Health and Home (Essex) Limited

Alexander House Private Nursing Home

Inspection report

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Essex
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

About the service
Alexander House Private Nursing Home is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for up to a maximum of 25 people. At this inspection 8 people were using the service, some of whom were living with dementia, had a mental health condition, were autistic and had a learning disability.

People's experience of using this service and what we found
The provider was not able to demonstrate how they were meeting the underpinning principles of 'Right support, right care, right culture'.

Right Support:
• The registered manager and staff team did not support people to have choice, control and independence or focus on people's strengths and abilities.
• There were not enough staff to fully support people to have a fulfilling and meaningful everyday life.
• The registered manager and staff did not support people to take part in activities and pursue their interests within their local area.
• Suitable arrangements were in place to ensure the proper and safe use of medicines.

Right Care:
• Staff were observed to deliver task-based care and support.
• Not all people's nutritional needs were being met in line with their care needs or care plan.
• Recommendations and advice by healthcare professionals were not always implemented or followed up.
• The registered manager and staff did not protect people from poor care and abuse.
• People did not routinely take part in activities or pursue interests that were tailored to them.

Right Culture:
• The leadership, management and governance arrangements did not provide assurance that the service was well-led, that people were safe, and their care and support needs could be met.
• The registered manager and staff team did not help people lead inclusive and empowered lives.
• The registered manager and staff team did not ensure people are always put first. People did not receive care that was person centred or protected and promoted people's rights.
• A 'closed culture' had been developed at Alexander House Private Nursing Home, whereby there was a risk of harm for people living there.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate [published December 2021]. The provider did not complete an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider seek guidance to ensure the premises were suitable to meet people's needs. At this inspection we found the provider had not fully acted on this recommendation and only minor improvements had been made.

Why we inspected
The inspection was prompted in part due to continued concerns received about people living at Alexander House Private Nursing Home not having access to professionals and stakeholders. involved in their care. The provider was continuing to not allow professionals and stakeholders to access the service to carry out their statutory obligations to ensure people's safety and wellbeing. A decision was made for us to inspect and examine those risks.

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

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 monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, consent, risk management, safeguarding, meeting people's nutritional needs, governance and staffing at this inspection.

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
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Alexander House Private Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors.

Service and service type
Alexander House Private Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Alexander House Private Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

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

manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from the Local Authority who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 7 people about their experience of the care provided. We spoke with the deputy manager, a senior member of staff, 3 care staff and the services chef during the inspection. We also spoke with the provider, in their role as both provider and the registered manager. We spoke with 1 healthcare professional.

We reviewed a range of records relating to people using the service. This included 8 people's care records and risk assessments, medication administration records and people's financial records. We reviewed staff training and supervision data. We looked at some of the provider's auditing arrangements.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection to the service in October 2021, systems were either not in place or robust enough to manage and mitigate risks for people using the service. This placed people at risk of potential harm. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and the provider remained in breach of this regulation.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Not all risks to people's safety and wellbeing were assessed, recorded or provided enough detail as to how identified risks should be recorded or mitigated. For example, risks relating to the care and management of people's long-term health conditions such as diabetes, diverticulitis, mental health and self-harming were still not being assessed. The failure to provide staff with all the information they needed to understand how to support people safely, placed them and staff at potential risk of harm.
• People's individual Personal Emergency Evacuation Plan [PEEP] assessments failed to consider their mental health and/or learning disability needs, people's visual, hearing or sensory impairment and the impact this might have on their ability to evacuate the service safely. A PEEP is a bespoke plan for people who may have difficulties evacuating to a place of safety without support or assistance from others. The PEEP did not consider who might panic or react adversely if there was a need to evacuate the service in an emergency, or if there was a fire. This information is critical for staff in an emergency situation.
• Some people's bedrooms on the first and second floors had fire escapes which opened onto a wrought iron balcony and stairs. The balcony and stairs were unsafe. They were thickly covered with pigeon feathers and excrement, which was wet and a potential slip hazard, particularly in the event whereby staff and people using the service had to exit the building in an emergency.
• Staff had completed online fire safety training but not 'practical' fire safety instruction. The deputy manager stated an evacuation sledge had recently been purchased. The purpose of this equipment is to enable staff employed to evacuate a physically impaired person easily and safely downstairs or when a passenger lift cannot be used in the event of an emergency such as a fire. The deputy manager had not received specific training relating to the use of the evacuation sledge but was providing staff with 'in-house' training. This did not safeguard the health and safety of the person using the service or staff employed.
• Hot water outlets were tested at regular intervals to ensure hot water emitted remained safe and within recommended guidelines. However, where cold-water outlets were not regularly used, frequent flushing is required to prevent the risk of legionella bacteria multiplying in the water system. Staff told us this was not happening or being monitored. No further analysis for legionella had been carried out since October 2019. This remained outstanding from our previous inspection conducted in October 2021.

• This inspection highlighted lessons had not been learned and improvements made since our inspection in October 2021. At the inspection of October 2021, 4 breaches of regulation were cited, the overall rating of the service was rated inadequate, and the service was placed in 'Special Measures'. The purpose of 'Special Measures' is to ensure that providers found to be providing inadequate care significantly improve for the benefit of the people using the service. At this inspection, these breaches remained, and 3 additional breaches of regulation highlighted.
• The above demonstrated the provider continued to put people's safety and welfare at risk because there was not a culture for learning lessons and enabling reflection and using them to improve the service.

Suitable arrangements were not in place or robust to manage and mitigate risks for people using the service. This placed people at risk of potential harm. This was a continued breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our last inspection to the service in October 2021, effective arrangements were not in place to protect people from abuse. This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and the provider remained in breach of this regulation.

Systems and processes to safeguard people from the risk of abuse
• People were exposed to the increased risk of harm and abuse as safeguarding procedures were not being followed. A serious allegation of abuse was disclosed to staff in August 2022 by a person using the service. The registered manager failed to raise a safeguarding concern with the Local Authority or to notify the Care Quality Commission. The internal investigation report for the above incident was not robust and indicated the person's concerns were not taken seriously. Following the inspection, the Care Quality Commission raised a safeguarding referral with the Local Authority, and this was being followed up by the police.
• Staff had received safeguarding training but did not understand their role and associated responsibilities to protect and keep people safe from harm. The registered manager cited the above incident did not meet their threshold for reporting to the local safeguarding team. No other member of staff had reported the incident. It was of great concern that neither the registered manager or senior staff members recognised the seriousness of the incident and the requirement to report the incident to the appropriate authorities.
• Financial discrepancies were found for 3 people using the service. Despite the service being a nursing home, staff told us that a nurse was employed on an 'ad-hoc' basis to administer injections for 2 people and to change 1 person's dressings. The financial records for these people found they were being charged £40.00 for each injection or change of dressing. There was no justification for such payments being made by people using the service for external nursing tasks. Following the inspection, the Care Quality Commission raised a safeguarding referral of financial abuse with the Local Authority.

Effective arrangements were not in place to protect people from abuse. This was a continued breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment
• Inadequate arrangements were in place to ensure there were enough staff to give people the care and support they needed. Staffing levels of 1 senior member of staff and 2 care staff throughout the day, did not enable people using the service to have community access. Meeting minutes referred to 2 people being supported by staff to access the community to go shopping. However, care records showed that over a 6-week period, 1 person went shopping on 3 occasions and the other person was not supported with shopping.
• The registered manager was responsible for developing the service's staff roster. However, a dependency

tool was not evident for all people using the service to demonstrate how the registered manager had decided current staffing levels were appropriate to meet their needs. Observations showed staff did not routinely sit and talk with people for a meaningful length of time.
• Although the registered manager delegated roles and responsibilities to senior members of staff, the staff rosters did not include the registered manager's hours of working at the service. It was unclear how the registered manager split their time between Alexander House Private Nursing Home and their 'sister' service.

There were not enough skilled staff to meet the needs of people using the service. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• We were unable to assess staff recruitment procedures at this inspection as no staff had been recruited since our inspection in October 2021. We looked at staff recruitment practices in October 2021.

Preventing and controlling infection
• Although the provider recorded staff had received infection control training, a member of staff was observed to assist a person to eat orange segments by placing these in the person's mouth with their fingers. This was not hygienic, and the inspection team had to intervene and tell the member of staff this was not appropriate. This meant staff were not using Personal Protective Equipment [PPE] effectively and safely or following safe infection, prevention and control guidance.
• The service did not have a designated cleaner as cleaning tasks were undertaken by both day and night staff. However, our observations found the service to be clean and odour free.

Using medicines safely
• Suitable arrangements were in place to ensure the proper and safe use of medicines. The medication rounds were evenly spaced out throughout the day to ensure people did not receive their medication too close together or too late.
• We looked at each person's Medication Administration Records [MAR]. These showed people received their medication at the times they needed them, and records were maintained and kept in good order. Appropriate arrangements were in place to ensure medicines were stored securely for safekeeping.
• Staff who administered medication had received training. Staff had their competency assessed to ensure they were competent to undertake this task safely.

Visiting in care homes
• Visiting arrangements for people's relatives were in line with government guidance on visiting in care homes.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection to the service in October 2021, suitable arrangements were not in place to gain consent from people using the service, those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found not enough improvement had been made and the provider remained in breach of this regulation.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• People were not supported to have maximum choice and control of their lives. Restrictive practices were in place at Alexander House Private Nursing Home. A person told us they did not have access to money and were solely reliant on staff to purchase items for them. The person told us they would have liked to keep some of their own money in their purse. People told us they were not supported by staff to enable them to have community access.
• Restrictions were imposed on people using the service. Not all people using the service had access to appropriate professionals and stakeholders involved in their care. The provider was continuing to not allow professionals and stakeholders to access the service to carry out their statutory obligations to ensure people's safety and wellbeing. People had not consented to this decision and there was no evidence of

assessments demonstrating it was in their best interest.
• Staff did not always enable people to consent to their care or support. For example, people were not routinely offered a choice of drinks by all members of staff on duty or given a choice where they ate their meal at lunchtime, what was on the television, or the type of music played. This did not provide assurance staff understood the requirements about involving people in decisions and enabling them to consent to their care.

Suitable arrangements were not in place to gain consent from people using the service, those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Not all people's nutritional needs were being met in line with their care needs or care plan. For example, a person who was living with diabetes was not being supported to have a healthy eating plan in line with their medical condition. Another person was assisted to eat small orange segments. There was a potential risk of aspiration and choking for this person as the fibrous part of the orange segments [white pith] had not been removed by staff. Staff were not meeting people's nutritional needs in line with their care plan. This placed people at risk of not having their nutritional needs met.
• Although people's dietary needs were recorded within their care plan, the service's chef was not aware of each person's specific dietary needs, what this entailed or how to manage this. This meant the chef wasn't aware of the person who required a low fat, low salt and low cholesterol diet. This placed the person at risk of not having their specialist nutritional needs met to support ongoing good health.
• The dining environment was noisy with 2 televisions on different channels and the radio on simultaneously. People were not given the choice or opportunity to move from the communal lounge and to sit at the dining table. This did not enable people to have a change of location and to have their meals in a calmer and less distracting environment to enable them to eat their meals. This did not provide assurance people using the service were given appropriate support to eat or drink.
• Where people required staff support to eat and drink, this was not always provided in a supportive manner. Staff were repeatedly observed to stand over people when assisting them to eat and drink, instead of sitting at the same height as the person being supported. This meant the member of staff was not able to face the person, provide good eye contact and ensure the person was able to eat at their own pace. Staff were observed to provide limited verbal interactions and encouragement whilst assisting people to eat and drink when they needed it.

People's nutritional needs were not being met. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff had received training in several key areas. However, the deputy manager confirmed staff had not received 'practical' moving and handling training, despite several people requiring staff assistance to mobilise. A senior member of staff told us they last received 'practical' moving and handling training over three years ago. This meant staff may not have had the skills and competencies needed to hoist and transfer people safely.
• As detailed within the 'Safe' section of this report, staff had not received practical fire safety training or training relating to the use of the evacuation sledge. This did not safeguard the health and safety of the person using the service or staff employed.
• Staff training information demonstrated staff had not received appropriate training relating to people's care and support needs. This referred to people's specific health conditions.
• Staff had attained online training relating to safeguarding, person-centred care and the Mental Capacity

Act 2005 [MCA]. However, observations of staff's practice did not provide assurance staff were skilled and competent to undertake their job role effectively. Safeguarding procedures were not being followed, observations demonstrated people did not receive care and support that was person-centred and there was a lack of understanding of MCA principles.

Appropriate arrangements were not in place to ensure staff received appropriate training to meet the needs of the people they supported. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff received regular supervision, but these consisted of discussions relating to work related topics and nothing to suggest the staff member's welfare, training needs, monitoring of their performance was actively discussed and recorded. This evidence is records based as staff told us they felt supported.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider had not worked with other agencies in an effective and timely way as highlighted and demonstrated throughout this report.
• Records showed recommendations and advice by healthcare professionals were not always implemented or followed up. For example, a person was assessed by an Occupational Therapist in August 2022 relating to their moving and handling needs. Based on their observations a more supportive sling was recommended to provide comfort and safety to the person using the service. Although information was provided by the healthcare professional to the service, staff told us the sling had still not been purchased.
• Two people had a hospital passport. A hospital passport is a way of communicating to healthcare professionals about the best way to support a person while they attend an appointment or spend time in hospital. A person's hospital passport was incomplete as it did not contain relevant information about them and how they communicate their needs.

Adapting service, design, decoration to meet people's needs
• Since our last inspection to the service an orientation board detailing the date and day of the week and a large clock had been purchased. However, improvements were still required to the environment for people living with dementia or mental health conditions. There were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.
• People were primarily seated against the wall of the 'L' shaped communal lounge, with two televisions and the radio on simultaneously. There were no designated quiet areas for people to go to, other than the dining room, or their bedroom. There was no designated area for people to see visitors in private [other than their bedroom or the dining room] or to participate in meaningful 'in-house' activities.

We recommend the provider seek national guidance to ensure the premises are suitable to meet people's needs and for the service provided at Alexander House Private Nursing Home.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
• We were unable to assess this fundamental standard as no new people had been admitted to Alexander House Private Nursing Home since our inspection in October 2021.

Inadequate

Is the service caring?

Our findings

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

At the last inspection where we looked at the key question of caring, we rated this Requires Improvement. At this inspection the rating has changed to Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• People told us they were lonely, bored and isolated. Not all people living at Alexander House Private Nursing Home wished to live there. People did not want us to raise these concerns with the management team or staff as they were fearful of the potential consequences and repercussions.
• Staff treated people kindly, but the care and support provided by staff during all three days of inspection was observed to be intuitive and task focused. This meant the majority of staff interactions with people using the service centred on their personal care, comfort needs and mealtimes, with little thought given by staff to meaningfully interact with them at other times. This indicated the routines of the day took priority over person-centred care.
• People with complex mental health and/or learning disability needs were left seated in the communal lounge for the duration of each day with little or no interaction or stimulation. During the 3 days of inspection, only 1 person was observed to be accompanied by a staff member to walk to the local shop to purchase sweets and drinks for themselves and others living at the service.
• The provider was unable to demonstrate how they ensured people received person-centred care in line with the guidance entitled, 'Right support, right care, right culture'. The latter refers to any service that provides care and support to autistic people and people with a learning disability. Alexander House Private Nursing Home was providing support to 2 people who had a learning disability and/or were autistic.
• The Commission's regulatory approach states what we expect good care to look like for providers when supporting autistic people and people with a learning disability. The ethos of this guidance is that 'autistic people and people with a learning disability are as entitled to live an ordinary life as any other citizen.' The culture of the service did not ensure this was happening as highlighted within this report.

Supporting people to express their views and be involved in making decisions about their care
• Little information was provided to demonstrate how the views and experiences of people were gathered and acted on to shape and improve the service or the culture of the service.
• Several people using the service were allocated an independent advocate. The role of an advocate is to support a vulnerable person to have a 'voice' and ensure their rights are being upheld. The provider did not allow all assigned advocates to access the service to carry out their duties to ensure people's safety and wellbeing.

Although people were treated with kindness, people did not receive person-centred care that met their needs. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection where we looked at the key question of responsive, we rated this Requires Improvement. At this inspection the rating has changed to Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
• People did not receive personalised care and support that was planned and tailored to meet their specific care and support needs.
• Care plans did not reflect individuals' preferences, interests, aspirations, strengths or their abilities for independence.
• Care plans did not provide sufficient detail to guide staff on how to deliver the right care and support that was responsive to people's needs and promoted their wellbeing. The lack of information placed people at potential risk of receiving inappropriate care and support.
• Where people could be anxious and distressed, individual care plans did not have personalised information needed to guide staff on how to intervene effectively through de-escalation techniques or other agreed good practice approaches.
• No one using the service was judged to be at the end of their life. However, people had not been consulted about their end of life care and there were no advanced care planning documents in place to inform staff of their wishes. Training information provided to the Care Quality Commission showed staff had not received end of life training.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
• People did not get information in line with their communication needs. The activity programme was not provided in an easy read and large print format. This was displayed on a large wall within the communal lounge with lots of other information, which some people may find difficult to decipher and understand.
• The menu was handwritten and not in an easy read or large print format and pictorial communication cards were not used by staff to enable people to make an informed meal choice.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were not engaged in meaningful activity throughout the day to help reduce the potential risk of boredom and loneliness. One person told us they stayed in their room every day watching the television.

The same person stated staff occasionally took them round the block. Another person told us when asked about social activities at the service, "I like to watch films but there is nothing going on here [Alexander House Private Nursing Home] much."
• Observations showed limited meaningful day-to-day opportunities were provided for people using the service to participate in social activities. People were not being supported by staff to lead a fulfilling life that promoted their health and wellbeing. For example, enabling people to maintain their interests and have the opportunity to develop new ones. Throughout the inspection, there was an over reliance on the use of the television and radio to entertain people using the service.
• Information available showed people had limited opportunities to experience activities within the local community. This was despite the location of the service being close to shops and cafes in Westcliff on Sea and the seafront.

People did not receive person-centred care that met their needs. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• People did not feel able and confident to raise a complaint or concern with the management team of the service and staff for fear of repercussions. Three people told us they did not know how to make a complaint or raise a concern.
• The deputy manager told us the service had received no complaints or compliments.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection to the service in October 2021, effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and the provider remained in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Working in partnership with others; 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 provider who is also the registered manager of the service did not ensure Alexander House Private Nursing Home was well-managed and led. Lessons had not been learned to drive improvement or to ensure the quality and safety of the service for people using the service.
• The provider failed to respond to advice and recommendations of external agencies including the Care Quality Commission to achieve compliance with regulatory requirements. This indicated a 'closed culture'.
• The provider did not create an atmosphere that encouraged openness and transparency. The provider maintained their systems and arrangements were best and they were not receptive to guidance or our findings to improve the service.
• The provider continued to not work in partnership with professionals and stakeholders by not allowing them to access the service to carry out their statutory obligations with people using the service.
• The provider's behaviour during the inspection was not appropriate or professional. The provider frequently raised their voice, talked over members of the inspection team and refused to listen to the grounds provided where the service was in breach of regulatory requirements.
• Quality assurance and governance arrangements continued to not be reliable or effective in identifying shortfalls in the service. Specific information relating to this is cited within this report and demonstrated the provider's arrangements for identifying and managing shortfalls and areas for development were not robust. There was a lack of understanding of risk and the potential impact this had on people using the service.
• The lack of effective oversight and governance of the service has resulted in continued breaches of regulatory requirements relating to consent, risk management, safeguarding and governance. Additional regulatory breaches of regulation have also been cited relating to person-centred care, nutrition and staffing during this inspection.

• Effective auditing arrangements were not in place. The purpose of auditing is to enable the provider to establish, validate and review their arrangements to comply with regulatory requirements and ensure the service is operating effectively and as intended.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager's understanding of their roles and responsibilities was not reliable or effective. The registered manager did not recognise improvements were needed following our inspection in October 2021 or where improvements were required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Limited information was available to demonstrate how people's views and experiences were gathered and acted on to shape and improve the service or the culture of the service. Meeting minutes with people using the service were evident. However, there were no action plans completed to evidence how issues discussed were to be addressed or outcomes.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. There were no action plans completed to evidence how issues raised and discussed were to be addressed, dates to be achieved and if these had been resolved or remained outstanding.

Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance with regulatory requirements. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care Although people were treated with kindness, people did not receive person-centred care that met their needs. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place to gain consent from people using the service, those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Variation of condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Suitable arrangements were not in place or robust to manage and mitigate risks for people using the service. This placed people at risk of potential harm. This was a continued breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The enforcement action we took:

Urgent variation of condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective arrangements were not in place to protect people from abuse. This was a continued breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not being met. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance with regulatory requirements. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable arrangements were not in place to ensure there were enough skilled staff to meet the needs of people using the service. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The enforcement action we took:

Urgent variation of conditions