Care Quality Commission

Mrs. Mercy Amartiokor Cofie-Cudjoe

Alexandra Lodge Care Home

Inspection report

2 Lucknow Drive
Mapperley Park
Nottingham
Nottinghamshire
NG3 5EU

Tel: 01159626580

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alexandra Lodge is a residential care home providing personal care to up to 19 people. People are supported in 1 adapted building. The service supports older people, some of whom are living with dementia and mobility needs. On the day of our inspection, there were 8 people using the service.

People's experience of using this service and what we found
The premises and environment were poorly maintained, and staff training and competency was poor, this put people at risk of significant harm. Action identified in previous urgent enforcement action had not been taken and further risk was identified. The provider failed to take action to mitigate significant risk to people. This meant the environment and risk management was ineffective, which placed people at risk of harm and therefore, following this inspection, people were transferred to alternative care homes.

The home was not safe. Environmental risks were not managed. The provider had not been carrying out health and safety checks where they should, to ensure risks relating to windows, hot surfaces, and infection control were safely and appropriately managed.

The service failed to protect people from poor care and abuse. The provider had failed to have systems and processes in place to monitor and review incidents and the quality of the care provided to people. This resulted in poor care and no action taken to prevent reoccurrence of incidents.

Medicines were not managed safely. The provider failed to appropriately stock check medicines. Multiple medicines could not be accounted for meaning people were at risk of under or over administration of medicines.

People received poor quality care, due to staff not having the required skills and abilities to meet people's needs. Staffing levels were consistently low, some staff were expected to fulfil dual roles, which meant people received inconsistent care from staff due to insufficient time to meet people's needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a poor culture at this home. Staff told us the home was not safe and the provider did not listen when they raised concerns. This meant there was no focus on continued improvement and assessment of the quality of care at this home.

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 28 June 2023)

At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 28 June 2023. During this inspection the provider did not demonstrate improvements have been made. The service remains rated as inadequate overall. Therefore, this service remains in Special Measures.

Why we inspected
The inspection was prompted in part due to previous urgent enforcement action resulting in conditions added to the registration. Concerns were received these conditions were not being met in regards of risk oversight and governance improvements, additionally concerns with the environment, infection control, staffing and leadership. 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.

The overall rating for the service remains inadequate. This is based on the findings at this inspection. We found evidence the provider needs to make significant improvements. Please see the safe and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alexandra Lodge on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, staffing, safeguarding people from risk of abuse and good governance at this inspection.

Following the inspection we suspended the providers registration. This means the provider cannot support any people for a period of time.

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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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Alexandra Lodge Care 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 carried by 2 inspectors.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
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.
We spoke with 2 people who used the service. We spoke with 5 staff including, a cook, care assistant, senior care assistant, administrator and the provider. We reviewed 8 people's care records. We looked at 4 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, safety checks, incidents, and accidents.

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 we found that there were issues regarding staffing medicines, risk management and environmental safety. This was a breach of Regulation 12, 13, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found a continued risk in staffing, environmental safety, medicines, risk management and safeguarding, and further risk with infection control. This means that the service remains in breach of all of those Regulations.

Systems and processes to safeguard people from the risk of abuse

- People were not kept safe from avoidable harm. During our inspection we found the provider had failed to properly assess and mitigate a wide range of potential risks to people's safety and welfare, in areas including nutritional risks, environmental safety, medicines management, infection prevention and control and staffing.
- Records showed not all staff had received safeguarding training, Staff did not always demonstrate knowledge of how to recognise and report abuse. When we spoke to staff, they consistently told us the service was not safe and they had raised this concern to the provider, but the provider had been unwilling to make changes, to improve the safety of the service.

Assessing risk, safety monitoring and management

- People's risks were not managed. We found historical information in care plans and risk assessment not relevant or conflicting with people's current and ongoing needs. This meant people's risk were not assessed, monitored or managed effectively, leading to poor care for people.
- People were at risk of choking due to their adapted diet not being sufficiently assessed and risks were not mitigated. For example, 2 people required a 'soft and moist' diet. We reviewed both care files and found choking risk assessments which stated they could eat a normal diet. Additionally, foods listed they could eat located in the kitchen were unsuitable and not within the IDDSI framework (International Dysphagia Diet Standardisation Initiative), placing them at significant risk of choking.
- Fire risks were not always well managed. Risks found at the last inspection including not all fire doors operated as they should, had not been acted upon meaning they continued to not close or were not fitted correctly. This placed people at ongoing risk of harm due to a failure to ensure fire safety equipment was in full working order.
- At the last inspection we found window restrictors were not always fitted to comply with Health & Safety Executive (HSE) Guidance. Restrictors fitted to people's bedroom windows on the first floor were not tamperproof or robust. A first-floor hallway and bedroom window did not have any restrictors fitted. We found on this inspection the windows remained the same, meaning there was a continued risk to people who could fall out of windows.
- Risks relating to hot surfaces continued too not be well managed. We told the provider at the last

inspection some radiators in the building were not covered and in line with HSE guidance: 'Managing the risk from hot water and surfaces in health and social care'. People remained at risk of falling, this meant there was a continued risk of burns and scolds from hot surfaces.
● We told the provider at the last inspection freestanding furniture was not always secured, meaning if a person used furniture to steady or pull themselves up there was a risk this could fall on them. We found at this inspection not enough action had been taken to assess furniture in the care home and found a further 4 large pieces of furniture were not secure. A continued risk remained due to poor environmental safety.

Using medicines safely
● At the last inspection we found medicines were not managed safely. At this inspection we found no improvements had been made and poor management of medicines resulted in increased risk for people.
● There continued to be no evidence that all staff who supported people with medicines had been trained to do so. The provider failed to take action following the last inspection. The risk of staff not having the skills and knowledge to ensure people received their medicines safely continued.
● Systems and processes for safer medicines management had not been developed or implemented. We found stocks of medicines was not recorded meaning there was no way of knowing if medicines had been administered due to lack of stock counts. This continued to place people at risk due to poor management of medicines.

Preventing and controlling infection
● Several areas of the environment were very unclean which posed a risk of infection and compromised the effectiveness of cleaning. We found stained mattresses in peoples' bedrooms. The provider had no system in place to check mattresses were fit for purpose.
● Some areas of the home had strong malodours and indicated cleaning had not taken place for some time. For example, a bathroom had a strong odour of urine and stained equipment in the room.
● Additionally, dedicated domestic staff were not in place to ensure cleaning processes were completed each day. We were informed staff had dual roles along side caring duties. This meant cleaning was not planned for or maintained. This placed service user at risk of infection from poor cleaning standards.
● We found excess waste stored outside the entrance and this posed a risk of infection and pest concerns. While awaiting the pickup of waste no interim arrangement had be made to ensure the safe storage of waste to reduce the risk infection and pest infestation.

Visiting in care homes

Due to the purpose of the inspection and the risks and the unsafe environment within the care home, visiting was not reviewed, and we are unable to make comments on the visiting arrangements at the care home on this inspection.

Learning lessons when things go wrong
● There was no evidence of learning from incidents. As detailed above, concerns with environmental safety, Infection control, risk management and mismanagement of medicines continued, and further risks were found with nutritional safety.
● The provider failed to respond appropriately to concerns raised at the last inspection and during the inspection we found significant risks in all the aforementioned areas. This demonstrated that the provider did not always learn lessons when things go wrong.
● The provider failed to ensure staff reported and recorded incidents appropriately, we found no evidence incidents were reviewed or monitored to prevent reoccurrence. Systems were either not in place, needed embedding or robust enough to address the concerns identified during the inspection. Due to systematic

failures the provider failed to ensure the safety of people meaning they were at risk of harm.

The provider systematically failed to assess and manage a wide range of risks which placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found the service was not working within the principles of the MCA.
● During the inspection we reviewed DoLS applications and found for some people applications made over 6 years previous had not been followed up. There was no evidence the provider had completed reviews to ensure the restrictions were still necessary and people were not unlawfully restricted. This placed people at risk of having their liberty deprived without the appropriate legal safeguards in place.

Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority. This placed people at risk of harm. This was a breach of Regulation 13(5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At the last inspection we highlighted there was not enough staff deployed to ensure people's safety and the safe running of the service. . We found at this inspection no action had been taken to review staffing numbers, only 2 staff continued to be scheduled during the day and night, meaning safe evacuation in the event of an emergency could not be achieved. This was because some people needed 2 members of staff to help them transfer and move safely around the home.
● During our last inspection we raised a concern that there was not a dependency tool in place to help the provider to determine how many staff were needed to provide safe care. No action had been taken to address this. We also found staff were providing care for people without the required skills and experience. This meant the provider had continually failed to consider the staffing levels and skills mix needed to meet people's needs.
● Additionally, staff were given dual roles, for example, on the day of the inspection one staff member was allocated to be the domestic cleaner and also deliver caring duties. This meant staffing was reduced to 1 staff member when they were redeployed to cleaning duties. This placed people at risk of not receiving care in a timely manner.

The provider failed to deploy sufficient numbers of skilled and experienced staff. Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection we found the provider did not have robust recruitment policies and procedures. This meant there were no set standards concerning pre-employment checks to ensure staff were suitable and recruited safely. At this inspection no action had been taken to mitigate this ongoing risk.
- DBS checks provide information, including details about convictions and cautions held on the Police National Computer. We found at the last inspection a staff member had not had a DBS check carried out since 2005, and records showed 11 other staff had not had a DBS check within the past 3 years. The provider failed to take any action to carry out DBS checks. This meant there was a continued risk staff were not suitable for their roles which could place people's safety at risk.

The provider had failed to implement and operate effective systems to ensure safe staff recruitment. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We found indicators of a closed culture within the service. This was due to the provider's unwillingness to engage with external agencies or take onboard and rectify significant concerns highlighted by the commission and the local authority during the last inspection. This resulted in an unsafe environment, with poor management and no clear guidance and delegation of responsibility.
● The provider had failed to ensure people's needs were correctly assessed and met and the environment was safe. Staff comments included "It's bad" and "The provider was usually not around". Inconsistent and infrequent provider oversight within the service, meant we found a decline in care standards delivered and people were at risk and had their care impacted, due to inadequate support.
● At the last inspection the provider told us they recognised they needed to improve; however, they had no plans in place of how this could be achieved. At this inspection, the provider failed to make sufficient improvements, and again we found no documented evidence the provider could independently identify actions and concerns that needed addressing.

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 had failed to make adequate improvements at the service. This was evidenced by the continued failings we found at the inspection and further risk not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.
● We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider failed to demonstrate any understanding regarding the severity of the concerns, when asked about the environmental and safety risks, the provider told us, "All work has been done". However, this was not the case as detailed in the 'Safe' section of this report. This gave us no assurance the provider was able to make the required improvement in leadership and care delivery in the service.
● There remained an inconsistent approach to documenting accidents and incidents. In addition, we asked the provider to develop a policy for managing accidents and incidents as this was not in not in place at the last inspection. We were shown an 'Accident Policy' which consisted of an extract from a first aid manual only. The provider failed to implement an effective policy which gave guidance to staff to improve people's safety following accidents and incidents.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements
● Governance processes were ineffective. At the last inspection we found no systems or processes in place to monitor the safety and effectiveness of service provision. The failure to have these in place significantly restricted the provider's ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.
● During this inspection organisational governance and quality monitoring systems remained ineffective and had failed in assessing, monitoring and mitigating potential risks to people's safety. They had not identified environmental and infection control risks and risk management, which resulted in poor care and the quality and safety of the service had declined further.
● Audit documents we reviewed for the environment, health and safety, care plans and medicines were ineffective. The provider failed to recognise the risk identified at the last inspection, we asked the provider to make improvements and during this inspection we found improvements had not been made and further risk found. Consequently, we found significant concerns in these areas as detailed in the report, which posed risk to people.
● Furthermore, we asked the provider at the last inspection to improve and develop systems to monitor staff training needs and evidence staff were trained and competent to meet people's needs. At this inspection the provider showed us documents which failed to demonstrate staff were adequately trained. In addition, training booked was planned for several months later, meaning timely action had not been taken to ensure staff were trained. There was a continued risk of staff not having the required skills and knowledge to meet people's needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The had failed to develop meaningful and productive professional relationships with external agencies to improve people's care. Due to poor leadership, a closed culture approach and a reluctance to engage with professional services, we could not be assured people received the referrals to relevant healthcare professionals as and when needed.
●The provider continued to fail to meet deadlines in submitting information requests to the local authority and the commission. The provider lacked the skills or ability to undertake these tasks, but also told us, "I do not trust anyone", and relied on a staff member to complete this if and when they were available. Due to consistent delays from the provider and a reluctance to involve anyone else, systems remained ineffective and external professionals could not always be involved promptly in managing risks and improving the quality of the service.

The provider systematically failed to implement and operate effective systems to ensure the quality and safety of the service. This was a 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider systematically failed to assess and manage a wide range of risks which placed people at risk of avoidable harm.

The enforcement action we took:

Urgent Suspension

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 Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority.

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider systematically failed to implement and operate effective systems to ensure the quality and safety of the service.

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to implement and operate effective systems to ensure safe staff recruitment.

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of skilled and experienced staff. Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people.

The enforcement action we took:

Urgent Suspension