BEN - Motor & Allied Trades Benevolent Fund

Alexandra House Care Centre - Southport

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

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, and to pilot a new inspection process being introduced by CQC that looks at the overall quality of the service.

This was an unannounced inspection. Alexandra House Care Centre is a large care home that provides residential and nursing care for up to 56 people. The home is situated within walking distance of Southport town centre. Accommodation is provided over four floors, with the dining room, lounges and some bedrooms on the ground floor. It has a passenger lift and a garden to the side of the building.

Summary of findings

A registered manager was in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People living at Alexandra House Care Centre were kept safe because they received good care and support that was tailored to meet their individual needs. Staff ensured they were kept safe from abuse and avoidable harm. Regularly reviewed risk assessments and care plans were in place for people with risks associated with their health and welfare needs. Staffing levels were sufficient to meet the needs of people living at the home.

Nobody living at the home was subject to a Deprivation of Liberty Safeguarding (DoLS) order. The registered manager and staff had a good understanding of DoLS and gave relevant examples of situations where people could be deprived of their liberty.

New staff underwent robust recruitment checks to ensure they were suitable to work with vulnerable adults. Staff were well supported through induction process and on-going training programme. Staff appraisals and supervision were behind schedule but this had been recognised by the registered manager and a system had been developed to address the matter.

We found staff were caring and treated people with dignity and kindness. People's individual needs and preferences were respected by staff. People were supported to maintain optimum health and could access a range of external health care professionals when they needed to. People received adequate to eat and drink and were encouraged to maintain a healthy balanced diet.

The culture within the service was person-centred and open. People and families were involved in planning and reviewing care. From listening to people's views and discussions with staff, we established that the leadership within the home was strong and effective. A process was established for managing complaints. The registered manager advised us that no formal complaints had been received within the last 12 months.

Summary of findings

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. People living at Alexandra House Care Centre were protected from avoidable harm and potential abuse. Staff understood what abuse was and they were aware of what to do if they suspected abuse had occurred.

There were sufficient numbers of staff on duty at all times to meet people's personal care, nursing needs and to keep people safe throughout the day and night.

Robust recruitment checks were in place to ensure staff were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective. People's care needs were assessed when they first came to live at the home and staff had the knowledge and skills to provide effective care.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where appropriate, mental capacity assessments had been completed for people living at the home. Risk assessments were in place and there was good balance between managing risks whilst supporting people to be independent.

We found people's care records were personalised and provided clear guidance on how their care needs should be met. People were supported to access healthcare from a range of external professionals when they needed it.

People received a balanced diet. They had sufficient to eat and drink throughout the day and night.

Staff appraisals and supervision were behind schedule but this had been recognised by the registered manager and a system had been developed and put in place to address the matter.

Is the service caring?

Good

The service was caring. We observed that staff were caring and treated people with dignity and respect. This was supported by the people, families and visiting professionals we spoke with.

We determined through discussions with people, families and by looking at care records that people and/or their families were involved with making decisions about their care and support.

Is the service responsive?

Good

The service was responsive. A range of methods were in place for people to express their views about the service, including a 'residents forum', a satisfaction survey conducted twice a year and 'matron's coffee mornings.'

A process was established for managing complaints. The people living at the home and families we spoke with were aware of how to make a complaint or raise a concern. They were confident their concerns would be dealt with effectively and in a timely way.

Summary of findings

Is the service well-led?

Good

The service was well led. Through observation and speaking with staff, people living at the home, their families and external healthcare professionals, we determined that the service embraced a culture that was person-centred, inclusive and open.

From listening to people's views we established that the leadership within the home was strong and effective. Established structures were in place to monitor the quality and safety of the service.

Alexandra House Care Centre - Southport

Detailed findings

Background to this inspection

This was an unannounced inspection. We visited the Alexandra House Care Centre on 8 July 2014 and spent time with six people and invited them to share with us their views and experience of living at the home. We spoke with five family members who were visiting their relatives at the time of the inspection. We also spoke with a registered nurse, a member of the care staff team, a member of the catering team, a member of the housekeeping team and the registered manager.

We observed care and support being delivered in communal areas. We had a look around the building, including a visit to the kitchen and we looked at some of the bedrooms. In addition, the inspection involved looking at a wide range of records, including four people's care records, three staff recruitment files and records to support how the home was managed.

The inspection team comprised an Expert by Experience and a CQC inspector. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home including the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the commissioners of the service and Healthwatch to obtain their views of the service. We spoke with two healthcare professionals who visited the home on a regular basis.

Good

Is the service safe?

Our findings

The people we spoke with said that staff supported them in a safe way. They told us they did not have any concerns about staff treating them unkindly. A person said, "I've been here a long time. I like the staff. They are very nice." Another person told us, "I am fortunate to have found such a lovely home. The staff are kind and there are always plenty of them around."

Families we spent time with said their relatives were supported in a safe and kindly way by staff. A family member said to us, "Staff are lovely. There are no nasty staff here." Another family told us, "I'm more than happy. If I thought [relative] was in anyway neglected I would bring her home. I feel she is safe here and well cared for."

Families were satisfied with how the home involved them in discussions about any risks, and the care and support in place relating to those risks. A family member said, "I think [relative] is safe because staff regularly come into her room to check her. She hasn't got a bell in her room to call staff because of a previous incident with the bell cord but there is always someone passing her room to check on her."

We could see from the care records that family members were contacted if their relative experienced an event which had caused harm or put the person at risk. The registered manager told us that a structure was in place, referred to in the home as 'hourly rounding', whereby a staff member was designated to check on each person every hour during the day and night.

Two health care professionals who visited the home on a regular basis were satisfied with how the home managed individual risk and how people were treated.

The people we spoke with, family members, visiting professionals and staff told us there were plenty of staff on duty during the day and night to ensure people's safety. People said requests for support and call bells were responded to promptly. One person told us they occasionally had to wait a bit longer if staff were busy. We observed during our visit that there were sufficient staff on duty and people's needs were met in a timely way. We also observed staff supporting people in a safe way.

Regularly reviewed assessments and care plans were in place for people with risks associated with their healthcare and welfare needs. These included risks associated with swallowing food and risks in relation to mobilising. When a risk was identified and, if appropriate, staff referred people to a relevant external professional. For example, we observed from care records that a person was referred to the local falls team following a series of falls within a week. The registered manager confirmed that people were referred to the falls team if they experienced three falls over a short time frame. This showed the service had a strategy in place for managing falls.

There were risk assessments and care plans in place for a person who exhibited periodic behaviour that challenged. Staff maintained a record of each episode of the behaviour to look for any triggers and patterns. The home had made a referral to a relevant external health professional and the person was awaiting an assessment. Although staff were managing each episode in a safe and dignified way, we noted the care plan lacked sufficient detail about the actual behaviour and how staff should consistently support the person when they presented with the behaviour. We highlighted this to the registered manager and staff. Staff advised us they would review the care plan.

Risk assessments were in place for people who used bedrails and they clearly indicated that bedrails were used to keep the person from falling out of bed rather than as a form of restraint. The assessments were signed by either the person or a family member indicating their agreement for use of this equipment.

We found staff were appropriately identifying and recording incidents, accidents and near misses in accordance with the home's risk management policy.

We observed that guidance about how to make a safeguarding alert was displayed on noticeboards throughout the home. We spoke with two staff about safeguarding. They had a good understanding of what abuse was and were able to clearly describe how they would respond if they identified potential abuse. This was in accordance with the home's adult safeguarding procedure. Staff told us and records confirmed that the full staff team had received annual training in the safeguarding of vulnerable adults.

A person living at the home told us, "Staff are very health and safety conscious", which the person found frustrating as they said it limited their ability to move around the home independently using specialist equipment. We looked at the person's care records and discussed the

Good

Is the service safe?

matter with the registered manager and staff. Although the person had full mental capacity, there was an on-going risk with mobilising independently around the home. Detailed risk assessments had been undertaken, external professionals consulted and family had been involved. Although the person could mobilise independently in their bedroom, a safety measure had been put in place for communal areas that involved the person mobilising with staff supervision. This showed that the home had considered the risk and put measures in place to minimise it whilst ensuring the person maintained as much independence as possible.

Staff we spoke with, including a newly recruited member of staff explained the recruitment process to us and the checks that took place to ensure staff were suitable to work with vulnerable adults. They said their induction was thorough and they had the opportunity to shadow a more experienced member of staff. We were informed that registered nurses should a more experienced nurse for a week when they first started. The staff personnel files we looked at confirmed recruitment and induction practices were consistent and robust.

Good

Is the service effective?

Our findings

The people we spoke with said they had access to healthcare services and received information about their healthcare needs. One person told us, "I think all my health needs are met. I tell staff I would like to see my own doctor but staff tell me he is part of a large practice and it could be any doctor I see. It could take over a week to see my own doctor. I see a district nurse occasionally when I need a pain relief injection. I know what tablets I take and what they are for. Staff do tell me about changes in medication." Another person said to us, "I know some of the medication I'm on. I'm mostly on pain killers. I was taken to the hearing clinic this morning because I've had so much pain."

Equally, families we spent time with were satisfied with how their relatives were supported to maintain optimum health. A family member told us, "I can chat to the nursing staff if I have concerns. I feel all [relative's] healthcare needs are being met and that he is as comfortable as he can be." We heard from another family that staff invited them to meetings about their relative's care and staff contacted the family regarding any changes to their relative's healthcare needs.

We looked at the care records for four people and could see that detailed records were maintained of consultations with healthcare professionals, such as the GP, district nurse, speech and language therapist and dietician. We spoke with two healthcare professionals who visited the home on a regular basis. They said the standard of care provided at the home was good. One professional said, "They act on concerns promptly and follow guidance and instructions given."

The registered manager had attended training in the Mental Capacity Act (2005) and demonstrated a good understanding of the Act. The Mental Capacity Act (2005) is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Although not all of the wider staff team had received this training, the staff we spoke with said mental capacity was discussed at their annual mandatory refresher training. In addition, the registered manager advised us that matters related to mental capacity were shared at staff meetings and handovers. The staff were clear about the principles and their responsibilities in accordance with the Mental Capacity Act (2005). A mental capacity assessment had been conducted for each person and these were contained in the care records.

Nobody living at the home was subject to a Deprivation of Liberty Safeguarding (DoLS) order. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The registered manager had a good understanding of DoLS as they had previously worked through the assessment process for a person who lived at the home. Equally, the staff we spoke with had a good understanding of DoLS and gave relevant examples of situations where people could be deprived of their liberty.

We sat with a group of people who were living at the home at lunchtime. The room was spacious, airy and well lit. Tables were well laid with cloth tablecloths, paper napkins, cutlery, salt and pepper. Staff served the people who were able to eat independently. They were attentive and pleasant when serving people and meals were served in a timely way. People had a choice of two main meals and several choices of puddings, both cold and hot. A variety of cold drinks were served with the meal and a hot beverage at the end of the meal. We sampled both the main meal and the hot pudding; both of which were made from fresh ingredients. The meal was appetising and well presented.

People who needed assistance with eating and drinking were supported by staff. Sufficient staff were available to ensure people were supported with their meal in a timely way. Some people had a special diet, such as a softened meal, pureed diet or thickened drinks. These special diets were presented in an appetising way. The care records informed us that regularly reviewed risk assessments and care plans were in place for people with special nutritional and dietary needs. We also noted that external healthcare professionals were involved in the development of some people's nutritional plans. People had their weight checked each month to monitor for any fluctuation.

We asked people what their views were regarding the quality of the food, menus and access to drinks. The feedback was mixed. One person told us, "The food is pretty average. The quality varies. I've asked for more cheese on my cauliflower cheese. Once they did put more on but mostly you can't taste the cheese. The food is reasonably alright but can be repetitive. There's always a

Good

Is the service effective?

jug of water in my room." Another person said, "I'm weighed and I've lost some weight but nothing worrying. They do give us a good diet but it's not varied enough. We very rarely get changes in the menus. In the main, the quality of food is good but the menu lacks imagination. We are still waiting for the summer menu and it's now July." Furthermore, a person told us, "The food is very good. I like it. I get drinks of tea and I like the potatoes. I don't know what weight I am. They have a machine and I get weighed." The care records we looked at confirmed people were weighed on a regular basis.

We discussed the menu with the registered manager who acknowledged that the summer menu was late being produced due to the member of staff responsible for the menus leaving the service. The registered manager said the new menu was being finalised and would be introduced within the next week. The registered manager confirmed changes to the menu had been based on a recent survey, which all people living at the home had had the opportunity to participate in.

Families were satisfied with food and the way in which it was presented. A family member told us, "My relative can choose and is asked what they would like. My relative has a soft diet and they [staff] cut it up small. It is always presented nicely. People who need help with eating have a carer to help them. The carers chat to people when they are helping with the meal." Another family member said, "My relative has pureed food but the ingredients are kept separate on the plate. I assist him with food sometimes when I'm here."

People and their families told us they had confidence that staff had the skills and knowledge to support people with their specific needs. A family member said, "Staff seem to know what they are doing. My relative has a key worker and when she isn't around I can always speak to any other staff." Another family told us, "From what I've seen the staff do have the right skills to look after [relative]."

The two healthcare professionals we spoke with were satisfied with how the staff provided care to people. One of the professionals said, "Staff do ask for support from our service and they seem to be up to date on procedures. All staff seem to be up-to-date with training."

From discussions with staff and looking at the staff training records, it was clear staff were up-to-date with mandatory training. Staff said the training provided was of good quality and the home was supportive if they wished to undertake training for professional and/or career development. The registered manager informed us that volunteers who worked at the home were required to complete mandatory training.

Information we reviewed prior to the inspection indicated 50% of the staff had received an annual appraisal. Some of the staff we spoke with had participated in an annual appraisal. Others had not had an appraisal in the last year but said their appraisal was due. We discussed this with the registered manager who acknowledged that completion of the annual appraisals and formal supervision throughout the year was behind target. The registered manager had devised a new structured process for completion of appraisals and supervision. Staff had received a letter explaining this new system. We were shown how the system operated and how it was monitored. A member of staff had been designated the role of monitoring the progress of appraisals and supervision.

Good

Is the service caring?

Our findings

We asked people if they felt well cared for, respected and were included in decision making about their care. Overall, people were satisfied and they felt the staff team were caring. A person described for us their experience of the home as: "I like pottering about. I have my TV in my bedroom. They get me out of bed at about 8.00 in the morning. I like getting up at 8.00 am. They come and put me to bed at about 10.00 in the evening and I can sit in bed and watch my TV. I like it here. It's nice."

Another person said to us, "In the main staff do respect me. I loved the barge trip we had. I love these surprise treats but we don't always have the staff [for trips out]. I wish we could have more treats. We used to go on trips three or four times a year but now we are lucky to get one trip. On the whole we don't do too badly but I'd like more events such as this." The person was referring to a presentation at lunchtime for two members of staff who were leaving. We observed that people living at the home were involved in the event and seemed to genuinely enjoy the occasion.

A family member said to us, "I visit nearly every day and at various different times. They [staff] don't know I am coming and the care is always consistently good. They do kind things like turn the television around so [relative] can see it. The staff are very friendly, it's like they are part of the family." Another family told us, "Staff are genuinely fond and care about [relative]. I do know staff come and talk to him. We can make ourselves drinks when we visit in a little utility room along the corridor." Families were pleased with the range of activities provided at the home. A relative said, "There is always some entertainment going on; sing-alongs, quizzes and group chats. My relative enjoys these."

The two healthcare professionals we spoke with were positive about the care provided. One professional said, "All staff are very approachable. Staff treat residents in a kind and dignified manner." The other professional said, "I am here once a week and the standard of care is very good."

Staff described good team work and based on mutual respect for each other. Staff told us, and records confirmed that the full staff team had received training in dignity and respect. Throughout our visit we heard staff communicate with people in a kind and respectful way. We observed staff taking time and not rushing people. We overheard them engage in friendly conversation with people whilst providing support.

We observed that staff were polite and knocked on people's bedroom doors before entering. Signs were available for bedroom doors stating 'nursing procedure in progress' or 'engaged' to remind staff and visitors to respect the person's privacy by not entering the room.

We had a look in some of the bedrooms. Information was available in each bedroom, which included the name and a photograph of the person's keyworker. Some people had a brief overview of their preferences and care needs in their bedroom. This included the person's preferred name, key people in their life, their interests, preferred routines and dietary preferences. This was intended for people who could not verbally express their needs especially with new or unfamiliar staff. The care records we looked at were person-centred and included more in-depth information about the person's life, preferences and interests.

Good

Is the service responsive?

Our findings

People and families told us staff responded to people's individual healthcare needs in a timely way. A person said to us, "They [staff] do get a doctor when I ask for one." A family member told us, "At Christmas staff told me my relative wasn't himself. They got the doctor's advice, medication was changed and he picked up." We heard from people that they received their medication at a time when they needed it. Families told us they could visit their relative any time they wished.

We noted that call bells were activated continuously in the morning and periodically in the afternoon. Staff responded to them in a timely way.

The care records we looked at showed that care plans reflected people's needs. The person or a family member had signed an agreement indicating the care plans had been discussed with them. We noted they were reviewed on a monthly basis and took account of any changing needs. The staff we spoke with had a good understanding of the needs of the people they supported. They said handovers were thorough and highlighted any changes to people's needs or changes of medication.

Information for people was displayed on prominently located notice boards throughout the home. It included the complaints procedure, courtesy code, smoking policy, arrangements for the next 'resident's meeting' and timetable of recreational activities. Most information was displayed using large, clear and bold print and at a height that enabled wheelchair users to see it. An assistive listening system was installed in the home for people with a hearing impairment.

A process for making a complaint or raising a concern was in place. People told us they could raise any concerns they had with the matron (registered manager). A family member said they had been informed about how to make a complaint when their relative first moved to the home. The registered manager advised us that no formal complaints had been received in the last 12 months. The registered manager maintained a log of low level concerns raised by people. Good detail was recorded of each concern and the action taken to resolve the matter. For example, we saw that a person raised a concern that they had not been consulted about some dining room tables being moved. The registered manager apologised for this oversight and provided a rationale as to why the tables had been moved. The person was satisfied with this outcome.

We observed an afternoon activity session taking place that involved eight people and a member of staff. The staff member facilitated the session well, involving all people and making the experience both enjoyable and stimulating.

Good

Is the service well-led?

Our findings

The home had a clear management structure in place led by a registered manager who was very familiar with the service. The home accommodated both people with nursing needs and people who needed residential care. Defined staffing arrangements were in place for these two distinct specialities. There was a dedicated staff team managed by a clinical nurse manager and led by at least one registered nurse on each shift for people requiring nursing care. A separate staff team led by a residential care manager supported the people who required care and support. We spoke with staff from both specialities and they were clear about their role, responsibilities and accountability within the overall structure of the home.

From our conversations with people and their families, we determined they were knowledgeable about the management and staffing arrangements. The culture of the service was open and transparent as people were included and involved with their care planning, and any actual or proposed developments concerning the home. People and their families were aware of whom to approach if they had a query or concern they wished to address. We observed that information was available for people and visitors in communal areas of the building. This included the home's statement of purpose, previous CQC inspection report, the outcome of an external quality assurance audit, business continuity plan and the outcome of the environmental health report. Information was also displayed outlining the members of staff with the lead for adult safeguarding and infection control.

The healthcare professionals we spoke with said the home was well run. A professional said to us, "The home is well led. I think the leadership is very good. We have had no concerns about the home at all."

A 'resident's forum' was established. A list of the forum members along with the most recent meeting minutes were displayed on various notice boards for people and visitors to access. The meetings were held on a quarterly basis and forum members raised matters on behalf of other people. Whole home 'resident's meetings' were held as and when needed and usually these were organised when specific information needed to be shared. For example, two meetings were held in June 2014 to remind people of the fire procedure.

The registered manager and another senior member of staff held an informal coffee morning most weeks. These were popular events and people referred to them as 'matron's coffee mornings'. They were held with small groups of people. A schedule was in place to ensure everyone living there had an opportunity to attend. Personalised invites were sent to people when it was their turn to attend. We could see that some people responded with an acceptance card. The registered manager advised us that an agenda or minutes were not produced for the coffee mornings as they were seen as a social event. People could raise any topics they wished to talk about, including expressing their views about the service.

The home produced a quarterly newsletter for people living there, visitors and staff. We looked at the spring edition and noted it provided information on forthcoming events, staff changes and general activities at the home. Arrangements were in place for conducting a feedback survey twice a year, both for people living at the home and their relatives. We looked at the questionnaires completed by relatives over the last year and the feedback was positive.

We asked the registered manager and staff what they thought were the key achievements of the service. Consistently we heard that the home provided good end-of-life care and the professionals we spoke with confirmed this view. The home had good links and access to the local hospice service.

Furthermore, we asked the registered manager and staff what they thought were the key challenges for the service. There was a consistent view that the layout of the building could be limiting in terms of balancing the risk of falls with maintaining the independence of people. This was an area the provider (owner) was currently considering and the building had been assessed to see if any further changes could be made. Each person living there had a mobility/ falls risk assessment and care plan. Measures were in place to ensure people remained as independent as possible. A falls audit was conducted on a monthly basis and any increases in falls were reviewed and addressed.

The home was part of the CQUIN scheme. This is national scheme which stands for Commissioning for Quality and Innovation. It is designed to focus on quality, innovation and seeks to improve the quality of data. This meant the registered manager collated information each month and forwarded it to a central data base either monthly or three monthly. It also meant the manager was routinely

Good

Is the service well-led?

monitoring and reporting on quality and risk issues, such as the number of DoLS assessments completed, number of safeguarding referrals made, numbers of complaints received and the number of falls.

A structured process was in place for managing accidents, incidents and near misses. The registered manager reviewed all incident reports and staff provided us with examples of changes that had been made as a result of learning from an incident. We observed from the care records we looked at that they were audited on a regular basis with recommended actions identified where a shortfall was found. We could see that previous actions identified had been addressed. Other established service audits included, a health and safety audit, bed audit and infection control audit.

The staff we spoke with were aware of the policy framework for the home and how to access a policy if they needed to. In particular, they had a good understanding of the whistleblowing policy and in what circumstances they would use it.

From our discussions with staff, we found they had a detailed understanding of each person's needs. They said they received a thorough handover at the beginning of each shift that provided information about any changes to people's needs. The registered manager attended the handovers where possible and provided staff with feedback from any incidents that had occurred or the outcome of complaints.

A structure was in place for the formal sharing of information and monitoring of the service. Full staff meetings were held twice a year, one in November and then another in the summer. Health and safety meetings were held every six months. Heads of department meetings were held each month at the home.