Fidelity Residential Ltd

Alexander Care Home

Inspection report

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Overall summary

This was an unannounced focussed inspection undertaken on the evening 26 February 2015 by one adult care inspector. A focused inspection is carried out to look at specific areas of concern that have been raised with us.

This was the first inspection to take place since the home changed ownership and was registered with the Care Quality Commission (CQC) on 22 January 2015.

Alexander Care Home is registered to provide accommodation for up to 31 older people who require support with personal care. At the time of our inspection there were 26 people using the service.

The inspection was undertaken because we had received information of concern and complaints from a number of sources which included staff and relatives and also information we had received from the local authority commissioning and quality assurance services.

The concerns raised included that, since the change of ownership of the home, staffing levels had been reduced and this had impacted on the safety and quality of care people who used the service had received. Complaints included problems with the heating and hot water systems and that accessibility to food and drink had been reduced; for example the kitchen had been locked in the evening.

There was a registered manager in place at Alexander Care Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

We found that the records we saw showed there had been a signification drop in the care staff hours available to support people. There was evidence to support that people who used the service did not always receive the support, care and treatment they needed, for example weekly checks on people's weight had not been carried out.

We found that there were problems with the heating system and that the temperature to radiators and hot water taps were not consistent throughout the building. We were informed by the provider that arrangements were in place for a plumber to visit the home the day after our inspection visit to check the heating system.

We noted that there was evidence to support that the registered provider was investing in improvements to the building particularly in relation to prevention and control of infection processes.

There was a lack of effective systems in place to monitor the quality of the service provided and show how management decisions were being made.

Summary of findings

We found evidence that where complaints had been made by people who used the service there was no written evidence to support that they had been acknowledged or what action was to be taken to resolve the concerns raised. However the provider was working within the timescale of the home's complaints procedure.

Summary of findings

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.

There was not enough evidence to demonstrate that there were sufficient staff with the right qualification, skills and experience, at all times to meet people's needs.

There was evidence that improvements were being made in relation to the prevention and control of infection by the provider and to the premises.

Is the service well-led?
The service was not well-led

There was a lack of effective management systems in place to monitor the quality of the service provided and how decisions were being made.

New systems were being put into place by the provider for example the way food is purchased, to improve efficiency at the home.

Alexander Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service

This was an unannounced focused inspection which took place on the evening of 26 February 2015 between 6pm and 9pm by one adult social care inspector.

The inspection was undertaken because we had received information of concern from a number of sources which included staff and relatives as well as information shared with us by the local authority commissioning and quality assurance services.

The concerns raised with included that, since the recent change of ownership of the home staffing levels had been reduced, complaints made by relatives had not been acknowledged and acted upon, people had experienced problems with the heating and hot water systems and that accessibility to the kitchen had been restricted.

We spent time talking with the registered provider and the registered manager about the concerns raised and looked at records that related to the management of the home. Records included staffing rotas, complaints, care audits, hot water temperature checks, menus and the food people received. As well as invoices relating to improvements the new provider had made we also received information we had requested from them about their plans for further improvements for the home.

Because our visit in the evening we did not want to inconvenience people who used the service who were getting ready to retire for the evening and staff were assisting them.

Is the service safe?

Our findings

Prior to our inspection we had received information of concern from staff and relatives about the reduction of staff and how this was impacting on the care of people who used the service.

We had contacted the registered manager about these concerns and received a written response from them on 13 February 2015. They informed us that staffing levels had been reduced in response to occupancy levels and that they were being reviewed on a daily basis with the provider.

Concerns raised with us included for example, people having to wait to go to bed and getting up late in the morning, not receiving their medication on time and a person being left in the bath while staff went to answer a call alarm. There were also complaints that the home was cold and the temperature of the hot water was cold in some areas of the building, as well as changes to the arrangements for food.

At this visit we analysed the rotas from the 13 week period 24 November 2014 to 1 March 2014. The rotas showed that care hours had dropped markedly since the change of ownership for the same occupancy levels. The records we saw showed there were discrepancies between the care needs analysis documents relating to dependency levels completed by the registered manager and the rota's and were therefore in need of urgent review.

We talked with the provider and the registered manager about the rotas. The registered provider told us that the staffing rotas were the responsibility of the registered manager and that they did not influence the staffing levels set in any way. However the registered provider told us that they thought the deployment of staff could be better arranged, for example one senior care worker giving out medication rather than two.

Not being able to demonstrate that there are sufficient staff with the right qualification, skills and experience, at all times to meet the needs of people who use the service is a breach of Regulation 18 Staffing.

Within the complaints we received about the home were references to the heating system not working in parts of the home. We checked the thermometer in the main dining area of the home which showed that the room was reaching a temperature of 22C. There was no thermometer in lounge/conservatory area. The radiators in this room were protected with covers to prevent people burning themselves on them. We found that the radiators were cool. During our visit we also spent time in the manager's office where the radiator was felt be excessively hot. The contrast between radiator temperatures suggested there was a problem with the heating and hot water system.

The provider had been made aware of concerns by relatives about radiators in five people's bedrooms that were cool. The provider told us that they had found a portable radiator in one of these rooms but was concerned that the type that could present as a fire hazard so it had been removed. The provider, whilst not qualified to do so, had attempted to solve the problem by bleeding air from the radiators and a plumber had been arranged to come in and check them the day after our visit. We saw in the improvement plan requested by us from the registered provider that a second boiler is to be fitted to the home within the next year and that faulty radiators would be replaced as soon as possible.

The provider told us they had identified a number of environmental risk areas that needed improvement throughout the home and that they had already started to make them. We requested invoices from the registered provider to support what action they had taken. They showed the purchase of a new commercial washing machine with a full sluice and disinfection cycle and commercial dryer as well as new system for transferring laundry through the home. A new freezer, new fridge and the introduction of a dishwasher had been purchased for the kitchen. This equipment should help to improve prevention and control of infection systems in the home.

We were told that ill-fitting windows had been measured for replacement to some bedrooms. Arrangements had been made to make good the main hall ceiling prior to decoration and we were told that refurbishment of bedrooms would be carried out as they became vacant. It was noted that all lifting equipment, for example hoists had been serviced to ensure they were safe to use for the transfer of people who used the service.

Within the complaints we received about the home were references to access to the kitchen being restricted. We were told by the registered provider and the registered

Is the service safe?

manager that this had happened on one evening only to enable them and staff to undertake a thorough clean of the kitchen. We were told by the provider that staff still had access to the kitchen during this time.

Is the service well-led?

Our findings

We discussed with the registered provider and the registered manager the complaints and concerns that had been raised with us.

There was no written evidence available to support that good communication existed between the registered provider and registered manager. There was also no evidence as to how decisions were made by the provider and the registered manager regarding the running of the service for example management meetings. This would give the registered provider and the registered manager the opportunity to identify what changes were being made and the reason for them. The registered provider said that the changes that were in the process of being made to make improvements to the service. For example changes had been made to the ordering and purchasing of food so that it would be more efficient and reduce the administrative burden on the registered manager which in turn would enable them to spend more time with people who used the service and care staff.

There was no evidence of the registered provider and registered manager speaking to people who used the service, their relatives and staff about the changes being made at the home. We also looked at the care audits undertaken by the registered manager. These showed that no weekly weight checks had been carried out for people who used the service since 19 January 2014. This must be done for people who were identified as being at risk of losing weight and to identify people who may need additional nutritional support. Following the inspection we requested a written copy of the plans for the home and this was sent to us.

The lack of effective systems to monitor the quality of the service provided is a breach of Regulation 17 Good governance.

We looked at the recent complaints made by relatives and people who used the service but had yet to be entered on the homes formal complaints log. We saw that there had been nine verbal complaints made by people who used the service or their relatives and recorded by the registered manager and three formal complaints made by two relatives. The complaints raised concerns about the impact changes to staffing levels was having on people who used the service and the support, care and treatment they received.

The registered provider and the registered manager must protect people from the risks of unsafe care and treatment and have regard to the complaints, concerns and views of people who use the service and those acting on their behalf. However the provider was working within the timescale set by the home's complaints procedure.

The provider told us they were available and staying on site at Alexander Care Home on three consecutive evenings throughout the week and were accessible for people to speak to them if they wished.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 There was not enough evidence to demonstrate that there were sufficient staff with the right qualification, skills and experience, at all times to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use service and others were not protected against the risks associated with unsafe care and treatment because effective management systems were not in place.