Roseberry Care Centres GB Limited

Alexandra View Care Centre

Inspection report

Lilburn Place
Southwick
Sunderland
Tyne and Wear
SR5 2AF

Tel: 01915496331

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30 September 2020
16 November 2020

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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
Alexandra view is a residential care home providing personal and nursing care to 52 people. The service can provide care for up to 68 people.

People's experience of using this service and what we found
Prior to the inspection we received concerns linked to winter pressure beds beds operated within the home. The service had 20 beds designated for people being discharged from hospital. These were intended to be short-term (up to 6 weeks) until their longer care needs had been assessed.

Improvements were required to ensure people in these beds received the appropriate care. This was partly due to the process in place at the time for deciding which people should be referred to Alexandra View.

Health and social care professionals had acted to ensure appropriate referrals were made into the hospital contract beds.

The provider's quality assurance processes had not proactively addressed issues with inaccurate care records and delays in developing personalised care plans.

Some people who were assessed as high risk did not have specific moving and assisting care plans in line with the provider's guidance. Other risk assessments lacked detail about the measures needed to minimise risks to people's safety.

Relatives told us they felt their family members were safe living at the home.

Staff gave positive feedback about the registered manager. They said they felt supported and the registered manager was approachable.

There were regular opportunities for people and staff to give feedback.

Staff said they felt people were safe living at the home. They knew how to raise concerns and felt confident to do so.

Health and safety checks and environmental risk assessments were completed to help maintain safety. Incidents and accidents had been logged and investigated.

There were enough staff deployed to meet people's needs. New staff were recruited safely.

Medicines were managed safely. The home was clean and staff used personal protective equipment (PPE) appropriately.

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

Rating at last inspection
The last rating for this service was good (published 3 January 2020).

Why we inspected
We received concerns in relation to staffing levels, medicines management, poor communication with relatives, lack of information for people discharged from hospital into assessment beds, lack of care plans, poor cleanliness and dignity issues. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alexandra View Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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.

Alexandra View Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector carried out this inspection.

Service and service type
Alexandra View Care Centre 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 30 minutes notice of this inspection. This was to ensure we could complete the inspection safely.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection

We reviewed a range of records to enable us to check the safety and leadership of the service. This included a sample of care plans and multiple medicines records, as well as a variety of records relating to the management of the service.

After the inspection
We contacted eight relatives to gather their views. We also continued to seek clarification from the provider to validate evidence found. We looked at training data, updated policies and procedures and quality assurance related records.

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 good. At this inspection this key question has deteriorated 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

- People admitted from hospital into the designated discharge beds arrived with often minimal information about their needs and potential risks. This posed difficulties when determining how best to keep these people safe.
- Some people had been assessed as high risk in relation to moving and assisting. They did not have an specific moving and assisting assessment and plan as described in the provider's guidance.
- Although other risk assessments were carried out, these often lacked specific information about the measures needed to minimise risks to people's safety.

The provider had failed to fully assess potential risks in a timely way to help ensure people's safety. The above is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

- Health and safety checks were carried out to help keep the environment safe.
- The provider had procedures to deal with emergencies, including plans to ensure people continued to receive the support they need.

Systems and processes to safeguard people from the risk of abuse

- The provider had safeguarding systems and procedures to help protect people from the risk of abuse.
- Staff understood the safeguarding and whistle blowing procedures. They told us they were confident to raise concerns if needed. One staff member said, "People are safe. We do our best to try and make them safe and comfortable."
- Relatives did not raise any concerns about safety. One relative commented, "[Family member] is definitely 100% safe there."

Staffing and recruitment

- There were enough staff on duty to provide people's care and support. Staff commented, "We have the right amount of staff for the residents here."
- The registered manager regularly reviewed staffing levels to ensure they remained acceptable.
- The provider had effective recruitment processes to ensure new staff were recruited safely.

Using medicines safely

- People continued to receive their medicines safely.

● Medicines were stored appropriately. Records accurately accounted for the medicines people received.
● Management checked staff followed the agreed medicines management procedures.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Accidents and incidents were investigated and reviewed.

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 good. At this inspection this key question has now deteriorated 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.

Continuous learning and improving care

- The provider had a structured approach to quality assurance. Regular checks were completed and the regional manager also completed regular checks of the home.
- Quality assurance checks had not been effective in ensuring care plans and supplementary records, for people in the hospital discharge beds, were detailed and accurate. This meant staff did not have the information they needed to ensure people received appropriate care.
- People were admitted into the hospital discharge beds with limited information about their care needs and expected outcomes of their stay. There was no evidence to show action had been taken to address this situation.
- Detailed care plans were not in place for two people who had been in the home for a considerable number of months. This had not been identified and addressed through the provider's quality assurance (QA) processes. The QA processes had also not identified some people did not have appropriate moving and handling assessments completed.
- Supplementary charts and records were not always completed accurately, such as for positional changes and food and fluid records. This had been identified on as an on-going issue during QA checks. Care plan audits conducted between April and August 2020 all identified issues with inaccurate record keeping. However robust action had not been taken to address these issues.

The provider had failed to learn lessons and ensure robust action was taken to improve the quality of care records to confirm people had received the care they needed. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Working in partnership with others

- The provider had worked with health services to offer designated beds for people being discharged from hospital.
- Issues were identified with these beds including inappropriate referrals, lack of information and not having clear outcomes for people. Health professionals had been involved in improving the admissions process. This led to changing the admissions criteria for the home and ensuring community health professionals assessed people within an agreed timescale after admission.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

● Staff told us the registered manager was approachable and made them feel valued. They described good teamworking within the home. One staff member commented, "The manager we have is very good. He is approachable."

● Relatives also said the registered manager was approachable. One relative said, "[Registered manager] is lovely, approachable. He is really nice, he can't do enough for you."

● The home had a positive atmosphere. One staff member said, "It is better here with [registered manager], it feels more settled."

● There were opportunities for people and staff to share their views about the home, such as regular meetings and formal consultation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager submitted the required statutory notifications to CQC following significant events at the home.

● Staff described how the manager gave clear and constructive feedback. One staff member said, "If something is not right he is on the ball and tells you, but not nasty."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to fully assess potential risks in a timely way to help ensure people's safety.

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