Mr Paul Maple

Alandale Residential Home

Inspection report

9 The Drove
Whitfield
Dover
Kent
CT16 3JB

Tel: 01304824904
Website: www.alandaleresidentialhome.co.uk

Date of inspection visit:
07 December 2022

Date of publication:
09 February 2023

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
Alandale Residential Home is a residential care home providing personal care to up to 35 people. The service provides support to older people some of who were living with dementia in one adapted building. At the time of our inspection there were 33 people using the service.

People's experience of using this service and what we found
People and their relatives gave positive feedback about the service and support they received from staff. However, we found areas of the service which were not always well managed. Medicines administration and management was not always in line with guidance. Infection control risks such as incorrect bins being used had not been identified by the registered provider and registered manager. Accident and incident documentation, and oversight was not always robust. Risks to people's health were not always mitigated through clear guidance for staff to follow. Staff did not always document checks completed on people to support complex health conditions.

The registered provider and registered manager did not complete regular audits on the service to ensure it was safe and identify any areas for improvement. There was a lack of oversight for areas highlighted within this report including medicines, accident and incidents management, weights management and reviewing and updating care plans.

People and relatives told us there was a positive culture within the service. 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. People were safeguarded from the risks of abuse. There were enough staff to meet people's needs. Staff worked with stakeholders to ensure people received joined up care.

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 23 November 2017).

Why we inspected
We received concerns in relation to visiting the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
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 based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

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

Enforcement and Recommendations
We have identified breaches in relation to infection prevention and control, medicines management, risk management and governance and oversight at this inspection.

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

Follow up
We will request an action plan from 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 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?

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.

Alandale Residential 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 2 inspectors.

Service and service type
Alandale Residential 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. Alandale Residential 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.

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 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 5 people who used the service and 8 relatives about their experience of the care provided. We spoke with 7 members of staff including the registered provider, registered manager, deputy manager, office manager and care staff. We observed interactions between staff and people in communal areas. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

Using medicines safely

● Medicines management and administration was not always safe. One person had a prescribed medicine that was not listed on the medicines administration records (MAR). The administering staff member did not know if the person should have the medicine or not. During the inspection, staff located the MAR for the person, and administered the medicine. Missing a dose of this medicine, could cause a person to have a seizure.

● Medicated creams and ointments had not always been dated on opening in line with guidance. One person had been given an ointment that was out of the manufacture's expiry date.

● Medicated creams were stored in people's rooms; however no risk assessment had been completed to consider the risk to anyone who could become disorientated and accidently consume the cream. Temperatures of people's rooms were not routinely taken to ensure medicines were stored in line with the manufacture's guidance.

● MAR were completed, however stock balance sheets we reviewed were not always correct in relation to the number of medicines there should have been in stock against the actual number. Following the inspection the registered manager informed us medicines balance sheets had been checked, and errors identified with the documentation, and that people had received these medicines as prescribed.

The registered persons had failed to ensure there was proper and safe management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents and incident monitoring and oversight was not effective. Accidents and incidents were logged on two systems; the electric care planning system, and a paper based system. The registered manager told us they reviewed these incidents and ensured the relevant referrals were made. However, we identified that not all incidents were recorded on paper forms, and two incidents were logged on the electronic system but not logged on the paper system. The registered manager told us that although the system was to log events on both systems, they only reviewed the paper incident forms, therefore they did not review the two incidents only recorded on the computer system.

● Not all incidents and accidents had been logged on both systems. Staff told us one person had a suspected seizure, however an accident / incident form had not been completed for this. Another person had a suspected stroke, and whilst action was taken to seek medical attention, there was no paper log of the incident. As the registered manager told us they only reviewed the paper logs, there was a risk appropriate action would not be taken.

● There was no accident or incident analysis documentation in place to evidence that the registered

manager or registered provider had analysed for patterns and trends. Action had been taken on individual incidents, however the registered manager or registered provider could not evidence they had looked at trends, for example the time people fell to review staffing.

The registered persons had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Some people had skin breakdown and had guidance in their care plan to inform staff to encourage them to move every 3 hours. However daily records completed by staff were inconsistent and did not show the person was encouraged to move within that time scale. Although people's wounds had not deteriorated, there was a risk that without clear guidance, staff would not take the required action.

● One person's care plan stated they were at high risk of choking. There was no guidance for staff in their care plan on actions to take if the person was to choke, for example to administer back slaps or call 999. Staff we spoke with told us the action they would take should someone choke, however there was a lack of detailed guidance to follow.

● One person was at risk of falling and had fallen. Their care plan had not been updated to reflect the most recent falls and how staff could mitigate the risk to them. The registered manager and deputy had reviewed the risk assessment but it had not been updated on their care plan. Following the inspection, the registered manager sent us confirmation this care plan had been updated.

● People living with catheters did not have clear guidance in place to inform staff how frequently to empty the bag. A catheter is a tube that is inserted into your bladder, allowing your urine to drain freely. Staff did not always log when they emptied people's bag.

● Checks on the service were completed, however action to address shortfalls found was not always clear. For example, checks were completed on water outlets to ensure they were not too hot to cause a scalding risk. However, when temperatures were above the maximum temperature's there were no details of actions taken to reduce the temperature of the water.

The registered persons had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Any conditions related to DoLS authorisations were being met.

● Staff we spoke with understood their responsibilities regarding the MCA and told us examples of how they ensured people made as many choices for themselves as possible, for example, the clothes they wore.

Preventing and controlling infection

● Infection prevention and control processes were not robust and did not always protect people from the risk of infection.

● Used personal protective equipment (PPE) was not always disposed of in line with guidance. Used PPE had been discarded in open bins, or swing bins. This increased the risk of infection. There was little evidence that PPE was being changed frequently in line with guidance.

● Continence aids were not always disposed of in the correct bins. The bath hoist was rusty, which posed an infection control risk as staff were unable to ensure it was clean.

● The registered provider and registered manager had not always supported visiting in line with government guidance, however this had been reviewed and updated prior to our inspection.

The registered persons had failed to assess the risk of, and preventing, detecting and controlling the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People, relatives and staff told us there were enough staff. The registered provider completed a dependency tool to inform on staffing numbers needed. When staffing numbers were lower than expected, for example with short notice sickness the registered manager and deputy manager would support staff.

● A relative told us, "There always seems to be enough staff." Another relative told us that when people needed support, they received it quickly, "I've seen the response to pressing the button and how quick staff were."

● Before starting their roles at Alandale Residential Home, checks were completed to help ensure staff were suitable for their roles. These included references and a review of previous work placements and a Disclosure and Barring Service (DBS) check. The DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People we spoke with told us they felt safe living at Alandale Residential Home. A relative told us they knew their relative was happy and safe living there. A person told us, "I fell well looked after and safe here, that was an issue for me when I was home alone, I didn't always feel safe."

● Staff understood their responsibilities in relation to safeguarding people. Staff we spoke with told us they were confident to raise concerns and knew how to escalate any concerns they had.

● The registered manager understood their responsibility to report any incidents of abuse to the local authority safeguarding team and to the CQC.

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 Requires Improvement. At this inspection the rating has remained 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

- The registered manager and registered provider completed visual checks on some areas of the service, however there was not a formal system to audit all areas of the service.
- The registered provider and registered manager did not have an effective system in place to monitor and make improvements in relation to medicines administration and storage. The registered manager told us that medicines were checked in by themselves and the deputy manager but there was no audit or check on countdown sheets, MAR's, open dates or temperatures to identify and check for errors.
- There was not a clear system in place to ensure needs relating to catheter care were monitored. Staff documented the fluid input / output for people with a catheter, to check that the output was as expected based on the amount the person had drunk. If the output was not at the expected level this could mean the catheter was not draining correctly or the tubing was blocked. However, no checks were completed to ensure the output was at the expected level. When people's catheter was changed, staff had not always documented this to ensure it was changed regularly and when necessary, nor the type and size of catheter used.
- There was not a robust system in place to have oversight of accidents and incidents. Action was taken on each individual incident however, there was no system to look for patterns and trends.
- Care plans and risk assessments did not contain enough information to inform staff how to mitigate risks to people. The electronic system highlighted when care plans needed to be reviewed, however there was no system in place to inform staff to update care plans and risk assessments when people's needs changed.
- There was not a robust system in place to audit and monitor that health and safety practices and to ensure measures were implemented and were effective.

The registered persons had failed to assess, monitor and improve the quality and safety of the service provided. The registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives told us they were happy with the care they received at Alandale Residential Home. One relative told us they were happy with the activities on offer, "I come during the day and they have

a lot of entertainment and people doing stuff. They have a lot of it here it's a big positive regardless if you want to join in or not. There are various things that I've seen them do that I think yeah that's a good thing everyone has got something a bit different."

● Another relative told us, "I don't need to worry when I go out from here she is safe, warm, well fed, clean and her needs are catered for there are staff around for her, it's a great weight off of me." A third relative told us, "The way she is looked after is good. Mum has dementia which is getting worse, when I talk with her she seems happy and content. That's all I can gauge it on."

● Relatives told us people received person centred care, which created good outcomes for their relative. One relative told us their loved one came to the service in need of end of life support; however, with the support and dedication of the care team, their health improved and were no longer in need of end of life care.

● Staff told us that the service was a good place to work and that there was a positive culture. The registered manager and deputy manager worked alongside staff to keep up to date with people and their needs.

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

● Relatives told us they were kept updated with any changes in their loved ones needs. A relative told us, "There's been a couple of times they needed to call the doctor they have let me know about that." Another relative told us, "I have a lot of correspondence email wise with staff to sort out everyday stuff. I'm pretty sure if I wanted to talk to one of them they would make themselves available but I haven't needed to. At the start I had more contact and that made me more comfortable about her settling in."

● There were staff meetings where staff gathered to discuss aspects of the service, including any issues. Staff told us they found the management team approachable and helpful.

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

● The duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the registered manager understood their responsibility to comply with the duty of candour.

Working in partnership with others

● Staff and the registered manager told us they had positive relationships with stakeholders. This included the district nursing team and nurses from the primary care network.

● The registered manager had completed the relevant referrals to healthcare professionals to ensure people received joined up care. This included referrals to the falls clinic when people had a number or falls, and the frailty team when there were concerns about people's heath.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. The provider had failed to ensure there was proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to assess, monitor and improve the quality and safety of the service provided. The registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.