

# Sir Josiah Mason's Care Charity

## Alexandra House

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

The inspection was unannounced and took place on 18 October 2018.

Alexandra House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation with personal care for a maximum of 36 people. There were 28 older people living at the home on the day of the inspection, some of whom were living with dementia.

This is the third time the service has been rated Requires Improvement. For services rated Requires Improvement on one or more occasions, we will take proportionate action to help encourage prompt improvement. The service was rated requires improvement because the provider needed to embed their governance systems and improve the medication system, staffing numbers and record keeping. Two breaches of regulations were identified and we have also made a recommendation about the management of some medicines.

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

The provider had a programme of audits in place to monitor the quality and safety of people's care and support, however up until recently these had not been carried out effectively. The provider continually strived to make things work better so that people benefitted from a home that met their needs. However, further improvements are needed to demonstrate the provider's overall governance is implemented and sustained over time.

People told us staff were not always available at the times they needed them, including during the night. Staff turnover was high and this impacted on continuity of care and the overall cleanliness of the home environment. Care staff did not have time to spend time socially with people or offer and encourage activities.

People told us they received their medicines from staff who managed their medicines in the right way. People also felt that if they needed extra pain relief or other medicines as needed these were provided. People who administered their own medication needed to be better supported to ensure that both the person and staff had risk assessments and procedures in place. Staff wore protective gloves and aprons to reduce the risks of spreading infection within the home.

Overall, people told us they felt safe living at the home and that staff supported them with maintaining their safety. Staff told us about how they minimised the risk to people's safety and that they would report any

concerns to the management team.

People were involved in planning their care, which included end of life planning where required. Staff had a good understanding of people's care needs, however, people's care plans and risk assessments did not always contain up to date information which reflected their current needs.

Staff had undertaken training and their knowledge reflected the needs of people who lived at the home. People told us staff acted on their wishes and their agreement had been sought before staff provided support.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the provider's policies and systems supported this practice. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us they enjoyed their meals, had a choice of food and were supported to eat and drink enough to keep them healthy. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs.

People told us they enjoyed spending time with staff who respected their privacy and dignity was maintained with staff support. People's day to day preferences were listened to by staff and people's choices and decisions were respected. Staff told us it was important to promote people's independence and ensure people had as much involvement as possible in their care and support.

People were aware of who they would make a complaint to if needed. People told us they were happy to talk through things with staff or the registered manager if they were not happy with the care they received.

People enjoyed living in the home which, overall met their needs. The provider and staff demonstrated their commitment to care for people and told us of their plans for further improvements. They linked with care provider forums ensured people had access to the local community. The service had a good links with health and social care professionals.

Further information is in the detailed findings below.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we asked the provider to take at the back of the full version of this report.

## 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 consistently safe.

People's risks need to be clearly recorded, regularly reviewed and professional advice sought when required. People, relatives and staff told us they felt there were not always enough staff on duty and staff were not always available at the times people needed them.

People felt safe and protected from the risk of abuse and received their medicines where needed. Overall the home was clean and the provider had systems in place to manage the risk of the spread of infections.

### Is the service effective?

Good 

The service was effective.

Staff training was updated and staff were following good practice. People's dietary needs had been assessed and they had a choice about what they ate. People had regular input from a range of health professionals.

The Mental Capacity Act (2005) code of practice was followed to ensure people were supported to make their own decisions.

### Is the service caring?

Good 

The service was caring.

Positive relationships had formed between people and permanent staff members.

Staff were respectful of people's privacy and dignity and took account of people's individual preferences.

### Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

Care plans did not always reflect people's current care and support needs.

People were provided with some activities, but staff did not always have time to facilitate this or to spend time socially with people. Activities specific for people who lived with dementia needed to improve.

**Is the service well-led?**

The service was not always well-led.

The provider's systems to monitor, review and improve the quality and safety of the service were not consistently effective.

People and staff were complimentary about the overall service. There was open communication within the staff team and regular health and safety checks were in place.

**Requires Improvement** 

# Alexandra House

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection site visit activity started and ended on 18 October 2018 and was unannounced. The inspection team consisted of the lead Inspector, an Inspection Manager and an Expert by Experience who had experience of residential care settings. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home and looked at the notifications they had sent us. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection, we spoke with six people who lived at the home and two visiting friends and relatives.

We also spoke with six staff, a Director and the nominated individual who was a provider representative present for the inspection. We reviewed the risk assessments and plans of care for three people and their medicine records. We also looked at provider records for Deprivation of Liberty Safeguards, staff meeting minutes and 'residents' meeting minutes. We looked at the provider's proposed improvement plan and governance audits.

# Is the service safe?

## Our findings

At the last inspection in August 2017 we rated this question as Requires Improvement. This was because medicines were not consistently managed well. At this inspection we found that some areas of medicines management required further improvements.

All people we spoke with commented that there were not enough care staff, and that staff turnover was high and unsettling. They told us that staff were not always available at the times they needed them. They spoke of experiencing delays and frustration because of the pressures on staff time. People told us they were on occasion left waiting for assistance and had been reluctant to ask staff for assistance such as requesting a particular area of the home to sit. People told us this was because staff were busy, and they would often have to come back to offer the assistance asked for. One person told us, "I'm just sitting here like a dummy. I get worked up over it (the delay). Some say 'I'll be back in five minutes' and they are; some say 'I'll be back' but they don't re-appear." Another person said, "Sometimes I wait 2 minutes, sometimes 10, sometimes 30 (minutes)."

People also told us about delays at night when they had on occasion waited long periods of time for staff assistance. People told us how other people living with dementia may enter their room. One person told us, "At night some come and stand by the bed. It's not nice."

Staff turnover was high and there was a reliance on agency staff and we received negative comments from people about how this impacted on people's continuity of care. This also included comments in relation to agency domestic staff and the decline in the overall cleanliness of their bedrooms and communal areas.

Staff raised concerns with us that they did not have time to support people with social activities and they were concerned that there was not enough of them to support people during appointments outside of the home, such as medical appointments if required. Staff told us that some people's care dependency needs had increased however staffing levels had not.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these concerns with the provider who told us that immediate action would be taken to increase staff support during night time hours. They also told us that an evaluation of overall staffing levels was taking place.

Whilst people had concerns over staff numbers, people we spoke with overall, felt safe living at the home and staff supported them to remain safe. Relatives were confident their family member's safety were met as staff were available to assist 24 hours a day. One person said, "The staff are very good."

Care staff spoken with had a good understanding of the risks associated with people's individual care needs and support they were required to provide. We saw this care was provided. However, written risk

assessments were not always updated in a timely way to reflect the current support people received, for example in relation to the risk of pressure sores. We also found that professional advice had not been sought in relation to a person who had a poor appetite and the risks associated with providing their soft diet using a non-spill cup. We raised this with senior care staff who assured us professional advice would be sought without delay.

People were supported in regard to mobility, for example we saw they were reminded to have any aids close by, such as walking frames. Care staff we spoke with knew the type and level of assistance each person required and we saw people were assisted when walking.

When people needed medicines 'as required', there was minimal information in place in relation as to why and when the medication should be administered. Where people managed their own medication the provider had not ensured that care staff and people understood the risks and how best to record this. The provider's policy included guidance for people's self medication but care staff told us they had not used this. The provider agreed that further information and detail would be needed to ensure safe administration of these medicines.

We recommend that the service consider current best practice on giving PRN medication to people alongside their prescribed medication and promoting self-medication and take action to update their practice accordingly.

We observed part of the medicines rounds and saw staff checked people's medicines on the medicine administration records (MAR) and medicine labels. They explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines were appropriately checked, stored and secured and this included the arrangements for controlled drugs, which are medicines which may be at risk of misuse.

All of the staff spoken with told us they had been trained in safeguarding and there were also safeguarding procedures and guidance available for staff to refer to. This provided appropriate explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The management team were aware of when they needed to report concerns to the local safeguarding adults' team. Safeguarding alerts had been raised promptly. They were investigated and resolved to ensure people were protected.

Staff recruitment files we looked at had relevant references and a result from the Disclosure and Barring Service (DBS) in place. The DBS check shows if people have any criminal convictions before applicants are offered a job. Application forms included employment histories, however the provider will need to ensure a full employment history is recorded with an explanation for any breaks in employment. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with people who live at the home.

People's laundry was collected and washed within a separate laundry area to ensure good hygiene practice. We saw staff followed good food hygiene practices and care staff wore personal protective items such as gloves and aprons when required.



# Is the service effective?

## Our findings

At the last inspection in August 2017 we rated this question as Good. At this inspection we found the service remained Good.

People we spoke with were happy that staff understood their care needs well and were able to provide the care they wanted and needed. People had shared their needs and choices with the management team before coming to live at the home. The provider had completed an assessment of their care needs to assure themselves they could provide the care needed.

People told us care staff understood the assistance and support they needed and considered they were confident in the staffing team. Care staff told us they were supported in their role with regular training that provided them with the relevant skills to care for people living at the home. One staff member told us, "I have done my NVQ2 here, training is good." All staff told us their supervision from management and team meetings ensured a consistent and embedded approach to applying their learning when caring for people within the home. One staff member told us, "If we ever have any worries or anything we can phone [registered manager], or [senior managers names]. There is always someone to fall back on."

People enjoyed their meals and had been able to provide feedback about the quality of the meals. One person told us, "The food is very good and there is enough of it." There were a choice of meals and alternatives offered if requested by a person. People told us their personal favourites were on the menu and one person told us, "Fish and chips are my favourite. We get that on Friday." Where needed, people's food and drink intake had been recorded to ensure people received enough nutrients and fluids.

People told us about their appointments with opticians, dentists and where needed regular blood tests. The GP regularly visited the home to check people's health and medicines. Other professionals had attended to support people with their care needs, for example physiotherapy, chiropody and community nursing teams.

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 with appropriate legal authority. 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. The management team and care staff were complying with any conditions applied to the authorisation and knew who these were for and what the restriction were for. All staff had received training and

understood the requirements of the Mental Capacity Act in general, and the specific requirements of the DoL.

## Is the service caring?

### Our findings

At the last inspection in August 2017 we rated this question as Good. At this inspection we found the service remained Good.

People we spoke with complimented the care staff on the support provided. People told us they knew and like the staff group who were caring in their work. One person told us, "Yes, they [staff] are kind and helpful." People spoke with and chatted to staff, who responded with kindness, and was considerate to people's needs. One person told us, "I have no faults with them [staff] at all. They are nice to me. No complaints at all." Care staff had developed friendly relationships with people living at the home.

People were comfortable in the home and care staff understood who and what was important to the person, their life history and background. We saw that staff used touch as way to support and enhance people's experience and people responded with smiles and physical contact.

People told us about how much support they needed from staff to maintain their independence within in the home. Two people told us staff offered encouragement and guidance when needed. People were able to choose how they spent their time and were free to relax in their bedrooms or in the communal areas. People were able to maintain their independence within in the home with staff also offering encouragement and guidance if needed. We saw care staff were considerate not to take over and told us that they responded to people's independence depending on their needs that day. One person told us how some days they were less mobile, and that care staff recognised this and used their wheelchair.

People told us that staff supported them according to their wishes. Staff understood how to protect and promote a person's human right to be treated with respect and to be able to express their views. All people we spoke with said staff encouraged them to be involved in their care and that staff asked them how they would like their care to be given or knew their preferred routines.

People received care and support from staff who respected their privacy and people we spoke with felt the level of privacy was good. When staff were speaking with people they respected people's personal conversations. Staff spoke respectfully about people when they were talking and having discussions with us about any care needs. One person told us, "If my door is shut they always knock and wait for me to answer. They never come barging in."

Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing people options to help them make a choice such as two items of clothing.

## Is the service responsive?

### Our findings

At the last inspection in August 2017 we rated this question as Requires Improvement. This was because people activities were limited, and care plans were not updated as people's needs changed. At this inspection, we found these improvements were still needed.

People told us and our observations showed staff engaged and interacted with people when they were carrying out a task with a person. For example, when they offered people a drink, or when they helped people to mobilise. Care staff told us and we saw that concern for people's well being were responded to in a caring and meaningful way, but felt rushed. Staff told us they were kept busy and did not have time to sit with people. They said, in the afternoons there maybe a little more time, as mornings were very busy.

People's plans of care were structured and developed around their own health and care needs, however, they were found to be out of date. Care staff told us they were aware of this and they had not had time to focus on updating these given the recent pressures of supporting people with higher care dependency needs. One care staff member told us, "I know the care plans need to be updated but it is very hard with the two people with high dependency needs and there are others who are deteriorating. We need to use a stand aid for three people." Whilst the care staff were knowledgeable about people, this information had not been recorded so it could be shared across the staffing team, which due to the high use of agency staff would increase the risk of people's care needs not being met.

We saw people sat in lounges for much of the time. Those people who were able to communicate verbally received a little more interaction from staff, as they engaged with them to request assistance. We saw care was task centred rather than staff spending time socially with people. We saw some people were happily reading or watching television on their own. Although activities were available care staff told us it was a challenge to facilitate this. One care staff member told us, "We try to put activities on but half the time the buzzers go off and we have to stop. The manager has spent lots of money on things to do in the activities drawer but its finding the time to actually do it. I try and sit down and paint the ladies' nails when I have the time."

We recommend the home expands the programme of activities which includes people who live with dementia are kept stimulated and engaged.

People's families had helped to support their relatives and had given a lot of information to the registered manager about their relative's personal history and lifestyle. Some relatives continued to take an active role in ensuring that their family members received the support they required.

All staff and management told us they regularly spoke with people about their care and support. People told us that if their needs changed, care staff noticed and supported them. People gave us examples of how care staff responded on days when they felt unwell or low and care staff would show concerns and report to the GP if needed. People also told us if they felt unwell the care staff would regularly check on them.

When the care staff shift changed, any changes to people's health needs were discussed. Care staff reported changes in a person's needs to the senior care staff or registered manager for review and action. A communication log was maintained and staff told us that they referred to this if they had not been working the previous day. However, these changes were not always updated within people's care plans to reflect changes to how care was to be provided.

The accessible information standard looks at how the provider identifies and meets the information and communication needs of people with a disability or sensory loss. It relates to keeping an accurate record and where consent is given share this information with others when required. Staff told us they addressed the needs of each person as an individual.

The provider had equality and diversity policies and procedures in place, which staff knew about and told us the policies were easily accessible if needed. Staff were able to identify people's needs as part of the initial assessment process and during reviews with people.

All people and relatives we spoke with said they would talk to any of the staff if they had any concerns or complaints. The registered manager took a proactive approach and regularly spoke with people to see if they were happy. They told us they welcomed the opportunity to learn from complaints or to let staff know they were doing a good job. This reflected the views and opinions of people, their relatives and care staff we spoke with.

We spoke with the care staff about how people were supported at the end of their life. An end of life care plan would be completed which recorded the wishes of the person in the event of their death. Care staff showed a compassionate approach where they advocated for people with their end of life wishes and provided support in line with the person's preferences.

## Is the service well-led?

### Our findings

At the last inspection in August 2017 we rated this question as Requires Improvement. This was because the provider's governance systems were not always being operated effectively to assess, monitor and improve the quality and safety of the service. At this inspection visit we found improvements were still required and this is the third consecutive rating of requires improvement.

The provider's governance system had failed to bring about timely improvements for the benefit of people who lived at the home and the staff team. This resulted in staff not always being available at the times people needed them and a number of care and risk management records had not been reviewed or updated for a number of months. This meant that some people's care plans did not reflect their current care and support needs and risks associated with their care were not accurately recorded. Staff told us that they had not had the time to ensure people's records were up to date and up until recently they did not know who was responsible for completing these, given that a staff member with this responsibility had left their employment at the service some months ago.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits had been completed. The provider used a range of measures to assess and monitor the quality and safety aspects of the home. Audits were completed on a weekly, monthly, six monthly or yearly basis. Examples of audits completed were medicines, infection control, health and safety and reviews of complaints.

The registered manager had been in post since November 2017 and they were planning to leave their employment at the service in November 2018. The provider had recruited a new manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and care staff we spoke to told us they felt unsettled because of the pending managerial changes as there had already been managerial changes over the last year and a number of staff had left their employment at the service. The provider reassured us that staff would continue to receive support from all levels of management at the service.

People and relatives told us the registered manager and staff were supportive and approachable. We saw people seek advice and look to care staff who responded with answers to questions about what was happening in their home. The provider said they saw people regularly and knew them well. This was evident in interactions we saw and the conversations we heard. A recent 'residents' and relatives meeting had been held where information about the pending managerial changes was shared.

People and their relatives had contributed by completing annual questionnaires, so the provider and registered manager would know their views of the care provided. Team meetings also provided opportunities for staff to raise concerns or comments on people's care.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The manager understood their role and responsibilities and the requirements of the Health and Social Care Act 2008. They knew when notifications needed to be sent and we had received notifications when they were required.

The provider had a willingness to work in partnership with others including the local authority safeguarding and commissioning teams, to support and develop the service. This included reviews and advice from health and social care professionals; such as GPs, social workers and community nursing teams.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. The provider had displayed their previous rating so that people, visitors and those seeking information about the service can be informed of our judgements.

We discussed with the provider the shortfalls identified during the inspection. They were open and transparent about the challenges the service had and confirmed that they had already identified a number of the issues through the appointment of an external Consultant. This person was responsible for working with the provider to bring about the required improvements in relation to the quality and safety of service people received. They had produced an action plan which the provider shared with us. This had led to improvements to the living environment, training for staff and developing systems to better support the safety of people.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider current system in place to ensure the effective running of the service had failed. The provider had implemented an independent review and the actions developed and demonstrate sustainable improvements over time.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider failed to ensure there were sufficient staff to meet people's needs.</p>