

Cuerden Developments Ltd

Cuerden Developments Limited - Alexandra Court

Inspection report

Alexandra Court
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Alexandra Court is a 40-bed intermediate care centre that provides a time limited period of assessment and rehabilitation for people who may have had a hospital admission but are not ready to be discharged home safely or to be supported at home. It is a purpose built two storey building with bedrooms on both floors. There is a car park at the front of the home. It is located in Pemberton, near Wigan and is close to shops and public transport links. At the time of the inspection 18 people were using the service.

People's experience of using this service and what we found

We have made a recommendation about record keeping and promoting communication between people and their relatives.

People's needs were assessed before starting with the service. People and their relatives, where appropriate, had been involved in the care planning process.

Risks to people's health and wellbeing were assessed and mitigated. People's medicines were managed safely.

The provider followed safe recruitment processes to ensure the right people were employed. There were enough staff to keep people safe.

People were protected from abuse. Staff understood how to recognise and report any concerns they had about people's safety and well-being.

The home was clean, and staff followed procedures to prevent the spread of infections.

The provider and registered manager followed governance systems which provided oversight and monitoring of the service. More robust quality assurance systems were now in place to ensure any shortfalls were identified and to drive continuous improvement within the service.

When required, people were supported to access healthcare professionals and receive ongoing healthcare support. People were supported to share their views and shape the future of the care they received.

Care plans provided staff with the information they needed to meet people's needs. People could choose how they wanted to spend their time.

Staff worked with other agencies to provide consistent, effective and timely care. We saw evidence that the staff and management worked with other organisations to meet people's assessed needs.

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 27 June 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected

We carried out an announced targeted inspection of this service on 29 July 2020. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance arrangements.

We undertook this focused inspection to check they 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.

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 coronavirus and other infection outbreaks effectively.

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 has changed from requires improvement to good. 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 Alexandra Court on our website at www.cqc.org.uk.

Follow up

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?

Good ●

The service was 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.

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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 two inspectors.

Service and service type

Alexandra Court is an intermediate '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 announced. We announced the inspection the day before we visited to discuss the safety of people, staff and inspectors with reference to Covid-19.

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 our judgements in this report.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We sought feedback from the local authority commissioning team and health care professionals who work with the service. We used all of this information to plan our inspection

During the inspection

We spoke with three relatives of people using the service about their experience of the care provided. We spoke with seven members of staff including the registered manager, nurses and care staff. We observed staff's infection control practices. We did not speak to people using the service as everyone was safely isolating in their own rooms, in accordance with good practice.

We reviewed a range of records. This included three people's care records and 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 audits, policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with five professionals who regularly visit the service.

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 comprehensive inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

A targeted inspection was conducted on 29 July 2020. At that inspection we found the monitoring and management of risk was not always robust; systems were not in place to identify occasions where there had been a longer response time, when people had pressed their nurse call bells for staff assistance; the management of people's prescribed creams was also inconsistent. At this inspection we found enough improvement had been made to mitigate these risks.

Assessing risk, safety monitoring and management

- Information was now displayed in people's bedrooms on how to use the nurse call system. The registered manager completed monthly audits to identify staff response times for each bedroom. One staff member told us, "I do call bell audits three times a day for about 15 minutes and I will record how long it took to respond, what the reason for the call bell being pressed was, and the room number. The audits are done on a rolling basis so this weekend it will be my responsibility."
- During the inspection we observed staff responding quickly to any calls for assistance, and no-one had to wait for any significant length of time before staff assisted them.
- The registered manager kept a record of accidents and incidents and took appropriate actions to ensure they were minimised; these corresponded with notifications received by CQC.
- People had pre-admission assessments as part of the referral process before they moved into the service. This meant the service knew if they could cater for the person's care needs and the environment was suitable.
- Care plans included risk assessments in relation to people's specific care needs. People's ongoing risk assessments were reviewed when needs changed.
- A fire risk assessment was in place. Premises risk assessments and health and safety assessments were completed and reviewed on a regular basis. Premises certificates were in place. There was a contingency plan in place in case of an unexpected event such as fire or flood and a Covid-19 management policy had also been written.

Using medicines safely

- At our last targeted inspection, we found the management of people's prescribed creams was inconsistent and there were gaps in the records we saw. At this inspection we found comprehensive cream charts were in place, which were audited regularly.
- The service followed a nationally recognised five-step approach to preventing and treating pressure ulcers which helped to reduce the potential for skin breakdown associated with pressure from lack of physical activity.
- Locked cabinets had been installed in each bedroom to safely secure creams for all people. Paper records were now accurately maintained and evidenced the application of creams. One staff member said, "All staff

are now more aware of the importance of the care charts and how important it is to complete the charts."

- Staff who administered medicines received appropriate training and were subject to competency checks.
- Regular medicines audits were undertaken; these showed action was taken to address any issues or shortfalls identified.
- The audit information we saw provided evidence that people received their medicines on time and when they needed them.

Systems and processes to safeguard people from the risk of abuse

- The provider continued to ensure staff received training and support to recognise and respond appropriately to abuse. Staff understood the principles of keeping people safe. One staff member told us, "I would raise safeguarding with the manager or the nurse in charge if I spotted anything like abuse, financial abuse or if someone was vulnerable and they weren't treated in the right way. If I wanted to raise it outside of the company, I'd go to CQC or the safeguarding team."
- The registered manager kept a record of safeguarding incidents and assured appropriate actions were taken to keep people safe. There was an up to date safeguarding policy in place, along with details of the local authority safeguarding reporting process.
- People's relatives told us they felt [their relatives] were safe living at the home. One relative said, "[My relative] has been positive, when I have spoken to [them]; [my relative] has a nice room and has said the food is okay and no complaints. I do feel [my relative] is safe."

Staffing and recruitment

- Staff were recruited safely. The provider had robust recruitment checks in place to ensure staff were suitable to work in the care industry.
- There were enough staff on duty to safely meet people's needs and these corresponded with the planned staffing rota.
- The provider assessed people's dependencies to help calculate what staffing hours were necessary. One staff member told us, "[Registered manager name] is all over the home. There is no resident she doesn't know; she's not a manager who sits in the office, she really cares about the people."

Learning lessons when things go wrong

- The service had a policy to facilitate the analysis of incidents and accidents.
- Accidents and incidents were recorded and monitored by the registered manager for patterns and trends. Evidence was available to show that when something had gone wrong the registered manager responded appropriately and learning was shared at team meetings.
- Risk assessments were reviewed following incidents to ensure the service was meeting the needs of people appropriately.

Preventing and controlling infection

- We looked at infection control processes and procedures and observed staff practice. We were assured the service were following safe infection prevention and control procedures to keep people safe.

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 comprehensive 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.

A targeted inspection was conducted on the 29 July 2020. At that inspection we found auditing systems were not robust enough and action were rarely completed for tasks or discrepancies. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found enough improvement had been made and the service was no longer in breach of regulations.

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

- Auditing systems had been improved and were more robust. However, we found record keeping made it difficult to identify actions taken. Following the inspection, the registered manager provided detailed information about errors identified through the audits and what actions had been taken.
- Staff had received guidance and training; however, records did not always reflect this. The registered manager explained that a new system was being implemented to update records weekly and reflect training undertaken.

We recommend the provider reviews their records and record keeping, reflecting the practices, processes and systems in place.

- Detailed information recorded while audits were being carried out was filed separately to the audits.
- The management team had consistently promoted the importance of completing records through team meetings and supervisions. When individual errors had been identified, appropriate actions had been taken, such as increased staff competency monitoring.
- Staff felt well supported and were clear about their roles. One staff member said, "I feel confident with anything I need to do. They [the home] have supported me since I started." Another staff member said, "We get full support from [the registered manager], you couldn't get anyone who supports you more than she does."

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

- Person centred care was evident; we determined this through a review of care records, observations of care and discussions with staff and the registered manager.
- Pre-admission assessments included people's preferences, likes and dislikes, communication needs,

dietary requirements and cultural backgrounds.

- Several staff members referred to a commitment to understand each of the people who used the service. One staff member told us, "We review care plans every week, so we can make sure we meet people's needs, and their records reflect people's individual needs."

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; Working in partnership with others

- Professionals reported the provider worked closely with them to provide a multi-disciplinary approach in meeting people's needs and responding when things went wrong. Records reflected the provider working with, and reporting concerns to external professionals.
- The provider was proactive in reporting any concerns to CQC and submitted statutory notifications as necessary.

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

- Feedback from relatives about communication was mixed. Some relatives we spoke with felt communication with the home could be improved, however they also told us communication with the physiotherapy team was generally good. One relative said, "I have talked to physiotherapist at the home who kept in touch about progress." A second relative said, "Staff are great when you get through but getting through has been tricky." We discussed this with the registered manager who provided a detailed explanation of the actions they had taken to free-up the telephones, to enable them to be answered more quickly.
- People and their relatives had recently completed a survey and only a small number had reported feeling dissatisfied; this was predominantly because of a restriction on relatives visiting, as a result of the Covid-19 pandemic.
- The provider was proactive in reporting accidents, incidents and concerns to the appropriate professionals and bodies in a timely manner.

We recommend the provider promotes communication between people and their relatives in order to keep them up to date with any changes in the service or people's care.