Cuerden Developments Ltd

Cuerden Developments Limited - Alexandra Court

Inspection report

Howard Street,
Pemberton, Wigan
Lancashire
WN5 8BH
Tel:01942 215555
Website:

Date of inspection visit: 9 and 11 September 2015
Date of publication: 15/01/2016

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Alexandra Court is a 40 bed intermediate care centre that provides a time limited period of assessment and rehabilitation for people who may have had a hospital admission but are not ready to be discharged home safely or to be supported at home. It is a purpose built two storey building with bedrooms on both floors. There is a car park at the front of the home. It is located in Pemberton, near Wigan and is close to shops and public transport links. At the time of the inspection 38 people were using the service.

We carried out this unannounced comprehensive inspection on 09 and 11 September 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been

Summary of findings

implemented by the service following our last inspection on 28 January 2015. At the previous inspection on 28 January 2015 the home was found to have one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to receiving and acting on complaints. At the comprehensive inspection on 9 and 11 September 2015 we found that improvements had been made to meet the relevant requirements previously identified at the inspection on 28 January 2015.

However at the inspection on 09 and 11 September 2015 we found seven new breaches of regulations in relation to safe care and treatment, the safe handling of medicines, staff supervisions and staff meetings, staff competency assessments, obtaining people's consent to care and treatment, safe transfers between different care services, maintaining complete and contemporaneous records and good governance.

We found the service did not have appropriate arrangements in place to manage medicines safely in respect of safe storage, the accurate recording of medication administration records, risk assessing people who self-medicate, fridge temperatures and the inappropriate administration of some medicines.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines because people who used the service and others were not protected against the risks associated with unsafe or unsuitable management of medicines. CQC has issued a Warning Notice with conditions to be met by 17 January 2016.

We saw that some medication audits were being conducted, but it was not clear what actions had resulted and how this information had helped to improve practice. There was no evidence of near miss or error reporting relating to medicines.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance; because the service had failed to effectively operate systems and processes to ensure compliance with the requirements in this Part. You can see what action we told the provider to take at the back of the full version of the report.

As an integral part of the purpose and function of Alexander Court, staff members employed by the NHS or social services such as physiotherapists, occupational therapists, social workers and a GP are either based at the home, or work there on a regular basis.

There was a registered manager at the 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. On the day of the inspection the registered manager was unavailable due to annual leave and a duty manager, who was a long standing member of staff was in post and providing management cover.

We found the service had a safeguarding policy in place, but not all staff were able to describe the actions they would take in respect of referring a person to the local authority.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. You can see what action we told the provider to take at the back of the full version of the report.

The home had a whistleblowing policy in place which was out of date. Most staff were aware of the policy but did not know how it worked in practice.

The service had a wide range of health and safety policies which helped to assess the risks associated with buildings and premises.

One bathroom which was available to people who used the service was cluttered with equipment.

The service had identified minimum acceptable staffing levels and these were supplemented through partnership working with integrated care teams. On the day of the inspection staffing levels were sufficient to meet the needs of people using the service.

There was evidence of robust recruitment procedures. The staff files included application forms, proof of identity and references. Disclosure and Barring Service (DBS) checks had also been undertaken.

Summary of findings

Some staff had received supervision sessions with their line manager, but these were not regular and there was little documentary evidence of these meetings. There was no evidence of regular staff meetings being undertaken and staff competency assessments had not been undertaken.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to supporting staff. You can see what action we told the provider to take at the back of the full version of the report.

Staff demonstrated a working knowledge of the Mental Capacity Act (MCA) 2005, the principles of the Act and the decision making process. The majority of staff had undertaken training in safeguarding but not all were able to recall the processes involved.

The environment of the home was clean and free from mal-odours. The decoration was bright and the lounge areas had comfortable seating with the downstairs lounge providing easy access to the garden areas, but the home had few adaptations that would assist a person living with dementia to maintain their independence.

People who used the service and their visiting relatives told us that staff were caring and kind. We found the care and support being provided by staff to be caring and people's privacy and dignity was respected. We saw that staff ensured they obtained consent prior to delivering care or undertaking a task. We saw staff supporting and interacting with people who used the service in a respectful, caring manner. Staff communication with people was positive and their independence was encouraged.

We found that care management plans had not consistently involved holistic assessments of people's needs and did not support the provision of effective and appropriate care. Personal risk assessments related to people's safety were not consistently available in all of the care plans we looked at.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care. You can see what action we told the provider to take at the back of the full version of the report.

We saw that some people who used the service had been involved in planning and agreeing their own care with consent clearly obtained, but in some of the care plans we looked at we there was no information to suggest that people who were staying at the establishment, or their families were involved in planning the person's care.

The service did not routinely provide a range of activities due to it being an Intermediate Care facility with the high turnover of referrals and a short length of stay. People were able to bring personal items into their rooms as required.

People who used the service and their relatives told us that the transition from hospital to Alexandra Court was not always good and frequently disjointed and people often arrived late in the evening when staffing levels were reduced.

We found that one person had been placed at risk by being inappropriately referred to the establishment from the hospital.

This is a breach of Regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the process of transferring the person from hospital to the home was not done in a way that ensured their safety and welfare.

People we spoke with thought the service was well-led but some people who used the service told us they were dissatisfied with the length of time they had to wait on the hospital ward before transport arrived to take them to Alexandra Court.

Some people told us that they did not feel enough information was shared with them throughout their stay, including information about day-to-day treatment and support, and discharge planning.

We found that some care plans were not fully completed which meant that there was no reliable baseline for care intervention to be planned appropriately regarding people's rehabilitation needs. Care records were also not always up to date.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people care records were not contemporaneous. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

We saw that comments and suggestions were encouraged through a 'Quality Assurance and Patient Involvement' initiative.

The service did not routinely hold residents' meetings because the maximum stay in the home was six weeks and in most cases was less than this. Therefore each person was asked to complete a questionnaire and feedback form when they left the home. This information was reviewed quarterly and a summary of all the findings was discussed at the staff meetings.

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?

Requires improvement

The service was not consistently safe.

Several policies and procedures were out of date and required review.

Not all staff were able to demonstrate how to refer safeguarding concerns to the local authority.

The service did not have appropriate arrangements in place to manage medicines safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not receive regular documented supervisions with their manager.

Staff meetings were not conducted on a regular basis.

The service was unable to meet the needs of a person who had been inappropriately admitted.

The home had few adaptations that would assist a person living with dementia to maintain their independence.

Is the service caring?

Good

The service was caring.

People who used the service and their visiting relatives told us that staff were caring and kind.

We found the care and support being provided by staff to be caring and people's privacy and dignity was respected.

People completed a self-assessment questionnaire on their first day of admission to the home which was used to plan their care, rehabilitation and future support.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Personal risk assessments related to people's safety were not consistently available in all of the care plans we looked at.

We found that care management plans had not consistently involved holistic assessments of people's needs and did not support the provision of effective and appropriate care.

There was inconsistent documentary evidence to show that people who used the service had been involved in planning and agreeing their own care.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Some people said that they did not feel enough information was shared with them throughout their stay.

There as no evidence of near misses or error reporting relating to medicines and competence assessments for staff had not been carried out.

Medication audits were being conducted, but it was not clear what actions had resulted and how this information had helped to improve practice.

Requires improvement

Cuerden Developments Limited - Alexandra Court

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, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced comprehensive inspection of Alexandra Court on 09 and 11 September 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last focussed inspection conducted on 28 January 2015.

We inspected the service against the five questions we ask about services during an inspection, 'Is the service safe', 'Is the service effective', 'Is the service caring'; 'Is the service responsive' and 'Is the service well-led'.

The inspection was undertaken by two adult social care Inspectors, a specialist advisor (SPA) in nursing and a pharmacist inspector. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents.

We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority contracts monitoring team, the clinical commissioning group (CCG) We also reviewed the action taken by the provider following our previous inspection. We looked at records held by the service, including 11 care files and four staff personnel files. We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation.

We observed care within the home throughout the day. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with the duty manager, the managing director, seven care staff, eight people who used the service, three nurses, a visiting relative and three healthcare professionals.

Requires improvement

Is the service safe?

Our findings

During the inspection we looked at the way the service protected people against abuse. We found the service had an internal safeguarding policy in place, but this was out of date and in need of review. The Wigan Safeguarding Adults Board Multi-Agency Policy was also in place with guidance on the Independent Safeguarding Authority and multi-agency procedure. We saw that safeguarding information was displayed in the staff toilet relating to how to raise a safeguarding concern. The information stated: 'If you see or hear anything you don't like safeguard your patients and yourself by telling somebody. Who do you tell? – the nurse.' However, in one toilet this was written on a dry-wipe board and information was missing which meant that the information was not comprehensive.

We spoke to eight staff members about their understanding of safeguarding. However, other than reporting safeguarding concerns to their immediate manager, four of the eight members of staff we spoke to were not able to explain the correct procedure for referring safeguarding concerns to the local authority. The other four staff members detailed the actions that they would take if they suspected or witnessed abuse. Their explanations were appropriate and would support a person who was at risk of harm or abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment.

The home had a whistleblowing policy but this was out of date and in need of review. We spoke to staff about their understanding of this policy and most staff stated they were aware of a whistleblowing policy, but did not understand how this worked in practice.

We found that risks associated with people who used the service were communicated effectively amongst staff. We saw that where accidents and incidents involving people who used the service had occurred, these were recorded and monitored. Where necessary, we saw that appropriate preventative action had been taken by the service.

During inspection we looked at the care and treatment records of 11 people who used the service. We found that in some files there was a range of multidisciplinary risk assessments in place including those for falls, personal care and moving and handling. This multidisciplinary approach to risk meant that people who used the service were seen and assessed by a member of the multidisciplinary team in a timely manner and preventive strategies were implemented to reduce risk. For example, we identified one person who used the service had been assessed as being at risk of falls. We saw how this person was assessed by both the physiotherapist and occupational therapist and appropriate equipment was put in place to reduce the risk of falls.

However, personal risk assessments related to people's safety were not consistently available in all of the care plans we looked at. We found discrepancies within some admission assessments such as tissue viability, wounds and pain management. We saw that identified issues were not always supported with a care management plan. This meant there was a risk regarding the provision of individualised care, as care staff were not always fully informed of people's individual needs and how and when care should be delivered.

This is a breach of Regulation 9 (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment, as risks to people's health and safety were not consistently assessed .

In order to ensure the provision of safe care, the service had implemented a 'critical alert' form. This form was placed in each person's care record and provided a quick reference to essential information that might be required in the event of a medical emergency. The service had also adopted a pre-hospital early warning score (PHEW) protocol. PHEW scores were calculated after obtaining baseline observations such as blood pressure, heart rate and temperature of people who used the service. If the baseline observations of an individual were outside of normal parameters, this would provide an early alert to staff of the potential for an individual to deteriorate and to seek further medical advice.

During the inspection we looked at a number of communal bathrooms and toilets that were accessed by people who used the service. On the ground floor, we found a toilet/ bathroom was being used as a storage area which contained a pedal bike and a mattress. This was despite signage on the door clearly indicating the bathroom/toilet was for use by people who used the service. The pedal bike was leaning unsecured against a bath which was located directly next to a toilet and the mattress had also been

Is the service safe?

placed against a wall. This presented a risk to people who used the service. We raised our concerns with the acting manager and action was immediately taken to change the signage and to take the room out of use until the stored items were relocated elsewhere.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for September 2015 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. We asked the acting manager how the service determined staffing levels and later verified this with the registered manager who told us that staffing levels at Alexandra Court were not determined using a formal assessment tool.

The service had identified a minimum staffing requirement of three nurses per 8am to 8pm day shift for 40 people and 2 nurses per 12 hour night shift, which equates to a ratio of one nurse to 13 people and one nurse to 20 people respectively, with a supporting care staff team of 6 care staff per day shift and 4 care staff per night shift, which equates to one care staff to seven people and one care staff to 10 people respectively. The service also worked alongside integrated care teams which meant that the total minimum staff hours per shift were a ratio of one staff member to eight people during the day and one staff member to seven people at night. At the time of the inspection the service told us they were actively recruiting for two full time nursing posts. In the interim period the service was using regular bank staff and nominated agency staff to maintain stability and safety of care provision.

Additionally, the service recognised the daily challenges of admissions and discharges, the high turnover of people and the changing needs of these people and therefore aimed, on the whole to achieve four nurses and eight care staff each day shift and this could be increased further as needed due to the service having a small percentage of available and additional employee hours and access to bank or agency staff as a need arose. This helped to maintain safety of both the staff and people who used the service. The service also increased night staff numbers dependent upon the acuity of people's needs for example in relation to strokes, intensive input needs or two person dependency and manual handling equipment.

There was a notice board in the downstairs and upstairs corridors of the building that displayed the names and role of the staff members on duty each day.

We looked at how the service managed people's medicines. When we arrived at the home a medication round was being conducted by an agency staff nurse, which we observed. Medication was administered from original boxes that were kept in a locked medicines trolley against hand-written Medication Administration Records (MAR) charts.

We looked at the clinical room on the ground floor where the medication trolleys were located. The room was locked and the trollies were securely stored when not in use. The room was well kept and there was no evidence of it being overstocked. We checked the controlled drugs (CD) cabinet which was securely locked. The CD register was up to date and the balance of stock was correct.

We looked at the clinical room on the first floor of the home and this had the door propped open with two unlocked drawers containing a variety of medication. These could have been accessed by people and/or clinical staff. We informed the nurse on duty and asked them to immediately store these securely.

We saw that the MAR charts were not always doubly signed where required and in some cases had no signature to identify if the medication had been administered. Abbreviations are often used and amendments were not always clear or initialled.

There were discrepancies in the recording of medication for variable dose products. Sometimes these were recorded on the MAR chart and sometimes on a separate chart which was confusing for agency staff as there was no clear process to follow.

We observed a MAR chart where a person using the service had gone 3 days without pain relief as the medication was not in stock. An alternative product had not been used. This demonstrated that the ordering system was ineffective in this case.

There were a number of discrepancies identified on MAR charts and basic procedures such as double signing were not being followed. This was leading to unnecessary risk and was in breach of the homes own medication policy, which was due for review in October 2014.

We inspected the fridge which contained numerous medications. The fridge was unlocked and there was no

consistent temperature monitoring. We looked at the fridge temperature monitoring charts and there was evidence of the temperature being out of range in the past but no evidence of what action had been taken.

Alexandra Court is an intermediate care facility and it would therefore be normal practice for people to be encouraged to self-medicate where safe to do so. We were informed by the lead nurse that the average length of stay of a person at the unit was four weeks but the 'contracted' stay was six weeks. We saw that there were people in the home who self-medicate but there were inadequate risk assessments in place to ensure this was done in a safe and appropriate way. One person had changed from having their medication administered by a staff member to self-administration but there was no evidence of a risk assessment being undertaken. We asked the duty manager to clarify this and they were unable to demonstrate that this had occurred. No information was documented in the care plan for this person but the medicines were located in the person's room. There was no evidence to show appropriate follow- up that would identify the person was administering their own medication correctly.

We found that one person had received medication over a four day period that they had a documented allergy to and this had not been identified by staff members who administered the medication. We informed the duty manager about this situation and the person's GP was contacted to review the situation.

This is a breach of Regulation 12 (1) (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines because the service did not have appropriate arrangements in place to manage medicines safely. CQC has issued a Warning Notice with conditions to be met by 17 January 2016.

As part of the inspection we observed how the service managed the spread of infectious diseases. We observed one person with a difficult to manage infection. We saw that the service followed the appropriate infection control and prevention advice such as using personal protection equipment (PPE). However, information in the care plan for this person identified the need to ensure that the person only used their own identified en-suite toilet at all times. There was no sign on the toilet door that identified that it was for the sole use of this person which meant that there was still a risk that visitors may use the toilet. We identified this to the registered nurse who agreed to complete this as soon as possible

In addition we saw that care staff did not wear plastic aprons whilst serving lunch. This posed a risk of cross infection. We informed the duty manager of this issue who ensured that staff wore the appropriate protective clothing. The provision of sterilising hand gel was limited throughout the establishment. We asked staff about this and they were unable to provide an explanation.

We looked at four staff personnel files and there was evidence of robust recruitment procedures. The files included application forms, proof of identity and references. Disclosure and Barring Service (DBS) checks had been undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. Staff underwent a period of induction when they were supported by a colleague 'mentor.'

Requires improvement

Is the service effective?

Our findings

We spoke with eight care assistants, each of whom were able to tell us what their roles and responsibilities were. We found the service had an effective induction programme for new staff, which included orientation around the building, mandatory training (such as health and safety, moving and handling, fire safety and infection control), shadowing more experienced staff members and awareness of day-to-day policies and procedures.

There was a staff training matrix in place which recorded a comprehensive range of training activity for all staff roles. Staff told us that access to training and development opportunities were good. A wide range of training courses were provided by the service including opportunities to undertake vocational qualifications. We saw how two members of staff had recently completed additional training centred on the care and support needs of people following a stroke. Staff felt this enhanced their understanding of stroke care and enabled them to act as a 'stroke champion' and provide a higher level of care to people being supported in the service's stroke rehabilitation unit.

Staff told us they had received safeguarding training, which was delivered 'on-line' via 'e-learning' through an accredited external training provider and supplemented by knowledge-testing within the home and through the use of 'workbooks.' We checked the staff training records and found that 100% of nursing staff, 85% of night care staff, 100% of domestic staff, 83% of kitchen staff and 82% of day care staff had completed safeguarding training within the last two years and the remaining staff were in the process of undertaking this training.

The care staff we spoke with told us they had received an annual appraisal where training and development needs had been identified. We confirmed this by looking at appraisal and training and development records. However, staff told us they do not receive regular formal one-to-one supervision sessions and this was verified by the absence of regular supervision records in the staff personnel files. In one of the staff files we looked at there was evidence of the staff member identifying further training needs and this had been recognised and agreed by the registered manager.

Staff files contained records of supervisions and annual appraisals but most of these contained very little information. Some staff files contained letters that had been issued to them under the disciplinary process (for example if a complaint had been made or they had not attended scheduled training) but it was unclear what had happened as a result of these discussions. The format of the staff files was such that they did not contain different sections that would help to ensure that relevant information was included and assist with ease of access, and information was loosely placed in them.

Staff meetings were not carried out on a regular basis. We saw the record of one staff meeting where communication and the use of appropriate language had been discussed but this was not dated and there was no record of which staff had attended the meeting.

We asked the duty manager about training around medication and competency assessments. They were unable to provide copies of any assessments of staff competence and confirmed that they had not individually been the subject of any assessments.

This is a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to lack of regular and effective staff supervisions, a lack of regular staff meetings and the absence of medicines competency assessments.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.Staff demonstrated a working knowledge of the Mental Capacity Act (MCA) 2005, the principles of the Act and the decision making process. Staff were able to give examples of MCA decision making and were aware of working in people's best interests. At the time of the inspection no person staying at the home was subject to a DoLS.

In the care plans we looked at there was documentary evidence that people who used the service had been involved in planning and agreeing their own care with

Is the service effective?

consent clearly obtained. Where appropriate, each section of the care record contained a review date. Where a review had taken place, the outcome of the review had been clearly documented.

We observed the lunch time meal. We saw that sandwiches and soup were being served to everyone as no other choice was available. A care staff member reported that: "They (the people who used the service) are given a full hot breakfast so that is why soup and sandwiches are given at lunch time." When we arrived at the service we saw that a hot breakfast was being served as requested. We asked a person who used the service about the standard of food and they said: "We get warm soup and a sarnie at dinner time. I am starving at 3 o clock." They also reported that they were unable to order snacks in between meals. Other people who used the service told us: "The food is good and varied." "We get a choice of two main courses and desert" and "I can't fault the food." The service had a '4-week' menu in operation which identified a choice of hot and cold options for breakfast. The lunch time meal was identified as a 'snack-meal 'and this had choice options other than soup and sandwiches for some days. The tea time meal as identified as the 'main-meal' and included two options for each day plus a pudding.

At the time of the inspection, the establishment was accommodating a person who had been discharged from hospital with a specialist dressing in place which required specialist knowledge and experience to manage. However, the senior nurse informed us that staff had not received any formal training around the management of this particular dressing. Another nurse told us: "We all got together and worked through how to change the dressing. The person gave us their consent to do this." The person told us that they felt that the staff were scared of the dressing. They told us that on one occasion they reported to the night nurse at 4am that the chamber of the dressing was full and needed changing. After reminding staff on numerous occasions, the dressing was finally changed at 2pm some 10 hours from when it was initially reported. There was no record of this in the persons care records.

This meant that the person had been inappropriately placed at risk by being referred to the establishment from the hospital and this was agreed by the senior nurse and the covering GP on the day of the inspection. The person was subsequently transferred to the Surgical Assessment Unit for review and for placement in a more appropriate and suitable care facility that could meet their care needs. We brought this to the attention of the managing director who assured us that they would discuss this with the registered manager on return from annual leave.

This is a breach of Regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the process of transferring the person from hospital to the home was not done in a way that ensured their safety and welfare.

Information contained in one person's care plan identified that they had lost a significant amount of weight over a two week period. There was no evidence in the care plan to show that this had been acknowledged by the clinical staff and the weight loss recorded.. The persons' 'Professional Referral Form' confirmed that they had not been referred to a GP or dietician . We brought this to the attention of staff who confirmed that they would follow this up as a matter of urgency and a referral was made to the dietician.

The environment of the home was clean and free from mal-odours. The decoration was bright and the lounge areas had comfortable seating with the downstairs lounge providing easy access to the garden areas. On the day of the inspection new equipment was being delivered to the home form a partner facility such as beds and chairs. However, although the number of referrals to the home for people who were living with dementia was minimal, the home had few adaptations that would assist a person living with dementia to maintain their independence. There were no adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people to mobilise round the building or understand where they were if assisted by staff.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

Good

Is the service caring?

Our findings

One person who used the service told us "The staff are wonderful. They are very caring." A second person commented "The carers are very busy but they care for us well." A third person said "They (the staff) never come in with a long face, they're always happy." A fourth person who used the service told us: "Staff are helpful and very approachable." Another person who used the service said: "Staff do a good job. They're really pleasant and helpful."A visiting relative told us: "(My relative) has been looked after well since coming here from hospital. I've got no complaints."

We looked at the care records of 11 people who used the service and saw they had completed a self-assessment questionnaire on their first day of admission to the home. This asked people to explain in their own words: why they thought they had been transferred; health and medical issues; where they wanted to go once discharged and how they wanted to get there; what support was required following discharge; what they were able to do before admission; and how they felt this had changed. This information was used to plan their care, rehabilitation and future support.

We observed how care was being delivered throughout the day. People who used the service and their visiting relatives told us that staff were caring and kind. We found the care and support being provided by staff to be caring and people's privacy and dignity was respected. For example we saw that staff knocked on people's doors before entering their room and we also saw that staff ensured they obtained consent prior to delivering care or undertaking a task.

We observed people spending private time in their bedrooms if they wished. However, one person who used the service stated they would have liked the freedom to have better access to the communal outside area without having to ask staff to open doors, especially when the weather was nice.

We looked at how information was shared and how explanations were provided to people who used the service. We found the service had implemented a 'meet and greet' information pack, which was used by the care staff when people who used the service were newly admitted. This provided an opportunity for the care staff to meet with people who used the service on a one-to-one basis and to answer any initial questions. When people first started using the service, they were provided with a patient information leaflet, which explained about the facilities offered to assist them through the process of rehabilitation.

There was also a kitchen facility available for visitors to the service. On the door of the kitchen there was a sign that said: 'Please can all relatives and visitors be advised that if they wish to discuss the medical care or documented care plan for their loved one they must address the senior staff on duty in order that appropriate two-way communication can take place.

We saw staff supporting and interacting with people who used the service in a respectful, caring manner. Staff communication with people was positive and their independence was encouraged. For example we observed a staff member assisting a person to mobilise in the corridor whilst using a walking frame. We saw that the staff member was courteous and responsive to the individual being supported. The staff member informed the person they were going to walk behind them and we saw that they walked behind the person using the walking frame at a pace that was comfortable to the person, with a wheelchair in position in case the person wished to rest and sit down. The staff member encouraged the person throughout the observed time period and said to them: "You know how far you can walk so you just tell me when you're tired and want a sit down." In this way the person was supported to be independent as identified in their therapy plan but reassured that support was immediately available if they became tired.The staff member ensured that they were fully engaged when supporting this person and checked that the person had understood what they intended to do before carrying out support with them and asked for their agreement rather than assuming consent.

The service did not routinely provide end of life (EOL) care because as an intermediate care facility it provided a time limited period of assessment and rehabilitation for people with an average length of stay between four and six weeks. The duty manager told us that this was an exclusion criteria for any new referrals and therefore the service did not follow any identified model of EOL care. However on the date of the inspection one person was being appropriately supported by the hospice service prior to being discharged home.

Requires improvement

Is the service responsive?

Our findings

During the inspection we spoke to people using the service. One person said: "I loathe it here; it's like a train station. The noise is unmerciful." Another person told us: 'I have stayed in worse places than here. The only good thing is that the staff are nice – well most of them." Another person said: "The staff do as much as possible to help, they're great." A fourth person said that staff are: "Always polite and nothing is too much trouble."

The establishment used the Waterlow Tissue Viability Risk Assessment. From the care plans that we reviewed, two people had a documented score that fell under the category of 'high risk' for pressure breakdown. One Person had a category 'A' soft foam mattress in place which would support pressure relief whilst the person was in bed. However, the person chose to sit out in a chair during the day. The chair used was made of hard plastic and no pressure relieving cushion was in place. This increased the risk of the person obtaining skin/tissue breakdown whilst sitting, as there was no supportive care plan advising care staff of appropriate pressure care whilst sitting out of their bed. We brought this to the attention of the staff who said they would ensure the provision of a supporting cushion.

A comment in the communication book that was used by care staff mentioned that four people did not receive an assisted bath or shower the previous week, prior to the date of our inspection. The senior nurse told us that this was entirely due to the work pressures within the establishment and that these people would be bathed or showered first this week.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the provision of care and treatment that was appropriate and met people's needs.

We found that care management plans had not consistently involved holistic assessments of people's needs and did not support the provision of effective and appropriate care. Some care plans were 'generalised' in their comments and gave very limited information. Sections requiring vital information were left blank in some files (such as past medical history). Some people with identified tissue viability risks did not have a supportive care management plan. This would increase the risk of these people experiencing skin/tissue breakdown.

We looked at people's care plans to determine how they were safely discharged from the service. We found that some care plans were not fully completed, which meant that there was no reliable baseline for care intervention to be planned appropriately regarding people's rehabilitation needs and their safety when returning to their home.

On the first floor, 11 people's individual care needs were being monitored using an individual daily activity chart, which included areas such as fluids taken, toilet use and general care. The start time of these forms was 8am. However, at 2:30pm we noticed that all of these forms were blank apart from the person's name and date. This was brought to the attention on the senior nurse. A care staff member took all 11 charts and completed them retrospectively. This was both inappropriate and unsafe with regards to the provision of safe and appropriate care as it would be difficult for a care staff member to accurately recall the fluid intake and output of all 11 people over a six hour and thirty minute period.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because complete and contemporaneous records were not kept for each person using the service.

We saw that each person's bedroom had a television available and people were able to bring personal items of their choice such as family photographs. However, on the day of the inspection we did not see any other activities taking place. We asked the duty manager about this and they told us that additional activities do not take place because the home is an intermediate care facility with a high turnover of admissions and not a nursing home.

The duty manager explained that it was not practicable to hold residents' meetings because the maximum stay in the home was six weeks and in most cases was less than this. Therefore to ensure that people's views and opinions about the service were taken into account each person was asked to complete a questionnaire and feedback form when they left the home. This information was reviewed quarterly and a summary of all the findings was discussed at the staff meetings.

We looked at how the service managed people's transition between different services. The feedback received from people who used the service and their relatives indicated that the transition of people who used the service from hospital to Alexandra Court was not always good and

Requires improvement

Is the service responsive?

frequently disjointed. Some people told us how they had been discharged from hospital and arrived by ambulance at Alexandra Court without staff knowing that they were arriving. Staff members told us that people frequently arrive at the establishment late in the evening when staffing levels are reduced. This places additional pressure on staff and presents a risk to the person being admitted.

There was a sign on the visitor's kitchen door that identified what happened when a person was due for discharge from the home. This indicated that staff would assist with the packing of personal clothes and items and that the cleaning of their room would start at 10.30am onwards.

At the previous inspection on 28 January 2015 we found the service did not take appropriate steps to respond to complaints. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 9 and 11 September 2015 we found that the service was now meeting this standard.

We saw there was a 'complaints and concerns' policy in place, which had been reviewed in February 2015 and was now displayed throughout the public areas on all units and a complaints book was in use. There was a 'written record of a written or oral complaint' sheet being used. In addition there was a monthly 'complaints summary sheet' that identified the date the issue was raised, the detail of the complaint, the name of the complainant, the actions taken and the outcomes identified along with the date of resolution. We looked at several of the entries in these files and saw that the service had responded within the timescales identified in the complaints policy. Where there was a requirement to report any issues under The Duty of Candour, this had been identified.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager at the 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.

Most people we spoke with thought the service was well-led. One member of staff said: "The management are firm but fair. You can't ask better than that." Another member of staff said: "The manager is very approachable. I feel I can raise any concerns." However a third staff member said: "The nurses are ok but the manager is very strict and picky. I only come back to look after the patients." A fourth staff member told us: "We do our best with what we have. The manager is very money orientated. All you hear is 'there's no money for that'."

We looked at eight questionnaires that had been completed by people who used the service before they were discharged. Although the comments provided were mainly positive, we found two recurring negative themes relating to delays and lack of communication. In respect of delays, some people who used the service had indicated they were dissatisfied with the length of time they had to wait on the hospital ward before transport arrived to take them to Alexandra Court. The consequence of this was that some people were arriving at the establishment in the late evening and on occasions staff were not ready to receive them. In respect of communication, some people had stated that they did not feel enough information was shared with them throughout their stay, including information about day-to-day treatment and support, and discharge planning. Having looked at the questionnaires, we found no evidence of how the service had analysed this information or developed any actions for improvement as a result.

We saw that some medication audits were being conducted but it was not clear what actions had resulted and how this information had helped to improve practice. There was an audit form from July 2015 that highlighted some of the continuing issues that we observed during the inspection on 09 September. There was no evidence of near miss/error reporting and a lack of learning from mistakes previously identified.

We looked at how the service assessed the risks associated with buildings and premises. The service had a wide range of health and safety policies which included moving and handling, fire safety, electrical safety, general maintenance, water temperatures, lift safety and first aid. Most of these policies had recently been reviewed but some were out of date and in need of review to ensure the service had identified the latest guidelines and requirements.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to effectively operate systems and processes to ensure compliance with the requirements in this Part.

Staff meetings were not conducted on a regular basis.

We saw a variety of environmental risk assessments had been completed and were up-to-date. We looked at records which confirmed that regular checks of the fire alarm system were carried out to ensure that it was in safe working order. We saw documentation and certificates to show that relevant checks had been carried out for example on the gas boiler, electrical systems and fire extinguishers. A range of environmental cleaning schedules were being used and the home was generally clean throughout.

There was a comments and suggestions box on the wall in the downstairs corridor and suggestions were also encouraged through a 'Quality Assurance and Patient Involvement' initiative that was displayed in the entrance foyer to the home.

The service had a 'Statement of Purpose,' a 'Service User Guide' and 'Service User's Handbook' in place but these were last reviewed in November 2010 and in need of updating to ensure they contained the most recent information.

The service worked in partnership with Wigan Borough Clinical Commissioning Group (CCG.) We saw that a programme of visits had been scheduled for 2015. The purpose of these visits was to identify information to show that the service was providing safe and clinically effective care to people. At the inspection on 9 and 11 September 2015 we found that some of the previously identified actions from a visit in March 2015 had not been resolved.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a lack of regular and effective staff supervisions, a lack of regular staff meetings and an absence of medicines competency assessments. Regulation 18(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The process of transferring a person from hospital to the home was not done in a way that ensured their safety and welfare. Regulation 12(2)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care An appropriate assessment of peoples needs was not always completed prior to admission. Regulation 9(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Complete and contemporaneous records were not always kept for each person. Regulation 17(2)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service had failed to effectively operate systems and processes to ensure compliance with the requirements in this Part. Regulation 17 (1)(2)**
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Not all staff were able to describe the actions they would take in respect of referring a person to the local authority. Regulation 13 (1)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable management of medicines. Regulation 12 (2)(f) (g)(h)

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 17 January 2016.