Health and Home (Essex) Limited

Alexander House Private Nursing Home

Inspection report

25-27 First Avenue
Westcliff On Sea
Essex
SS0 8HS

Tel: 01702346465

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23 July 2019
29 July 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Alexander House Private Nursing Home is registered to provide accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury for up to a maximum of 25 people. At this inspection 15 people were living there, some of whom were living with dementia.

People's experience of using this service:
People, relatives and health care professionals told us they felt the service was safe and people received care and support in a safe way.

Risks assessments about people's safety and welfare were well developed and explicitly described how to manage the risks. Equipment used for people was well maintained. However, people who required the aid of a hoist for transfers had no individual slings provided for them which meant there was a risk of cross infection.

Staff knew the signs and symptoms of abuse and told us they always reported their concerns to their seniors, however they were unfamiliar with specific terminology as safeguarding and whistleblowing and the procedure they had to follow. Staff in more senior roles were knowledgeable about external safeguarding authorities and knew when and how they had to report any safeguarding concerns.

People received their medicines safely, administered by staff who received training and had been observed to be competent by the provider. However, medicines were not stored in line with nationally recognised best practice guidelines.

People told us there were enough staff to meet their needs safely. People living in Alexander House Private Nursing Home had different needs. Some people lived with a learning disability, mental health needs, dementia and physical disabilities. Staff had not been trained sufficiently to understand current best practice guidance for the different needs people had. Although staff were knowledgeable about people, they needed more training to enable them to meet people`s needs.

The outcomes for people with learning disabilities living in the home did not fully reflect the principles and values of Registering the Right Support. There was a lack of planned outcomes for people, limited choice and control about where people wanted to reside, limited independence and limited inclusion in the community. People were not supported to develop life skills or to work towards a goal of moving to less supported care environment although some people had capacity and expressed their wish to live independently.

The service was going through organisational changes and these included implementing new care plans, more training for staff, new governance and audit systems, and a new organisational management structure. The provider issued staff with clear guidance about their roles and responsibilities. The local funding authority had been involved in re-assessing people`s needs to ensure people were supported in the

right environment.

Feedback we received from people, health and social care professionals and family members was positive, they told us the service was safe and met people`s needs.

Rating at last inspection and Update: The service had a comprehensive inspection on 18 December 2018 and placed into special measures with an overall rating of Inadequate with breaches of regulation. The report for the inspection was published on 8 February 2019. On 04 June 2019 we carried out a focused inspection and found that the provider remained in special measures. The overall rating remained Inadequate. The report had been published on 24 July 2019.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

This service has been in Special Measures since 08 February 2019. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected: This was a focussed follow up inspection based on the previous rating to review whether those domains rated as inadequate had sufficiently improved.

Follow up: We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two 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. At this inspection 16 people were living at Alexandra House.

The service had a manager registered with the Care Quality Commission. This means that they and the registered 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 took place on the 16 July 2019 and was unannounced.

What we did:
Before the inspection we reviewed information, we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to

send us.

During the inspection we spoke with four people living at the service, one relative, the registered manager (who is also the company director), deputy manager, two care staff workers, the operations manager, the clinical manager, the cook, two visitors and a social worker. We also reviewed a range of records such as quality audits, provider policies and procedures and future plans for improvement.

We reviewed five people's care plans and reviewed the safety of medication administration.
Following the inspection: We asked health and social care professionals and relatives for feedback about the service people received. We received feedback from two health professionals, four social care professionals and one relative.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 12.

- Risk assessments were developed and in place for areas like mobility, choking, skin integrity and others. The risk assessments in place gave good detail about what the risks were and what measures were in place to mitigate risks. For example, choking risk assessments described why the person was at risk of choking and what staff had to do to prevent this from happening including first aids response in case the choking did occur.
- Risk assessments were developed recently in a new format and they were not as yet reviewed. This meant that we could not assess if the risk assessments would be updated and reviewed after an accident or incident occurred. The provider told us they implemented the procedure to update people`s risk assessments regularly or every time it was needed.
- Some people were prescribed pureed diets and thickened fluids. Staff and the chef were knowledgeable about the amount of thickener needed to be added to drinks to keep people safe. People who were at risk of developing pressure ulcers were monitored by staff. Turning charts and positioning charts were in place to prevent pressure ulcers from developing. Staff explained to us the difference between positioning and turning. Positioning charts were completed when people were sitting in the lounge and they had regularly been hoisted to relieve the pressure. When people were in bed the frequency of the turns were established by the nursing staff and this took account of night time when people were asleep.
- Staff were knowledgeable about risks to people`s health and well-being. They told us who was at risk of falls, choking, pressure ulcers but also people who had behaviours that challenged others.
- The risk of people accessing the balcony and the balcony railing had been assessed for each person who had access to it. The risk assessment looked at people`s mobility, mental health and other factors which may have increased the risk of people falling or general members of the public climbing over the rails.
- None of the people currently living in the bedrooms which had a door leading to the balcony could mobilise independently and access it. The provider told us they were planning to make adaptations to the balcony doors and with the exception of the one fire exit needed they were planning to transform the others in windows. We also discussed with the provider to consider installing an alarm system on the doors mainly to alert staff and people if anyone accessed the building from the outside.

Using medicines safely

● Medicines were administered by trained staff. Nursing staff had a good knowledge about what medicines people were taking.
● People`s medicines were administered safely, medicine administration record (MAR) charts were completed according to best practice guidelines. Hand written entries were double signed, counts of medicines corresponded to records kept. Time specific medicines were administered as per the prescriber's instructions.
●Medicines and clinical supplies like dressings were stored in the registered manager`s office and the cupboards were secured to the walls. However, the room had no temperature control other than fans. We discussed with the provider that the storage of medicines and clinical equipment was not in line with recommended best practice guidelines and a more suitable storage space was needed. The provider acknowledged this and said they will look into this.

Preventing and controlling infection
● Areas in the home were clean and with the exception of one bedroom there were no mal-odours. This room was regularly cleaned and there was a rolling-maintenance programme and work was carried out to refurbish and refresh the environment. Three bedrooms were deemed out of use by the provider and were undergoing full refurbishment.
● Social care professionals told us they found the home clean when they visited. One social care professional said, "I visited a person's bedroom which was situated on the first floor, the room was clean tidy and airy." Staff were seen using gloves and aprons appropriately.
● People who needed the aid of a hoist for transfers had no individual slings to mitigate the risk of spread of infections. The clinical manager told us they ordered more slings to ensure they could allocate appropriate slings for people.

Systems and processes to safeguard people from the risk of abuse
● Every person, relative and health and social care professional we spoke with felt the service was safe. One person said, "I am safe here." A health professional told us, "I feel they offer a caring safe environment for their patients with good knowledge of individuals."
● Some people told us they knew how to keep themselves safe when out and about on their own. People relying on staff`s support to have their needs met told us the care and support they received was safe and they trusted staff.
● Staff`s safeguarding knowledge varied. Care assistants were less knowledgeable than staff in more leading roles. Whilst staff were not always knowledgeable about the word `safeguarding` when we asked them what they monitored and looked for when caring for people, they all said they looked for signs of abuse. Staff told us they would report their concerns internally and externally; however, they were not familiar with the word Whistleblowing. They knew where they could find contact details for external authorities.
● The training matrix evidenced that some staff received abuse or safeguarding training when they commenced their employment. Not every staff member had annual refresher training to ensure they were up to date about current safeguarding processes. This was still an area in need of improvement.

Staffing and recruitment
● People told us there were enough staff to meet their needs. One person said, "Staff are always here. They help me when needed."
● Staff told us there were enough staff to meet people`s needs in a timely way and they covered for each other's absences if it was needed. Relatives told us staff were present in communal areas when they visited. One relative told us, "There seems to be ample staff in the main lounge area when I visit at the weekends."

Learning lessons when things go wrong

● Evidence of lessons learnt were seen in terms of the provider looked at the areas of failing from previous inspections. They changed and implemented a more formal governance system which allowed for regular audits to be carried out to monitor the quality of the care provided. Care plans were changed and staff`s roles and responsibilities were developed. The head office staff structure changed which freed the registered manager who was also a director of the company to spend more time in the service.

● Staff told us they discussed people`s care in handovers and meetings and if improvements were needed, these were implemented. We saw evidence of these in staff meeting minutes as well as relatives' meetings and resident`s meetings.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At the previous inspection we found that systems and processes for governance and quality assurance were ineffective and failed to assess, monitor and improve the quality of care being provided or mitigate the risk of harm to people living at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider made improvements to their governance systems. Some of these needed further developing and testing for being effective and able to sustain improvements. This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People knew who the registered manager was and knew staff by their names. Staff worked at the home for several years and they had a good understanding of people`s personalities, likes and dislikes. A relative told us, "I have complete confidence in the staff and management who look after my [relative`s] welfare."
- However, some practices we saw were institutional practice and were not promoting people`s independence or personalised care. For example, staff plated people`s food up and poured gravy on without giving people the option of serving themselves, no condiments or seconds offered. People were sitting in the lounge with chairs against the walls. People were not given the opportunity to make a cup of tea for themselves or cook their own breakfast although they had not been assessed as being at risk to do so.
- Staff cared for people with mental health needs, learning and physical disability, dementia and other needs. Current guidance like registering the right support or caring for people with mental health needs were not known and followed by staff. Some people were spending all their time in the community, however not supported to have a well-structured skills development program and move on to less supported care services. The provider and the registered manager told us they tried contacting social services for those people who did not want or needed to live in the home, however due to funding arrangements the process was delayed.
- We discussed the need for the registered manager and the provider to act as people's voice and ensure their voice was heard by involving independent advocates if people wanted and follow up on a regular basis with social workers about people`s needs.
- Care plans were developed in care plan A and B. Care plan A was kept in the main office and contained needs assessments carried out by staff in the home as well as other professionals. Care plan B was

developed following the assessments done for all the identified needs and these were kept at hand for staff to use. The provider was aware that they had to ensure that the two separate care plan documents were consistent and updated regularly when people`s needs changed. Care plans had not been reviewed as yet as only developed in the last month.

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

● Out of 12 staff training records the provider sent us, only five had basic mental health awareness training. The staff we spoke with could not tell us what the signs and symptoms of specific mental health conditions were. They told us, how they recognised when people had a good or a bad day and they reported it so that specialist mental health professionals could be involved. The providers training programme was mainly in house and only recently they booked staff on more specific training like Dysphagia, Parkinson's, oral care, documentation and record keeping. Staff had not had refresher training regularly after they completed their initial training at the beginning of their employment. This meant that some staff had no safeguarding training from 2014 or 2015. We discussed this with the provider who told us they were booking training for staff.

● A high percentage of staff were from overseas and their first language was not English. Staff could communicate in basic English with people and understood when people asked for support. However, they lacked confidence in talking to the inspectors, didn't understand specific language like safeguarding and whistleblowing and were not initiating conversation with people.

● We discussed with the provider their responsibility as an employer to support their staff to develop their language skills and understanding so that staff could support people in a more personalised way.

● Staff`s roles and responsibilities were re-developed by the provider so that staff were clear of what was expected from them. Policies and procedures were also developed to ensure these were supporting staff to provide care and support at a required standard.

● Governance systems were designed to address and support regular audits to assess the quality and safety of the services provided. The provider told us these were in the implementation phase and could not be tested for how effectively were used or if they sustained improvements in the quality of the service provided.

● Some competency assessments were carried out by external health professionals to assess staff`s competencies for example in blood glucose monitoring. The provider was planning to carry out more observations on staff`s practices to ensure they were competent in meeting people`s needs in a personalised way. We discussed with the provider how they made sure that the person assessing staffs` competencies was skilled in doing this effectively. This was because some staff members in key senior roles within the organisation worked for the provider for several years and there was a risk that they were not up to date with relevant current best practice and guidance as access to external training was limited especially training relevant to these key positions in the company. The provider told us they will look into more specialist training for staff.

Working in partnership with others

● The provider was working in partnership with health and social care professionals involved in people`s care. They had an annual visit from the local authority to review the care people received. The provider was getting a mixture of referrals from local authorities for people with various needs and often not accepted by other providers. Where people`s health improved over time and they become independent there was slow progress to ensure they could move on to less supported care services. People told us they would like to move out of the area closer to their family, but no arrangements or progress had been made on their behalf to achieve this. One person said, "I don't like to live here I would like to move closer to family. I am independent and go out on my own. I just don't know why the hospital sent me here.

● The provider sent us evidence that they had made enquiries with the local funding authorities for people

to move on, however progress was slow as at times people changed their mind or alternative accommodation was difficult to find by the local funding authorities.

● Health professionals were involved to meet people`s needs, mental health specialists, diabetic and Parkinson's nurse, GP`s and speech and language therapists. Feedback we received from them was positive. One health care professional said, "They [staff] have always acted in the best interests of patient and offer their patient good health and well-being support. Staff will ask on home care visits for us to look at patients if they have the slightest concern."

● The provider and registered manager were very passionate in providing good care to people. They proudly told us how people`s condition and well-being improved in the years they were cared for in the home. However, the provider struggled to develop practices and systems in line with changes of CQC regulations and nationally recognised best practice guidance when caring for people with learning disabilities and mental health needs. The provider told us they restructured their organisation and created specific job roles to ensure staff in senior management roles were able to implement new practices and achieve compliance with CQC regulations.

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

● People were given the opportunity to participate in monthly resident meetings and share their feedback about the service. Although specific action plans were not developed from these meetings, actions agreed were re-visited at the beginning of the next meeting to ensure these were completed.

● Staff and managers meetings were in place and staff told us they felt confident in giving feedback about the service.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not imbedded in practice. These were not tested for sustainability and if they could drive improvements to the quality of the service provided