Apex Care Homes Limited

Alicia Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
This report contains information about 2 different properties that are registered at the same location. They are Alicia Nursing Home and Atwell House.

Alicia Nursing Home is a residential care home providing accommodation and nursing care to up to 61 people across 2 buildings. The service provides support to older people, people living with dementia and people with a mental health diagnosis. At the time of our inspection only 1 building was in use, there were 34 people using the service.

Atwell House is a residential care home providing accommodation and nursing care to up to 7 people. The service provides support to people with a learning disability and autistic people. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: People were at risk of harm because risks were not always fully assessed. Risks in relation to the environment, medical equipment and medicines were not always managed safely. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: Staff understood how to protect people from poor care and abuse. People's needs were assessed, and their care regularly reviewed. People were treated with kindness, dignity, and respect. We observed positive interactions between people and staff. The provider worked in partnership with other professionals.

Right Culture: Audits and checks were not always effective to ensure quality of records and minimise risks. Feedback was gathered through questionnaires and meetings, however the action taken from this feedback was not always communicated. Feedback was overall positive about the management of 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
The last rating for this service was good (published 27 October 2017)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alicia Nursing Home on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to equipment safety and governance systems at this inspection.
We have made recommendations around recruitment processes, medicines, and least restrictive practices.

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, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Alicia 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. 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.

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
The inspection was carried out by 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Alicia Nursing 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. Alicia Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and 8 relatives. We spoke with 9 staff and received further written feedback from 5 staff, including the registered manager, nominated individual, quality manager, nurses, care staff and ancillary staff. We looked at a range of records relating to the management of the service including quality monitoring records, staffing documentation and policy documents relating to areas such as infection control, medicines management and safeguarding people from harm.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- The service was not always safe. In Atwell House, none of the windows on the first floor of the building, including people's bedrooms, had suitable window restrictors fitted. The Health and Safety Executive guidelines state that where there is a risk of people falling from windows, window restrictors should be in place. The height of the windows posed a risk of someone accidently falling from them as they could be opened wide enough for a person to easily climb up and out. The service supported people with learning disabilities and mental health conditions, and the provider had not identified the current measures in place to protect people were unsuitable as windows may pose a risk to people who could climb out and fall. This meant the premises were not fully safe and secure for people to be living in.
- Devices to monitor blood glucose levels were not checked as per the manufactures instructions. This meant the provider could not be assured the devices were working correctly and displaying the correct results, this placed people at risk as blood sugar readings could be incorrect.

Whilst we did not find these issues had impacted people, the provider failed to ensure that the premises and equipment used were secure and maintained. This was a breach of Regulation 15 (1) (b), (e) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acted immediately to address our concerns. A procedure was put into place, calibration solution was obtained, and suitable window restrictors were fitted during the inspection.

- Care plans contained detailed assessments to identify risks and keep people safe, for example, risk of skin damage, malnutrition and choking.
- Accidents and incidents were recorded and reviewed by the registered manager; any follow up actions were completed as required.

Staffing and recruitment

- The provider completed appropriate police and criminal records checks; however, records were disorganised and information was not always clear. We found some gaps in staff employment history.

We recommended the provider ensures recruitment processes are robust and all required checks are carried out and clearly recorded.

- Right to work checks were in place. References were obtained and verified, including for staff where they received references from outside the UK. Where people required professional registration, for example with

the Nursing and Midwifery Council, these records were stored and checked by the HR team.
● There were enough staff to support people, including where individuals received one to one support. Rotas confirmed this.

Using medicines safely
● Medicines were not always managed safely. For example, some medicines did not have opening dates recorded and staff were unclear in relation to expiry dates of medicine once opened.
● Where people received insulin, the injection sites were not recorded. It is important the injection site is changed regularly to reduce side effects and ineffective absorption of the insulin.

We recommend the provider review their medicines processes to ensure medicines are stored and administered in line with current best practice guidance.

We did not find anyone had been harmed by these issues. The provider responded immediately during and after the inspection.

● People received their medicines as prescribed, medicines administration records confirmed this. Staff received medicines training and regular competency checks.
● Medicines were stored securely and at the specified temperatures, this was monitored and recorded.

Learning lessons when things go wrong
● Individual Incidents were reviewed by the quality team and comments and suggestions were fed back to the service. However, there was no evidence of a detailed analysis over time to capture wider themes and trends
● Analysis was limited to reviews of falls, pressure sores and medicines errors. There was no evidence of analysis of other incidents, such as behaviours or unexplained bruising. We found 2 incidents where a large number of staff had been involved and found limited evidence this had been explored further and there were limited follow up actions.

We raised our concerns with the provider who told us they would review these incidents.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of harm and abuse and people felt safe. One person said, "I feel safe here, the people are kind and the meals are good."
● Staff received regular training on the signs of abuse and knew how to report any concerns. One staff member told us, "I will raise any concerns without hesitation and go higher if not acted upon."
● The provider had policies and procedures in place to protect people.

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)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
There were no restrictions on visiting and the provider was working within current government guidance.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were treated with kindness and respect. One person said, "I am happy here, they all work really hard. I feel safe here, they are kind to me." Another person said, "They really look after me."
- Staff were very caring towards people and talked about them with affection. We observed during lunch time, staff demonstrated kindness and patience when supporting people with their meals.
- Relatives were complimentary about the care provider. One relative said, "Without a doubt, it is a wonderful place." Another told us, "[Staff] are a very special breed of people, they are always very busy, but they do have time to interact with [person]. They know each person so well."
- Regular meetings were held with people to obtain their views.
- People were supported to express their views and make decisions. One person told us, "I've got everything I want; I sleep well. [Staff] take me to the "Singing for dementia" group by taxi, we went to the seaside for a picnic."
- People were given lots of opportunities for activities and engagement. In the activity room, there was something for everybody and the environment felt lively and fun. There were lots of photos displayed around the room of past activities and events.

Respecting and promoting people's privacy, dignity and independence

- People were supported to maintain their independence; care plans contained information about the level of support people required. We observed people being supported with patience and kindness throughout the inspection.
- People were asked in their initial assessment about their preferences. The provider worked with people to ensure these preferences were accommodated.
- One relative spoke highly of staff and how through them working closely with their relative, their independence had improved greatly.

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 our last inspection we rated this key question good. The rating for this key question has changed 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.

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

- Governance processes were not always effective at ensuring the quality and safety of the service. They did not identify the concerns found during the inspection. For example, in relation to window restrictors and medicines.
- Records were not always kept up to date or with the required level of information. We found omissions in records relating to medicines and recruitment records were disorganised.
- The provider had a range of checklists to monitor safety and drive areas of improvement in the service however these did not identify the issues found during this inspection and were not always completed in line with the provider's policy. For example, we saw the last monthly medicines audit was completed in July 2023 and the quarterly quality assurance audit was completed in April 2023.
- The provider had responded promptly to external agency findings with effective short term action plans and where required had addressed any issues identified, for example following an external health and safety audit. However, systems and process were not always changed as a result. For example, although the provider had addressed concerns following an environmental health inspection, their governance systems remained unchanged, potentially allowing similar issues to reoccur.
- Accident and incidents were recorded and there was evidence these had been reviewed. However, there was limited evidence of identifying themes and trends following on from an incident.

The provider failed to ensure appropriate records and effective governance systems were in place. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager demonstrated good understanding of their role and recognised the need for strong leadership and clear direction throughout the service.
- The registered manager and provider were open in their response to the findings of the inspection and acted promptly to take action where concerns were identified.

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

- The provider had not kept restrictions to people under regular review to ensure they remained the least restrictive options. For example, in Atwell House, the kitchen was locked, and a number of bedrooms and

the stairs had gates fitted to prevent people from accessing these areas.

We recommend the provider review their processes in line with current best practice guidance.

Following the inspection, the provider reviewed these areas and identified some restrictions could be removed and alternative options be put in place to promote people's autonomy. They consulted with a multi-disciplinary team to develop a plan to further promote the independence of individuals living in the service.

● Views had been sought from people and relatives through surveys. However, whilst opinions on the home and care provided was captured, there was currently no system in place for providing feedback to people and relatives on what actions had been taken to address any issues or act on suggestions. We discussed this with the provider, who agreed to look into how best to communicate this.
● People were encouraged to participate in activities and events they enjoyed and where able, were supported to go into the community.
● Relatives were very positive about the staff team. One relative told us, "The home has a very good manager, and the staff are a credit to them. They hold a monthly meeting, and they send me the minutes, I can add anything to it if I wish."
● The provider had introduced a number of initiatives to celebrate and support the staff team. This included employee of the month and a staff insurance scheme.

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
● Records confirmed managers of the service and the provider understood and acted on the duty of candour. Where things went wrong, the provider was open and honest with people and their relatives, providing an apology and outlining any learning.
● Statutory notifications are reports of certain changes, events and incidents that the registered providers must notify us about that affect their service or the people that use it. The provider had notified CQC as required.

Working in partnership with others
● The provider had good relationships with other professionals that worked alongside the service. Where required, staff acted promptly and appropriately to involve others, for example, the G.P, speech and language services and the palliative care team.
● A relative said, "I think the home is phenomenal, [person] has complex needs, they follow my advice on their care needs, they have a rapport with them. They know when they are unwell and will call a GP or ambulance if necessary."

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 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure that the premises and equipment used were secure and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes operated effectively to monitor and mitigate the risks relating to the health and welfare of people and to improve the quality and safety of the service provided.