private Nursing Home. This did not concur with what people told us. Relatives stated they only knew their family member had transferred to another service when they contacted the previous care home and requested to speak to their family member. Advocates spoken with did not know that people had been relocated to Alexander House Private Nursing Home.
• Following the inspection, consent forms relating to a change of accommodation were forwarded to us by the provider. The consent form for two people did not reflect the information recorded within their care plan and they had all been completed retrospectively. The care plans detailed both people lacked capacity to make significant decisions, but the consent forms stated both people had agreed to the move of

accommodation.
• Best interest decisions were not recorded where people had bedrails and alarm mats in place or where there were restrictions imposed.
• Staff did not always uphold people's rights to make day to day choices and decisions. For example, people were not routinely offered a choice of drinks by all members of staff on duty or given a choice where they ate their meal at lunchtime, what was on the television or music played. This did not provide assurance staff fully understood the requirements about involving people in decisions about their care.

Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• No information was available during the inspection to assure us staff had the skills and knowledge required to meet people's needs. The provider confirmed they were reviewing the service's staff training information, and this would be completed within the next 30 to 60 days.
• The provider sent us information for 10 members of staff. The overview of staffs training showed not all staff employed had training to meet people's needs. This did not provide assurance that staff had up to date mandatory training. There was no information to support the newest member of staff had completed training. Records received following the inspection by the provider did not include this member of staff. However, additional staff training information was submitted on 14 December 2021 and this included the newest member of staff.
• Information provided by the senior in charge recorded three people were living with a mental healthcare need, three people had a history of alcohol dependence and one person had an acquired brain injury. Training information provided demonstrated no staff had completed training relating to mental health conditions, two staff only had received training relating to alcohol dependency in January 2020 and acquired brain injury in February 2016. However, additional staff training information was submitted on 14 December 2021 and this demonstrated staff had now received training relating to mental health conditions.

• The provider confirmed since our last inspection to the service in February 2021, one new member of staff had commenced in post. The person was on duty when we inspected, and the provider told us they were being supervised. Our observations did not concur with the provider's statement as there were several occasions throughout the day when they cared for vulnerable people on their own and without other staff being present.
• There was no evidence of an 'orientation' induction having been completed for the newest member of staff employed.

Adapting service, design, decoration to meet people's needs
• The environment was not appropriate for people living with dementia or mental health conditions. There was a lack of visual clues and prompts, including signs using both pictures and text to help promote people's orientation and independence. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. There were no dementia friendly household items, such as clocks with large LCD displays, reminder devices or items to provide sensory stimulus. There were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

We recommend the provider seek national guidance to ensure the premises are suitable to meet people's needs and for the service provided at Alexander House Private Nursing Home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not assessed prior to their admission to the service. This referred to the newest person admitted to Alexander House Private Nursing Home in October 2021.
• There was no information for three people moved from the provider's other location to demonstrate if their care and support reflected current evidence-based guidance, standards and best practice in their new environment. All three care plans were from their previous care home.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they were content with the meals provided. Comments included, "The food is not bad" and, "The food is okay".
• Although people did not receive a choice of meals at lunchtime, staff confirmed alternatives to the menu were readily available. The meals provided were in enough quantities and looked appetising.
• Most people using the service were able to eat and drink independently. Where support was provided by staff for one person who used the service, the mealtime experience was not rushed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Relatives confirmed they were not kept up to date about their family members needs and the outcome of health-related appointments. Relatives told us information was not volunteered by staff and only given when they specifically asked for information.
• Records suggested people had access to healthcare services when needed, such as the GP and Speech and Language Team [SALT].

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

At our last inspection to the service in February 2021, effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

• The overall management of the service did not ensure it was consistently well-managed and led. Findings at this inspection demonstrated lessons had not been learned to drive improvement and to ensure the quality and safety of the service for people using the service.

• Governance arrangements were not reliable or effective to monitor the quality and safety of the service. The lack of effective oversight and governance of the service has resulted in a continued breach of regulatory requirement relating to governance. Further regulatory breaches of regulation have similarly been cited relating to consent, risk management and safeguarding during this inspection.

• The provider was unable to demonstrate effective auditing arrangements were in place. The purpose of auditing is to enable the provider to establish, validate and review their arrangements to comply with regulatory requirements and ensure the service is operating effectively and as intended. Where audits were in place these were basic, provided limited information or were not available. For example, the service's environmental audit was a tick box template and no information were recorded to show what had been checked.

• The provider did not have appropriate arrangements in place for identifying and assessing risks to people who use the service. An accurate and complete record in respect of each person who uses the service and staff employed were not maintained. For example, there was no care plan for the newest person admitted to the service and not all records relating to staff employed, namely training information was up to date. Following the inspection, additional staff training information was submitted on 14 December 2021.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The provider was unable to demonstrate how they enabled and encouraged accessible open communication with people using the service and those acting on their behalf. Relatives told us

communication with Alexander House Private Nursing Home staff and the management team was poor. Two relatives confirmed there was a lack of verbal communication or other initiatives [telephone or use of other electronic devices] to promote and support regular contact between the service and their family member. A relative told us their family member had told them, "The staff don't tell me anything."
• A culture of openness and transparency was not adopted and followed by the provider and indicated a 'closed culture' was in existence at Alexander House Private Nursing Home. Relatives spoken with stated although they knew who to complain too, they were not confident their concerns would be taken seriously and acted upon. One relative told us they made a complaint to the registered manager in December 2020 and this was followed up by a further complaint to the provider. At the time of writing this report they had not received a response.
• The provider demonstrated a poor understanding of the Mental Capacity Act 2005 and its application.
• The provider who is also the registered manager did not lead by example and failed to appropriately engage and respond to external organisations and professionals, such as the Local Authority and Care Quality Commission.
• The provider was not receptive to challenge by external organisations and professionals, such as the Local Authority and Care Quality Commission. There was a 'closed' response towards advice and support, rather than a willingness to cooperate. The provider did not respond to the Care Quality Commission for information in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• No information was provided to demonstrate how people's views and experiences were gathered and acted on to shape and improve the service or the culture of the service.
• No staff consented to undertaking formal interviews with us on the second day of inspection. We were not assured staff were supported or encouraged to raise concerns or 'speak out'. Therefore, we were unable to determine staff's understanding of the provider's vision and values of the organisation or how staff were actively supported to question practice or raise issues.

Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Two relatives told us one of the registered manager's was nice. One relative confirmed their family member got on very well with two members of staff and had a good relationship with them.