Alexandra Nursing Home Limited

Alexandra Nursing Home - Poulton-le-Fylde

Inspection report

Moorland Road
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Tel: 01253893313

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13 November 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Alexandra Nursing Home - Poulton-le-Fylde provides residential and nursing care for up to 117 people. The service has three units one with a separate dementia unit which is purpose built. This building adjoins the main home and provides dedicated care for people with a specified dementia condition. At the time of the inspection visit there were 93 people who lived at the home.

People's experience of using this service and what we found
The service was not safe. We found staffing levels were not adequately assessed and documented. Not all staff had completed the necessary training to keep people safe. Where people had risks to their personal safety identified and recorded documentation to lessen the risk was, at times, conflicting. We found concerns with the cleanliness and maintenance of the environment. We observed staff not following good practice guidance around infection prevention and control including the use of personal protective equipment. We have made a recommendation around safeguarding training for staff as not all staff had received safeguarding training.

The service was not always well-led. At this inspection we found failures in the provider's quality and assurance systems. Records relating to care and the management of the service were either incomplete, inaccurate and/or not kept up to date. This could have compromised the quality and safety of the service provided.

We found the management team receptive to feedback and keen to improve the service. The registered manager and provider worked with us in a positive manner and provided all the information we requested. Additionally, they responded promptly to our concerns during and after the inspection.

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 05 December 2018).

Why we inspected
As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that Infection Prevention and Control (IPC) practice is safe, and in line with best practice guidance and government guidance, in respect of the management of IPC risks during the Covid-19 pandemic.
We inspected and found there were concerns with IPC practices and quality assurance, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

The ratings from previous comprehensive inspections for those key questions not looked at on this occasion 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alexandra Nursing Home - Poulton-le-Fylde 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to staffing, safe care and treatment and good governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 provider submitted an action plan after this inspection to show what they would do and by when to mitigate the risks and improve.

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 safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Alexandra Nursing Home - Poulton-le-Fylde

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
The inspection team was made up of two inspectors and one pharmacist specialist.

Service and service type
Alexandra Nursing Home - Poulton-le-Fylde 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.

Notice of inspection
We gave a short period notice of the inspection to as we needed to be sure the provider or registered manager would be available to support the inspection.

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 Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was

not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with one person who used the service about their experience of the care provided. We spoke with 20 members of staff including the provider, registered manager, senior care workers, care workers and domestic staff. We carried out observations of care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and fire safety records.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

●The registered manager had not consistently assessed and managed risks to people's health, safety and wellbeing. Staff were not always provided with up to date guidance on how to keep people safe. We found care plans did not always accurately reflect people's current needs. We discussed this with the registered manager who agreed with our findings. In response, the registered manager told us the care plans would be updated.

● Fire safety was not adequately risk assessed and planned for. We found the fire risk assessment was not specific to the units and did not include all the required information. We found eight fire doors that did not close properly. We saw three doors that were being wedged open around the home, this was not identified within the fire risk assessment.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider had not ensured enough staff were deployed at all times to ensure people's safety. The service did not have a systemic approach to calculate the number of staff required. We spoke to the manager about this. They confirmed they could not provide evidence staffing levels were determined based on people's individual needs and in line with best practice guidelines.

● The provider had not adequately established and operated a robust system for ensuring staff were provided with training. Staff had not been provided with training in key areas in line with people's needs. This included first aid, dementia care, equality and safe restraint among other areas. People at the home required support in these areas and the lack of trained staff put people at risk of harm.

● Staff told us that some days there was not enough staff to meet people's needs. The service had no activities provided for people at the home as staff stated they did not have the time to complete activities.

We found no evidence people had been harmed however, staff had not received appropriate training. There was no systematic approach to determine the numbers and skill mix of staff needed to meet people's needs. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider followed safe systems for staff recruitment. Staff told us they were recruited safely, and mandatory checks were completed prior to them starting work at the home.

Using medicines safely

● Medicines including controlled drugs were not always managed safely. Medicines Administration Records (MARs) were not always completed fully. We found signatures to evidence the administration of medicines by staff were missing on some occasions, so we could not be assured people had received their medicines when they should have.

● Body maps were not always used by staff to record where a medicine patch had been applied. Using a different part of skin when applying new medicines patches reduces the risk of skin irritation and side effects. The absence of body maps where necessary in such circumstances meant staff would not be aware of where on a person's body the previous patch had been applied, to ensure that when applying the new patch this was placed in a different area.

● Letters from healthcare professionals about medicines were not always actioned increasing the risk of harm to a person. When medicines were given to people in a covert manner (hidden in food) guidance had not been obtained from a pharmacist to tell them how to do this safely. Best interest meetings did not always show that a doctor had been involved in the decision to administer medicines in a covert way.

● Fluid thickener to thicken a person's fluid to aid swallowing was not recorded so we could not be sure this was being managed safely.

● The time given was not recorded for 'time specific' medicines so we could not be sure enough time was left between doses of medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider had not adequately assessed, and managed risks related to the prevention and control of infection. During the inspection, we found the environment was unclean in several areas. We found equipment in communal bathrooms to be soiled. Peoples personal equipment such as walking aids were visibly unclean.

● We found the premises were not well maintained. We saw paintwork was chipped in some areas which could prevent adequate cleaning.

● We observed staff not following good practice guidelines around the use of PPE. Additionally, staff were not always following social distancing guidelines linked to the Covid-19 pandemic.

● The completion of cleaning tasks was not always checked and documented. We viewed recent environmental audits which had not recognised the issues we found.

We found serious concerns with regards to preventing and controlling infection especially during the time of a national pandemic. This placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home had an adequate supply of Personal Protective Equipment.

Learning lessons when things go wrong

● Lessons learnt information was not always fully completed and did not evidence that all the required action was taken following incidents. The registered manager provided an overview records of accident and incidents which did not include details of any lessons learned. The action taken following the incidents was brief and did not include if assessments and care plans had been reviewed. Additional information was provided following the inspection. We viewed two accident and incident reports and checklists. One of these

was not fully completed and didn't include any actions taken to prevent re-occurrence. The second suggested an action which should be considered but it was unclear if the action was implemented. Managers and staff told us they were aware of their responsibility to report and record, accidents and incidents.

● The registered manager told us that any lessons learned were shared throughout the staff team and across the staff teams at the provider's other locations. However, there was no documented evidence of this sharing of best practice and lessons learned.

We found no evidence people had been harmed however, systems were not robust enough to demonstrate leadership and quality assurance was effectively managed. This is a breach of regulation 17 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The service had procedures to minimise the potential risk of abuse or unsafe care. We found not all staff had received specific safeguarding training. However, management and staff understood how to safeguard people and were clear about when to report incidents and safeguarding concerns to other agencies responsible for progressing and investigating safeguarding matters. Staff told us they would not hesitate to raise concerns if they witnessed abuse or poor practice.

We recommend safeguarding training is provided and a clear record of completion is kept for all staff to ensure compliance.

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.

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

- The provider had failed to ensure sufficient oversight and leadership resulting in failure to meet regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This information has been addressed in the safe domain. Systems to assess, monitor and improve the service had not been implemented and operated effectively. We found no systematic approach to audits and many of the checks the registered manager told us were completed were not evidenced.
- We found some inconsistencies in documentation. These included out of date and/or incomplete information. During the inspection the issues we found had not been recognised by the registered manager or provider. The provider had no oversight for quality assurance to ensure that regulations were met.
- Staffing deployment had not been assessed or monitored to ensure people's safety and assessed risks were minimised.
- While the registered manager and the staff team were aware of their roles and responsibilities, we found they had not followed required standards, guidance and their own policies in various areas.

We found no evidence people had been harmed however, systems were not robust enough to demonstrate leadership and quality assurance was effectively managed. This is a breach of Regulation 17 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured by the registered manager and the provider that full oversight of the quality assurance systems would be introduced and carried out by them. The provider has been responsive to our inspection findings and following the inspection has submitted an action plan to show what they will do, and by when, to improve the service and mitigate risk in respect of the concerns that we have identified.

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

- The registered provider had systems for prompting person-centred care however, they had not been consistently applied to support the process. Systems for supporting staff including training were not adequately implemented to support the delivery of safe care.

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 registered manager was aware of their responsibilities and statutory notifications had been submitted to the Care Quality Commission (CQC).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received mixed responses from staff regarding the culture and management's ability to respond to staff suggestions. Some staff felt that they weren't listened to by management in respect of people's needs and staffing levels. However, staff did say that the manager is supportive in relation to their personal circumstances and they could approach them with any concerns.

● People were not routinely involved in the development or management of the service. Staff and the management team were not promoting or championing people's rights in this way.

● The service worked with external health and social care professionals. The registered manager explained how they had completed reviews and consultations with professionals using the tablet computer.

● Following the inspection, the registered manager and provider took immediate action to start addressing shortfalls we identified.

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 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff were suitably qualified and competent to make sure that they can meet people's care and treatment needs. The registered provider did always not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people and keep them safe. Reg 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure service users received care and treatment in a safe way and there was a failure in assessing risks to the health and safety of those who lived at the home; including doing all that was reasonably practicable to mitigate any such risks. The provider's medicines management systems were not always implemented effectively. The provider failed to ensure people were protected from the risk of infection, including the transmission of Covid-19. Reg 12(1)(2)(a)(b)(d)(g)(h)

The enforcement action we took:

Warning notice served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to establish effective governance systems, including assurance auditing systems or processes to assess, monitor, drive improvement and ensure compliance. The documentation did not always contain a complete and accurate record of people's needs. Reg 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning notice served