Mrs. Mercy Amartiokor Cofie-Cudjoe

Alexandra Lodge Care Home

Inspection report

2 Lucknow Drive
Mapperley Park
Nottingham
Nottinghamshire
NG3 5EU

Tel: 01159626580

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Alexandra Lodge is a residential care home providing personal care to up to 19 people. People are supported in 1 adapted building. On the day of our inspection, there were no people using the service. This is because we have suspended the registration of the service.

What we found
Our last inspection resulted in the registration of the service being suspended. This means the provider is able to remain registered, but is not able to support any people. A suspension of a provider's registration is time limited, so we returned to the service to assess if the provider had made improvements to the service since our last inspection. Our inspection was targeted to only look at the areas of concern at our last inspection.

During the inspection, we found that environmental risks remained at the service. There was hot water which could risk scalding. Fire doors did not close, which risks the spread of fire through the building. Windows were not restricted, which meant people could fall out of windows.

We found that some policies had been updated. However, these were not always good enough to guide staff.

Staff had updated DBS checks, to ensure they were still safe to work with people. However, the policy had not been updated to ensure that regular DBS checks would occur in the future.

At the last inspection, people were at risk of choking. At this inspection, kitchen staff had not received training and updated guidance on how to manage swallowing needs and suitable food preparation going forward. Therefore, the risk of people choking if they used the service remained.

Water maintenance was not completed. This lack of maintenance risked the build up of legionella bacteria in the water system. This bacterial build up can cause a respiratory illness and serious ill health.

At the last inspection we found there were not enough staff. The manager told us that they do not intend to increase staffing levels if people returned to the service. The manager had a tool to calculate how many staff were needed, however this was not fit for purpose.

Staff had now received training in how to give medicines safely. However, there were still unclear processes for how medicines would be managed and monitored at the service.

The cleanliness of the home had improved, however there was still a room that was malodourous and had dirty light pull cords. So, we were not assured that cleaning processes were fully embedded at the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 28 July 2023).

Why we inspected
After the last inspection, we suspended the providers registration. We returned to the service to see if any changes had been made. This is to ensure safety for people using the service in the future.

We completed a targeted inspection. This does not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement
The last inspection identified 5 breaches of regulation. This was due to concerns with safety, staffing levels, recruitment, safeguarding from abuse and governance.

At the time of this inspection, there were no people living at Alexandra Lodge. We were therefore unable assess if the service was still in breach of legislation. This means that these breaches of regulation remain and will be reassessed if suitable at a future inspection of the service.

Follow up
At the time of our inspection, the service had a time limited suspension. This prevented them from supporting people at the service. We are still considering our regulatory action and full details of this will be added once any appeals are concluded.

In the interim, we will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
At the last inspection, the overall rating for this service was 'Inadequate. This meant the service remained in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

Due to the targeted focus of the inspection, we have been unable to assess all key questions. Therefore, this service remains in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Alexandra Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had made improvements following our previous inspection.

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Alexandra Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Alexandra Lodge Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because the service was not currently supporting any people. So, staff were not routinely in the building.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the concerns observed at the last inspection. We then created an inspection plan, to specifically look at what changes had been made to these previous risks.

Since our last inspection, the service has not supported any people. We have therefore not received any updates from external professionals or members of the public.

During the inspection
We walked around the care home, to assess what changes had been made to the environment since the last inspection. We also reviewed governance records, to assess whether systems and processes had been altered since our last inspection. We spoke to 2 care staff and the responsible person for the care home.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had made improvements since we suspended the registration of the service. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse.

At the last inspection, the service was in breach of regulation 13 (safeguarding people from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some ongoing concerns. However, we were not able to fully assess this breach of regulation, as the service was not supporting any people.

● At the last inspection, people were not kept safe from harm. This is because action had not been taken to assess and mitigate risks to people. At this inspection, policies for safeguarding remained poor quality. This is because they did not refer to current legislation and did not describe all types of possible abuse. This poor-quality policy meant we were not assured that staff would now recognise and response to allegations of abuse.
● At the last inspection, staff told us they raised safety concerns to the provider, but the provider had not acted on their concerns. At this inspection, there was an unclear whistleblowing policy. The policy did not guide staff on a suitable external organisation to report concerns to. Not providing clear whistleblowing guidance to staff can risk a closed culture of abuse.
● At the last inspection, we found staff had poor knowledge on how to keep people safe from abuse. At this inspection, we found staff had not received further training or competency assessment. This risks ongoing poor knowledge on how to keep people safe from abuse.

Assessing risk, safety monitoring and management

At the last inspection, the service was in 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 some ongoing concerns with the safety of the environment and medicines. However, we were not able to fully assess this breach of regulation as the service was not supporting any people.

● At the last 2 inspections, we found fire risks were not well managed. At this inspection, we saw the environment had not been sufficiently improved to reduce the risk of fire. This is because 3 fire doors still did not close correctly. This risks fire spreading through the care home.
● At the last 2 inspections, we saw window restrictors were either not in place, or were poor quality. This

risks a gap, where people can fall out of the window and hurt themselves. At this inspection, we saw some improvements had been made but this risk remained for 2 windows.
● At the last inspection, hot radiator surfaces were not covered. This risked people burning themselves when touching the surfaces. At this inspection, improvements had been made and we saw most radiators were suitably covered throughout the building. However, 1 radiator cover still had gaps at the side presenting a burns risk.
● At the last inspection, people were at risk of choking due to poor processes associated with their altered diet. At this inspection, kitchen staff still did not have the knowledge and guidance on how to prepare suitably textured food. This would leave people at risk of choking on the incorrect texture food.
● People would be at risk of legionnaires disease if they lived at the service. Legionella is a water-bourne bacteria that builds up in water systems. When inhaled it can put people at serious risk of ill health. To reduce the risk of bacteria build up in the water system, the provider is required to complete maintenance routines. These maintenance routines had not been completed which increases the risk of this bacteria build up.
● People would be at risk of scalding if they used the service. Health and safety guidance is for water to be under 44°C. We found one sink at 69°C and one shower at 48°C. These temperatures present a scalding risk for people using the water. The provider had no system checks in place to identify and resolve this scalding risk.
● At the last inspection, freestanding furniture was not always secured. This risks the furniture falling on a person. At this inspection, we saw freestanding furniture had been safely secured to the walls.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● At the last inspection, we found people had been referred for a DoLs. However, there was no evidence the provider had completed reviews to ensure the restrictions were still necessary and people were not unlawfully restricted. At this inspection the provider advised they had not yet created a governance tool to oversee any new deprivation of liberty referrals. They advised this would be created once people started to use the service. As no tool had been created, we were unable to assess the effectiveness of this.

Using medicines safely

● At the last 2 inspections, systems and processes for medicines management had not been developed or implemented. At this inspection, we found policies were in place but were poor quality. There was a lack of guidance on how medicines would be managed safely. This risks ongoing unsafe medicine processes.
● At the last inspection we found staff had not received training on how to give medicines safely. At this inspection, staff had now received medicine training.

Preventing and controlling infection

● At the last inspection, we found the home was unclean and had malodours, indicating sufficient cleaning

had not occurred. At this inspection, we identified 1 malodourous bedroom and unclean light switches in communal bathrooms. While some improvements had been made, we were not fully assured that cleaning processes were embedded at the home.

● At the last inspection, we found mattresses were unclean and stained. We did not identify any mattress concerns at this inspection. However, the provider had not created an audit tool to ensure mattresses were checked in the future. This could risk mattresses becoming unclean again and not being acted on.

● At the last inspection, there were no dedicated domestic staff to ensure cleaning processes were completed each day. At this inspection, we were informed that there would be no changes to the amount of domestic staff. There had been no assessment of how many cleaning staff would be needed to maintain home cleanliness. This risks the home becoming unclean again.

Learning lessons when things go wrong

●The last 2 inspections of Alexandra Lodge Care home have identified concerns with: environmental safety, care planning, medicines, staffing levels and recruitment. At this inspection, minimal improvements had been made and people were left at risk of unsafe care. We are therefore not assured that lessons had been learnt.

Staffing and recruitment

At the last inspection, the service was in breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were not enough staff deployed at the service to keep people safe. At this inspection, we found some ongoing concerns with staffing levels. However, we were not able to fully assess this as the service was not supporting any people.

● At the last inspection we highlighted there was not enough staff deployed, to ensure people's safety. At this inspection, the provider advised that staffing levels would not change if they supported people again. This could leave people at ongoing risk of poor care from a lack of staff.

● At the last inspection, the provider had not calculated how many staff were needed. At this inspection, the provider explained that they had a tool they could use. We saw this tool was not fit for purpose as it did not result in clear staffing levels.

At the last inspection, the service was in breach of regulation 19 (fit and proper persons deployed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because of unsafe recruitment processes. At this inspection, we found some ongoing concerns. However, we were not able to fully assess this as the service was not supporting any people.

● At the last inspection we found the provider did not have robust recruitment policies and procedures. This is because staff had not had a DBS check after working for over 6 years. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. At this inspection, the provider had applied for updated DBS checks for all staff. However, the recruitment policy had not been updated, this meant that there was no process on how often DBS checks should occur in the future. This risks the same recruitment errors re-occurring. Putting people at risk of support from unsuitable staff members.

Inspected but not rated

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-centered care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had made improvements since we suspended the registration of the service. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
At the last inspection, the service was in breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some ongoing concerns. However, we were not able to fully assess this breach of regulation, as the service was not supporting any people.

● At the last 2 inspections, we found policies were not always in place to guide safe care. At this inspection some policies were still not in place. Policies that had been put in place were not always of a high quality, for example the training policy did not state what training was mandatory. There was also no induction policy, to guide what support would be available for new staff.
● At the last inspection, we identified concerns with safeguarding people from abuse, recruitment, staffing levels, safety and governance. At this inspection, these risks remained. We are therefore not assured about the leadership and oversight to make improvements.