Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Alexandra Nursing Home - Nottingham

370 Wilsthorpe Road, Long Eaton, Nottingham, NG10 4AA

Tel: 01159462150

Date of Inspection: 04 September 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Consent to care and treatment ✓ Met this standard

Details about this location

Registered Provider	Bupa Care Homes (BNH) Limited
Overview of the service	Alexandra Nursing Home - Nottingham is a care home that provides care for up to 39 people. This includes older people with Dementia of either sex.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Alexandra Nursing Home - Nottingham had taken action to meet the following essential standards:

- Consent to care and treatment

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

Not everyone we spoke with was able to converse with us. We saw family visitors who we had met before continued to visit and continued to help where they could. This was helpful to staff as they could ask about any consent issues arising from care provided by them to the family member. Family representatives told us they understood their relatives care plan and had agreed to help provide information to support their needs.

One person living at the home told us "care workers explain everything". Another person told us they were treated well and staff listened to them. We observed people's care and support during the visit and saw care workers were available to support them.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

During our inspection of 16 and 17 April 2013 we found issues around consent were not clearly documented in the care plans. The provider should be able to demonstrate how they have acted in accordance with people's wishes.
The provider wrote to us and told us they would review the care plans to ensure people's consent to care and treatment was included. They told us all staff would receive training in this area as part of staff understanding for this.

We visited the service on 4 September 2013. We saw staff had contacted people's family representatives and assessments had been made to include them. In this way decisions were being made to show people's best interest based on what people liked or disliked and around their needs. Family representatives were asked to help complete consent forms that related to different aspects of the person's life. A social history was obtained where care workers could use this to better understand the person in their care.

During a meal time we saw pictures of the meal choices available on the menu board. The pictures were large and clear. The pictures were shown in a way to make choosing a meal easier to do. We spoke with staff about the new picture format and they told us some people were helped by this. When people were asked about the type of food they preferred care workers could use the pictures to help the person to make a decision. The activities coordinator also played a useful role in helping people during the morning and again at lunch time to help with their selections. We observed all staff to be thoughtful in the way they helped people. Care workers were seen encouraging people back in to the lounge areas to keep a watch over them and to ensure their safe movement between the areas. We noticed the majority of external doors were alarmed to alert staff when they were opened. Access to the stairwell was restricted by a gate with key pad. We asked about this and the acting manager told us this was done for safety and security reasons. The gated access helped to prevent a person with frequent seizures from attempting to walk to the top of the stairs unsupervised.

In two care plans we saw other health care professionals had been contacted. This

included contacts with the mental health teams and seeking the advice of a specialist doctor. We saw the permission by the specialist doctor had been obtained to ensure the person took their medicines. This included covert or disguised medicines which could be hidden in food as a last resort. Other options such as using a different approach, using a different nurse or family member were usually tried first. The acting manager told us they had not needed to use this so far as the person seemed settled at the home. The care plan demonstrated the increased levels of contact between family representatives and staff at the home. In this way the person was being supported in a way that met their individual care needs. The issues surrounding consent to care and treatment were considered so that they could be reassessed as necessary.

For another person we saw a best interest assessment had been considered as part of their mental capacity to make informed decisions. The care plan informed care workers to consult with the community mental health team who had an in depth back ground to the family circumstances when important decisions needed to be made. Care workers now had clearer guidance to follow. This would help them to keep people safe within the home. The decision making process had been considered and evidence of this were now included. In another care plan we saw how this was particularly important when there was limited family contact for the person using the service. In this way where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We looked at a third person's files and saw they had a capacity assessment.
We saw there was documentation available for advanced decision making with regard to end of life care.

The acting manager told us that one person was currently being assessed for a Deprivation of Liberty Safeguards (DoLS) authorisation. The health and local authority were involved in the decision making processes. We saw records that showed all members of staff had received training in the Mental Capacity Act and associated Deprivation of Liberty Safeguards (DoLS) during April and May 2013. We also saw that training had taken place for staff in behaviour that challenges during May 2013. This means that staff received relevant guidance and knowledge to help them understand when they may be restricting people's liberty.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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