Rosedale Care Services Ltd

Alexandra Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Alexandra Court Care Centre is a residential care home providing accommodation and personal care. The care home can accommodate 84 people across three floors. At the time of the inspection, 77 people were living at the care home.

People's experience of using this service and what we found
Quality assurance systems had not highlighted or addressed all shortfalls identified during the inspection. Not all safeguarding concerns were appropriately reported on the provider's monitoring system or reported to the local authority safeguarding team. People, their relatives and staff raised concerns about staffing levels at the service. We made a recommendation about staffing levels. People's care plans and risk assessments were not always in place or up to date. We made a recommendation about monitoring and reviewing care plans. The provider had not ensured the Care Quality Commission (CQC) were informed of all notifiable incidents.

People's medicines were administered safely, and staff responded appropriately to accidents and incidents. Staff were recruited safely, and the resident ambassador helped with interviewing potential staff. The home was clean and well maintained.

Staff received an appropriate induction, regular training and development to ensure they had the relevant skills and knowledge to support people. Staff made appropriate referrals to relevant professionals and worked closely with them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Systems were in place to gather people's feedback which was used to help improve the service.

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

Rating at last inspection
The last rating for this service was good (published 1 April 2022).

Why we inspected
We received concerns in relation to staffing levels, falls management, food and drink quality, and not providing person-centred care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we found concerns with the availability of fluids and opened up the focused inspection to also include effective.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alexandra Court Care Centre on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have made recommendations regarding staffing systems, risk monitoring and food and fluids.

We have identified breaches in relation to safeguarding processes, the governance of the service and informing CQC of notifiable incidents at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Alexandra Court Care Centre

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 first day of the inspection was carried out by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. A medicines inspector attended on the second day of the inspection and 3 inspectors completed the inspection on the third day.

Service and service type
Alexandra Court Care Centre 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. Alexandra Court Care Centre is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced on the first day and the second and third days were announced.

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 also sought feedback from the local authority contracts team. We used all this information to plan our inspection.

During the inspection
We spoke with 15 members of staff including care staff, senior staff, laundry and admin staff. We also spoke with the deputy manager, the registered manager, the operations manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We also spoke with 10 people who used the service, 10 relatives and 2 visiting healthcare professionals. We also observed staff interactions with people at various times throughout the day.

We looked around the service to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files, and daily records for 10 people and medication administration records for 18 people. We looked at 3 staff recruitment files and reviewed documentation relating to the management and running of the service such as staff rotas, training and audits.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems in place to ensure safeguarding concerns were reported appropriately had not been effective. Staff understood the signs and types of abuse and who to escalate these to. However, we found several incidents which the management team had reviewed, but they had not made the required referrals to the local authority safeguarding team.
- Staff responded appropriately to accidents and incidents. Processes were in place for staff to report accidents and incidents, though we found some incidents had not been reported on the provider's reporting system which meant they had not been reported to the local authority safeguarding team.

The failure to ensure safeguarding systems and processes were operated effectively placed people at risk of harm and abuse. This was a breach of regulation 13 (3) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team monitored accidents and incidents to look for patterns and trends. However, it was difficult for them to identify patterns and trends as not all incidents had been reported on the system, which affected their oversight. Where possible learning was shared with the staff team in meetings.

Staffing and recruitment

- The provider had systems in place to determine staffing levels and these were regularly monitored and adjusted which included reviewing staff skill mix and deployment of staff. However, multiple times during the inspection, communal areas were not staffed which meant at times there were no staff available to manage risks and support people when they needed assistance.
- Some people and relatives raised concerns with us regarding staffing levels at the service and how long it took for staff to respond to buzzers. A person, told us, "It takes ages for the buzzer to be answered and I don't like bothering the staff, but I need help to use the bathroom." A relative said, "There is definitely a shortage of staff, buzzers are not answered quickly and there's no time for staff to have a chat."
- Staff told us the service was busy and could do with more staff. A staff member said, "The ground floor is the busiest. There never seems to be enough staff. Well, there is enough I suppose, but it's just that it's always busy with transfers, double ups and buzzers going off. So, there's never time for chatting to people."

We recommend the provider reviews their systems for determining and monitoring staffing levels to ensure sufficient staff are deployed to each unit.

- Staff were recruited safely. Systems were in place and effectively operated which ensured appropriate

safety checks were completed before staff started employment.
● Where possible, people who used the service were included in the recruitment of staff. For example, a 'resident ambassador' who used the service helped to interview potential staff.

Assessing risk, safety monitoring and management
● Care plans and risk assessments were not always accurate or detailed and some were not in place. For example, we found a person who displayed behaviours that may challenge others did not have an appropriate care plan and risk assessment in place. Another person's care plan contained conflicting information about the use of safety equipment.

We recommend the provider review their systems for monitoring and reviewing care plans and risk assessments to ensure relevant care plans and risk assessments are in place and appropriately detailed.

● Staff were aware of risks to people's safety and wellbeing and where possible responded to manage these risks.
● The provider ensured the safety of the building and equipment through regular maintenance and servicing. Though we found some slings had not been serviced due to being in use at the time of servicing and no action had been taken to manage this risk. We raised this with the registered manager who advised they would take them out of use and arranged another date for them to be serviced.
● Personal Emergency Evacuation Plans (PEEPs) were in place and regular fire drills were held to ensure staff had the skills and knowledge to support people in an emergency situation.

Using medicines safely
● People's medicines were administered safely and as prescribed.
● Systems were in place to safely store, administer and record the use of medicines. However, we found additional safety requirements for some medicines had not been properly identified and risk assessed. For example, where people were prescribed paraffin-based creams, appropriate risk assessments were not in place. We raised this with the management team who started addressing this during the inspection.
● Medicines were regularly audited to make sure procedures were followed. However, the shortfall regarding paraffin-based creams had not been identified.

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection and control practices.
● The home had a good standard of cleanliness. However, some we found some areas needed to be addressed and action was taken during the inspection.
● PPE was available throughout the service and was used by staff as and when needed.

Visiting in care homes
● People were supported to have visitors and to maintain important relationships through face to face meetings, trips out and phone calls. The provider was working in line with national guidance and implemented appropriate processes in the event of an infection outbreak.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
- Drinks were not always available to people when they needed them. We observed some people having to wait a long time for a drink.
- Some people needed specific diets to meet their nutritional needs and manage the risks of choking or aspiration. These were catered for by staff though care plans contained conflicting information, which meant new staff or agency staff may not know people's needs and how to support them.
- Records regarding how much people had eaten and drank were not always accurate. We found inaccurate food and fluid records for 2 people and another person's family raised similar concerns with us.

We recommend the provider reviews their systems for monitoring people's needs around food and fluid intake to ensure appropriate support is available and accurate records are maintained.

- Where people needed support to eat and drink, assistance was provided.

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.

- Staff sought people's consent before providing care.
- People's mental capacity had been assessed where needed and decisions made in people's best interests with the involvement of their relatives, legal representatives and relevant professionals. Though records of assessments and decisions were not always clear or individually recorded. The registered manager was

aware of shortfalls in mental capacity and best interest decision records and an action plan was in place to address this.
● Restrictions on people's liberty were recognised and applications to deprive people of their liberty had been made. Where conditions were attached, these were included in people's care plans.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to using the service to ensure their needs could be appropriately met. Information gathered was then used to created care plans.
● Assessment processes included people and their relatives and were conducted flexibly whilst taking into account people's circumstances. A relative told us about their positive experience of staff working with them to complete the pre-admission assessment in an emergency situation and they had been flexible with when their relative could move into the service.

Staff support: induction, training, skills and experience
● Staff received an induction which included shadowing experienced staff and completed regular training appropriate for their role. Staff received regular supervision to ensure they were able to meet people's needs.
● Staff were supported to progress with their careers through appropriate training and development opportunities.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals were made to relevant healthcare professionals when needed. Care plans documented when professionals had been involved and advice given. A relative said, "[Person's name] sees a chiropodist here, and has the hairdresser weekly. She's also got 2 new pairs of spectacles now. They arranged for her eyes to be tested and sorted the glasses."
● A visiting healthcare professional told us staff submitted regular referrals for people and they took appropriate action to manage risks. The healthcare professional also gave positive feedback about how a person's mobility had improved following the support provided by staff.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were spacious, nicely decorated and generally well maintained.
● Signs and pictures were used to help people locate communal areas or facilities.
● People could spend their time where they chose around the service. People had their own bedrooms and access to communal lounges and dining areas.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance systems were in place and regularly completed though they had not identified or addressed all the shortfalls found during the inspection. These included shortfalls in availability of drinks, daily care records, safeguarding reporting systems and staffing levels.
- Care plan audits had identified issues with care plans not always being in place for all people's care needs and shortfalls with records of mental capacity assessments and best interest decisions. Though they had not identified shortfalls in the quality of care plans and care records such as nutrition and hydration.
- An action plan was in place to address quality shortfalls and was updated during the inspection with the shortfalls found.

The failure to operate effective systems to improve the quality and safety of the service and to keep accurate records placed people at risk of receiving a poor-quality service. This was a breach of regulation 17 (1)(2) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback from people's relatives and staff regarding the support and the availability of the management staff. A person told us, "I don't know the registered manager so I couldn't complain about anything." A relative said, "You don't really see the registered manager. She just stops in her room." A staff member told us there was an open-door policy and the management team were available for them to speak to.
- Most staff interactions with people were positive, though some lacked engagement with people which meant people were not always fully engaged in decisions regarding their care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider's systems had failed to ensure all notifiable incidents were reported to CQC. These related to related to safeguarding concerns.

The failure to inform CQC of all notifiable incidents was a breach of regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009.

- The management team understood their responsibilities under the duty of candour. They had notified

people and their relatives when things went wrong. However, some safeguarding concerns had not been referred to the local authority safeguarding team.
● Systems were in place to support learning from accidents and incidents, though some lessons still needed to be embedded.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems such as meetings and questionnaires were in place to seek feedback about the service from people, their relatives and staff.
● Following changes being made to the service in response to feedback, people and their relatives were informed of changes to the service through wall displays.

Working in partnership with others
● Referrals were made to relevant professionals when required. The management team and staff engaged with healthcare professionals about people's needs to promote good outcomes.
● We received positive feedback from visiting healthcare professionals regarding the timeliness of referrals, staff following professional advice and positive working relationships.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to inform CQC of all notifiable incidents. Regulation 18 (2)

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 The provider failed to ensure safeguarding systems and processes were operated effectively Regulation 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to improve the quality and safety of the service and to keep accurate records placed people at risk of receiving a poor-quality service. Regulation 17 (1)(2)(b)(c)