Leonard Cheshire Disability

Alne Hall - Care Home with Nursing Physical Disabilities

Inspection report

Alne Hall
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place over two days on 13 and 20 July 2016. The first day of the inspection was unannounced.

Alne Hall is registered to provide nursing care for up to 30 people with physical disabilities. When we visited there were 25 people living at the home. People at Alne Hall were living with complex physical conditions such as multiple sclerosis and motor neurone disease, which cause multiple symptoms.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection on 15 November 2015 we found the provider was in breach of one regulation. Records relating to the care and treatment of people who used the service required updating. We made a number of recommendations with regard to staff training and medicines management.

We found that remedial action had been taken to address shortfalls identified at our previous inspection.

People said they felt safe. Staff and volunteers were recruited following a robust selection process, to ensure they were suitable for their role and responsibilities in the home. Although person centred care planning and equality and diversity training required updating we found that staff training was mostly relevant and up to date.

A number of staff including the registered manager had worked at the service for a long time and were familiar with people who lived there and their care needs. Although we raised one issue with regard to maintaining people's dignity we observed that staff demonstrated a positive regard for the promotion of people's personal dignity and privacy.

Staffing levels were assessed according to the individual needs and dependencies of the people who used the service. Although the home had experienced some staffing difficulties the registered manager used agency staff who were familiar with the service wherever possible and this helped to minimise any disruption to people using the service.

The registered manager and staff followed the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and ensured people were not being deprived of their liberty in an unlawful way.

People told us the quality of their food was good and their nutritional status was monitored to ensure risks from malnourishment and dehydration were acted on with involvement of specialist health care

professionals when required.

There were effective arrangements in place for the maintenance and upkeep of equipment and the premises.

However, we identified that auditing systems were not sufficiently robust to ensure the quality of the service could be effectively monitored and assessed on an on-going basis and that people could be confident that their care needs would be consistently met. We found that people's care was not always planned to ensure that people received appropriate care that met their individual preferences and promoted their wellbeing. We asked the registered manager to make a safeguarding referral with regard to the care of one person living at the service.

There was a committed staff team. However we found that where individual complaints and differences of approach had been raised with managers these had not always been dealt with effectively and this had impacted adversely on staff morale.

We found the home was in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance and person centred care. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff received safeguarding training and safeguarding procedures had been reviewed and updated.

We identified one incident that needed reporting under safeguarding procedures.

There were sufficient skilled and experienced staff on duty to meet people's needs.

Robust recruitment procedures were in place for the safe recruitment of staff and volunteers.

Appropriate systems were in place for the management and administration of medicines.

Management systems were in place for the on-going maintenance and safe upkeep of equipment and the premises.

Is the service effective?

Good

The service was effective.

Staff undertook a range training to help them support people who used the service.

People were supported to make informed choices and decisions about their lives.

Assessments were completed and where people lacked capacity to make decisions about their support, these were completed in their best interests. The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were met.

People were provided with a variety of wholesome meals and their nutritional needs were monitored to ensure they were not placed at risk from malnutrition or dehydration.

Is the service caring?

Good

The service was caring.

Staff knew people really well and used this knowledge to care for them and support them in achieving their goals.

People told us their views were taken into account and used to help shape the service.

We observed staff engaged sensitively with people and were respectful.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support was not always planned in a way to take account of people's changing care and support needs.

We were told of plans to consult further with people to look at future options and plans.

We saw people were encouraged and supported to take part in a wide range of activities.

The people we spoke with were aware of how to make a complaint or raise a concern.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Management systems and processes were in place. However, these were not being used effectively to enable the quality of the service to be assessed and to identify where changes were needed.

Staff were not confident that senior management would support them effectively if they raised any concerns with them.

People living in the home were able to contribute towards meeting and surveys.

Alne Hall - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 13 and 20 July 2016. The inspection visit on 13 July 2016 was unannounced and was undertaken by one inspector. On 20 July 2016 two adult social care inspectors inspected the service. The registered manager was given 48 hours' notice of that visit.

Before the inspection, we reviewed the information we held including notifications submitted by the registered manager. We reviewed the Provider Information Return (PIR), which the provider completed in 2014. This asks them to give key information about the service, what the service does well and what improvements they plan to make. We looked at the action plan, which the provider submitted following our last inspection in November 2015 and updated action plans from the registered manager dated 22 March and 20 June 2016. We ask a provider to submit an action plan when improvements are needed so that they can document how they will be addressed. Local authority safeguarding and quality performance teams were contacted as part of the inspection process, in order to obtain their views about the service.

During our inspection we observed how staff and voluntary workers interacted with people who used the service. We spoke with 11 people living at the home, eight care staff, five ancillary staff, the activities co-ordinator, volunteer coordinator, care supervisor and the registered manager. We contacted health care professionals and social care professionals to gain their views about the service. We reviewed the care records belonging to five people who used the service, recruitment and supervision files for three staff and for two voluntary workers. We looked at a selection of documentation relating to the management and running of the service. This included staff training files, staff rotas, meeting minutes, maintenance records, recruitment information and quality assurance audits. We also undertook a tour of the building. Following

our visit to the service we contacted the head of operations for the organisation.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and trusted the staff. One person said, "Yes, I'm safe here." Another person told us, "I feel safe," and, "I would talk to [the manager] if I was upset or had any worries." Speaking about the home one person said they had chosen to use the service on a permanent basis after a holiday in the home some years before. They told us, "On the whole it is very good." Another person said, "I wouldn't want to live anywhere else."

At our last inspection on 18 November 2015 we found that safeguarding procedures needed to be reviewed to make sure there were clear reporting procedures within the management team. At this inspection we found safeguarding procedures had been reviewed and updated making it easier for staff to understand and follow local safeguarding protocols.

On the second day of our inspection we observed one person had bruising to their arm and a mark where their arm was trapped between their body and the bed rail which was not cushioned. We spoke with a member of staff who repositioned the person's arm. On reviewing their daily records we noted that old bruising had been identified and the member of staff had written that a pillow should be placed between the person's arm and bed rails for comfort and to protect their skin. However, their risk assessment and care plan had not been updated and this information was not shared with staff at either of the two handovers we attended. This meant the person was at risk of harm. We discussed the care of this person with the registered manager and asked them to submit a safeguarding alert, which they subsequently confirmed they had done. We did not identify any further concerns regarding safeguarding issues during our visit and we concluded this was an isolated incident. The registered manager told us they would ensure the person had bed rail safety bumpers fitted as a priority and they subsequently confirmed this had been done. Following our inspection the head of operations confirmed that since the inspection a formal support plan and risk assessment have been updated. A safeguarding strategy meeting took place at the service on 5 August 2016 and the matter was closed at the end of the meeting.

We saw that safeguarding training was updated on a regular basis to ensure staff were familiar with their professional roles and responsibilities to protect people from potential harm. Policies and procedures were available for staff to follow which were aligned with the local authority's guidance for reporting safeguarding concerns. Staff confirmed they were aware of their duty to report potential concerns about issues of poor care when this was needed. The registered manager told us about a recent occasion where they had instigated the safeguarding procedure in relation to an allegation. They had also reported this to CQC as required.

Since our last inspection a full audit of care files was being undertaken and this was in progress when we visited. The audit included a review of risk assessments to ensure information they contained was accurate and staff had all the guidance they needed to help people to remain safe. Risk assessments and plans were in place to reduce the risk of avoidable harm to people who used the service. For example people at risk of pressure ulcers had detailed risk management plans in place which provided staff with guidance about how to manage this and the service had sought advice from relevant healthcare professionals.

People's personal care files contained assessments about a variety of known risks on issues such as falls, skin integrity, moving and handling and nutrition, together with details about how these were risks were managed by staff, whilst enabling people to be as independent as was possible.

We spoke about staffing with people who used the service and with staff. Overall people told us there were sufficient staff available to meet their needs. Some people who used the service told us that they thought staffing levels could be improved and made negative comments regarding the use of agency staff. Staff told us they were busy however they said staffing levels were sufficient to carry out their roles. We observed staff provided people with assistance when needed and people told us staff answered their call bells promptly. One person said, "Staff come quickly if I need anything." Another person said, "Staff come quickly, I don't have to wait long," and, "I get all the help I need." We observed there were sufficient numbers of suitably qualified staff to meet the needs of people who used the service on our visit. The registered manager told us they helped out on shift when required. They told us staffing levels were assessed according to the individual needs of people who used the service. Wherever possible, they said they always used agency staff who were familiar with the service and knew the people who used the service. This meant the service tried to ensure consistency of staff for people who used the service.

We spoke with the nurse who had lead responsibility for medicines at the service. They told us that since the last inspection care staff responsible for providing medicines to people had completed training on this element of their work. We were told this was followed up by a medication competency assessment to ensure staff were safe to carry out this aspect of their role. Staff confirmed their training was backed up by regular in house 'e learning'. This meant people could be assured staff had been provided with the skills they required to safely administer people's medicines. We saw temperature levels were recorded of the clinical room to ensure medicines were stored within safe temperature levels. Whilst we found these had been satisfactorily maintained, we noted on one day when we visited these had reached the upper limits of those recommended. We spoke to the registered manager about this and they told us that they were looking into purchasing a fixed ventilation system. In the meantime, they had hired an air conditioning unit to ensure effective temperature management within the clinical room and we saw this working during our visit.

We observed staff spoke patiently with people whilst administering their medicines and provided explanations about what these were for. People's medicines were securely stored and good practice information was available in relation to their individual medical needs and medicines provision.

We saw medicines audits were carried out on a daily and weekly basis, to enable potential medication errors to be promptly recognised and acted on to minimise future mistakes. There was a weekly audit in place as described to us in the provider's action plan. The nurse we spoke with said any identified issues would be addressed with the members of staff concerned in their personal supervision meetings. Some people who used the service were prescribed medicines controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. We checked the controlled drugs book and saw that the records of medicines administered to people were checked against the stocks for those that were maintained. For one person, we saw they had specific needs in terms of getting their medicines. This person was on an individualised medicine regime to treat their symptoms. When we visited we saw that staff followed this regime.

Personnel files for staff and volunteers contained evidence that potential applicants were screened and checked before they were allowed to start work in the service, as part of the service's recruitment procedures. This enabled the provider to minimise risks and ensure new staff and volunteers did not pose a risk to people who used the service. We looked at the files of three members of staff and saw these contained clearances from the Disclosure and Barring Service (DBS). This demonstrated the provider was

taking appropriate steps to ensure they only recruited people who were suitable to work with people who lived at the service.
Checks of nursing qualifications had been carried out prior to nurses starting work and regularly thereafter, ensuring they were suitably qualified for their role. Nursing qualifications and registration details were checked with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The organisation maintains a register of all nurses, midwives and specialist community public health nurses eligible to practice within the UK.

There was evidence that employment and character references of staff were appropriately followed up by the registered manager before offers of employment were made. We saw that checks had been made of job applicant's personal identity and previous employment experience, to enable gaps in their work histories to be explored.

We found a variety of checks and tests of the building and equipment were carried out to ensure people who used the service and staff were kept safe from harm. We saw that items of equipment were regularly serviced and that contracts were in place with the suppliers of these. There was a business continuity plan available for use in emergency situations, such as heat wave, outbreaks of fire or an infectious disease, together with fire training delivered to staff and fire drills that took place. Effective systems were in place to ensure that established staff took control in the event of a fire alarm and possible evacuation of the building. The registered manager was able to give us an example when this system had worked well following a fire alarm in which the fire officer had commended the staff actions.

Before our inspection the registered manager informed us of one instance of petty theft from a person living at the home. During our visit we also heard garden furniture had gone missing after a recent social event. We observed that disabled access was provided at the side of the premises with automatic doors which meant that anyone could access the home without having to request staff assistance. We were told these doors were locked at nightfall. We discussed the security of the building with the manager who confirmed that CCTV cameras were installed in the grounds and that they would review the use of these and the security of the building.

We found the building and furnishings smelt fresh and observed domestic staff following cleaning schedules to ensure the service was kept neat and tidy. We saw that domestic staff were provided with sufficient supplies of cleaning materials such as gloves and aprons to enable risks of cross infection to be safely managed. One person who used the service commented, "We have got good cleaning staff and the laundry is very good."

Good

Is the service effective?

Our findings

People who used the service were positive about the care and support provided by the core staff team and said staff promoted their quality of life. One person told us, "They [the staff] are very good." Another person told us, "I like all the staff; they come and explain things to me."

A health care professional told us, "All my patients have been and are very happy there. We are always confident about sending residents back from an inpatient stay knowing our advice will be followed and staff have always contacted me if they have any concerns about a resident." Another social care professional described one person who had lived at the service for a long time and had complex needs. They said, "A lot of the staff have worked at Alne Hall for a long time, they are familiar with [Name] needs and this has a positive effect on [Name]."

Case files belonging to people who used the service detailed their individual medical needs, together with evidence of on-going monitoring and involvement from a range of health professionals, such as GPs, district nurses and other specialists to ensure their wellbeing was promoted. There was evidence of regular evaluations of people's support, together with updates and details where changes in their health status had been noted.

During our visit we observed two handovers and these covered information about each person and their medical and health care needs together with any specific instructions, health visits or appointments for staff coming on duty. For example, for one person the senior care supervisor noted that the hot weather temperatures meant they required additional fluids through their percutaneous endoscopic gastrostomy (PEG) feeding tube. A PEG is a medical procedure in which a tube is passed into a person's stomach, to provide a means of feeding when oral intake is not adequate. Later we checked this person's records and saw they had been given extra fluids as instructed. This meant there were systems in place to ensure people received effective care and support.

Each person had a hospital passport, which was held in a separate folder together with documentation about consent to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) where this had been agreed. A hospital passport is a document to help people with lifelong disabilities when they are admitted to hospital. The aim of the hospital passport is to provide staff in a hospital setting with information to help them work in partnership with the person when meeting their needs when using hospital services. We were told that this information also accompanied people on holiday so that this information was available if required in an emergency when they were away.

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager understood their responsibilities in relation to DoLS and had made applications to ensure people were only deprived of their liberty lawfully and in line with current legislation.

Training about the Mental Capacity Act 2005 (MCA) had been provided to ensure staff were aware of their professional responsibilities in this regard. We observed staff engaged and communicated sensitively with people to ensure they were in agreement and consented to care interventions before they were carried out. We saw evidence of assessments of people's capacity to make informed decisions were completed as part of their care planning process, before any decisions were made on their behalf. This ensured people's legal rights were protected and promoted. Where people lacked capacity to make informed decisions, we saw best interest meetings were held involving relevant healthcare professionals and people with an interest in their care.

We found staff were provided with a range of training to ensure they were equipped to carry out their roles effectively. Training comprised a combination of electronic 'e learning' together with practice-based sessions to enable staff to develop their skills and have their competencies assessed. A training and development plan was in place which was monitored by the manager that included courses on moving and handling, first aid, infection control, safeguarding adults from harm, food and fire safety. At this inspection we found that only 40% of staff had received updated training in person centred care planning, 38% of staff had received behaviour support awareness and 16% of staff had received 'people focus' training.Although we identified staff needed updated training with regard to person centred care planning, behaviour support awareness and 'people focus' other staff training was up to date.

There was evidence in staff files of supervision meetings with senior staff, to enable their performance to be monitored and their skills to be formally appraised. The care supervisor who was a registered nurse told us that they had accessed systems to support nurses in their revalidation. Revalidation is the process where registered nurses and midwives are required every three years to demonstrate to the Nursing and Midwifery Council (NMC) they remain fit to practice. We spoke with the volunteer co-ordinator who said that as part of their role they provided volunteers with pastoral support, supervision and encouragement. This was important because student volunteers from overseas lived at the home during their stay, which could be up to 12 months at a time.

Staff spoke very positively about the quality of the training they received. One staff member told us, "I completed a management training course and it has made me look in an entirely different way at how our team can develop and how we can provide person centred care." We saw that some staff had also received training on personalised care planning and equality and diversity however there was no renewal date for this training and not all staff had completed it. We discussed this with the manager who agreed that they had fallen behind with some of the staff training and had plans in place to ensure these were renewed.

We observed a variety of nourishing home cooked meals were provided and the menu was displayed in the dining room. There was a light-hearted and positive atmosphere throughout mealtimes with people chatting happily together, enjoying opportunities to socialise and enjoy their food. We saw tables were laid out with tablecloths and cutlery, together with condiments, serviettes and glasses for drinks. When we visited we observed staff provided assistance to people requiring support with eating their meals and saw this was carried out with friendly encouragement and at people's own pace. This ensured their personal

dignity was maintained. We observed staff offered people support and reassurance using touch and getting down to their eye level in order to ensure they were understood. There was evidence both care staff and catering staff were aware of people's food preferences, dislikes and allergies and that special diets were catered for.

People's personal case files contained evidence of nutritional assessments about their dietary needs and regular monitoring and recording of their weight, together with involvement from community professionals, such as speech and language therapists and dietitians when this was required. We were told that the chef spent time with people and asked them about their choices and preferences, to ensure they were happy with meals that were served. The subject of the food provided was also discussed at the residents meetings. One person who used the service confirmed, "We have got a very good chef. The food is really good." Another person told us, "The food is lovely and the chef will cater for your needs." People said they could make suggestions about the food on offer either at the residents meetings or through the suggestion box and one person said, "If you want to make a suggestion they always try to accommodate it." The service had been awarded a five star rating by the local environment health department for the cleanliness of the kitchen facilities on their last inspection, which is the highest score that can be achieved.

Accommodation was provided in a detached, 'listed' building that had been extended and adapted for its current use. Bedrooms in the extension had patio doors, which gave people accommodated in this part of the home access to the garden. We noted that the home was equipped with adapted bathroom and shower rooms and adapted furniture and ceiling track hoists were provided where needed. Some of the bedrooms had limited space for the amount of equipment some people required but staff said they felt this was mitigated to some extent by the size of the communal areas in the main part of the building. The registered manager said wherever possible they tried to ensure the larger rooms in the main part of the house were accommodated by those people who required extra space owing to the type of equipment they needed or lifestyle and hobbies. One person confirmed that their new room gave them more space for their motorised wheelchair. The two upper floors comprised staff offices including the manager's office and the care supervisor's office, training rooms and the accommodation for overseas volunteers. The majority of people living at the home would not be able to access this part of the home.

Although staff accommodation was upstairs and not accessible to most residents, there is a staff office downstairs which is accessible to all, there are also accessible rooms available that can be used for confidential meetings as required. In addition, the head of operations told us many people choose to meet with the manager or external professionals in their own rooms. They said the manager was very visible in the service spending time both in and outside of office hours with residents and staff. For example, when they arrived at the service each day the registered manager had a routine of speaking to staff on duty in each department of the service together with residents. As a registered general nurse the registered manager also spent time working as a nurse on the floor as required and was therefore very aware of each individual living at the service as they were of her.

A refurbishment plan was available to ensure the equipment and fittings were replaced when required and we were told this included development of an updated specialist sensory room. We heard that bathrooms had been substantially refurbished since the last time we had inspected and that a plan was in place for making further adaptions and improvements to the service. This included roof repairs, and a refurbished kitchen, sluice and new hairdressing room. We saw that the refurbished bathrooms and shower rooms had been finished to a good standard and were told that people who used the service had been included in the planning of these. A healthcare professional said, "It is a very clean, caring and pleasant environment."

Good

Is the service caring?

Our findings

At our last inspection on 18 November 2015 we recommended that the provider reviewed the use of communication aids to make sure that people had the support required as specified in their care plans to ensure that communication aids, such as picture boards or communication books, were always located with the people that needed them.

In their action plan the provider told us that communication care plans were to be reviewed. The activities coordinator and a member of care staff had been identified as 'championing' communication. They stated that communication also comprised part of personal care planning reviews. Where communication aids were used they said they would ensure communication aids were available and we saw these being used when we inspected.

At this inspection we found people's care files contained details about their personal preferences and likes to help staff understand and promote their individual needs. People told us they were involved and encouraged in making decisions and choices about their lives, such as what time to get up and go to bed and how they spent their time.

Nineteen people living Alne Hall were able to respond to surveys and we were told that 16 people had responded to the last survey. In their feedback 100% of people responding said they were either happy or very happy with the quality of the service. 100% of people said they would recommend the service to other people and that they or their relative was treated with respect. One person told us, "It's second only to being at home, I give it an A plus." Another person said, "Staff treat me with dignity and respect; they make sure I have my privacy." A healthcare professional said, "I have worked closely with staff and they have a very holistic attitude towards residents and it is always obvious how greatly they care for the residents in their care. I always see a lot of smiles and hear a lot of laughter when I am there." We saw quotes from relatives in their feedback to the home were positive. One person had said, "I am so happy [my relative] lives here. It is an exceptional home," and, "Everyone is very nice and friendly and obliging."

There was evidence of meetings with people who used the service to enable their involvement in decisions about the service. People told us staff involved them in making choices about their support and they were appreciative of the support that was given. They told us staff talked to them and were friendly and kind and usually treated them with respect. One person did make reference to the fact that staff talked 'over their head' on occasion and did not always include them in the conversation. The person did not wish to be named but said they would raise this issue themselves with the manager. We informed the manager of this conversation. People told us their wishes for privacy were upheld and were able to spend time in their own rooms when required. People had a range of adapted equipment for their use such as large buzzers and pendants to request staff assistance. This meant people were supported to be as independent as possible.

We saw information about the service on display together with details about the use of advocacy services to enable people to have access to independent sources of advice and support. There was evidence people who used the service and their relatives were invited to contribute and be involved in reviews and decisions

about support that was provided to ensure they were happy with the way this was delivered. A social care professional told us, "[Name] obviously trusts their keyworker very much and when in a stressful situation like a review, he holds her hand for reassurance. She also has accompanied him to hospital for treatment and knows the early signs when [Name] is uncomfortable or in pain and what action to take to prevent it flaring up."

There was a core group of staff who had worked at the home for a long time and people told us the regular staff were good. One person commented, "Overall, I am happy here." Another person said, I can't complain, nowhere is perfect," and, "I think compared to others it is one of the best places I've come across." However, people were less complimentary about the quality of the care they received when agency staff were on duty. One person said, "On the whole it's very, very good but they [the agency staff] just don't know us as well." We saw that staff had made efforts to ensure that people's specific care needs were identified and agency staff were kept informed and updated on their care needs. For example, we saw individual placemats were used to specify people's specific dietary and feeding needs. These were developed to ensure individuals with communication impairment were safeguarded at mealtimes by detailing their likes and dislikes, together with allergies, food preferences and any special dietary requirements. However, these could be removed when not needed otherwise they are out for everyone to see. We also saw the catheter bag for one person who was in bed was laid in a washing up bowl in view of the open door and anyone passing, which compromised their dignity. We discussed the care of this person concerned with the registered manager.

Records of people's daily activities were kept in a diary in either people's own rooms or in the ground floor office. Care plans and other care records were securely stored in the ground floor office and we observed that details that needed to be communicated about people were passed on in private.

When we visited we observed staff and volunteers were attentive to meeting the differing needs of people who used the service and saw they demonstrated a positive regard for what was important and mattered to them. We saw staff provided support to ensure people's dignity was promoted and observed interactions between staff and people were open, positive and friendly.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2015 we recommended that the provider reviewed the use of daily notes to make sure that records were factual and did not reflect the views of staff. The provider told us in their action plan that recording would be discussed at staff meetings and reinforced through updated care plan training and 'behaviour awareness' training.

The provider stated in their action plan that this work would be undertaken when discussing people's personal plans at meetings and they said they had also provided leaflets about personal centred planning.

When we visited in November 2015 we were told by the registered manager that care plans were being re-written. In their action plan, the provider told us they would take action, "To complete a full audit of all personal plans ensuring that paperwork is completed fully and reflects the needs and wishes of the service users and authorisation signatures are in place. To continue to include residents families if the service user wishes." They told us that communication care plans would be reviewed and where communication aids used ensure communication aids were available. All of this work had a completion date of 31 March 2016.

In an update to their action plan dated 17 March 2016 the registered manager told us they had completed a quarter and had a new target date for completion mid-June 2016, to include new consent and best interests form. The activities coordinator and care assistant were identified as 'championing' communication, and they said person centred planning reviews were on-going. This date was extended owing to staffing issues and the care supervisor covering nursing shifts and was on-going at this inspection visit. At a meeting held with the head of inspection and the registered manager on 13 August 2016 the registered manager confirmed this work was completed by the end of July 2016.

In a recent survey people said they were happy with the care overall. However, 65% of people said they were not actively involved in developing and reviewing their support plan. We saw daily records were completed but we found some inconsistency in the way staff used these to assist them to evaluate whether people's care plans remained appropriate. For example, one person was nursed in bed in response to a potential risk of pressure damage when seated in their chair. An intermediate care plan was in place to deal with their pressure area care and the registered manager told us they were sourcing new seating, together with family support. However, this person's care plan regarding their social and emotional needs had not been reviewed and updated to take account of the fact they were being nursed in bed. This meant that their care plan did not include a consideration of the impact this change may have on the person and their behaviour or what action staff could take to reduce the risk of the person becoming isolated.

During the time we spent with them the person repeatedly asked for assistance to ensure their comfort. They were unable to summon assistance of staff via a call bell due to their physical disability and there was nothing in the person's care plan which addressed this need. While the use of intermediate care plans provided a good audit trail for nursing tasks we found that this person's social care plan had not been updated to ensure all of their care and support needs were appropriately met at this specific time. We discussed the care of this person with the registered manager and the head of operations. They told us that

under normal circumstances, the individual chooses to spend large amounts of time in their room away from communal areas preferring to watch their TV sports. Whilst in bed the person was observed at a minimum hourly period; there was a tick sheet in the office. This was put in place due to the person having a varying ability to use his call bell.

People's rooms were highly personalised. The garden had been landscaped and a wheelchair swing and outdoor gym equipment had been purchased. We also heard about plans to refurbish the sensory room and we saw that eye gaze computer equipment had been purchased. This was specialist equipment designed for people who have difficulty physically using a computer.

Dedicated activity staff were employed and staff and volunteers provided activities such as knitting, artwork, trips out and parties to celebrate the 60th anniversary of the service. There was a thriving resident's committee and funds from their fundraising and from two local Leonard Cheshire shops were used to enhance the general activities, provide specific items of equipment and pay for additional staff to support people.

The service had its own minibuses and a rota of volunteer drivers who assisted with trips and holidays and we heard of some good examples where people were supported to follow their own interests and pursuits such as fishing or attending church. We were told that everyone who wished to go on holiday had been away that year. Examples included barge holidays, hotels and visits to other Leonard Cheshire care homes. One visiting professional said, "There are always plenty of activities and days out going on with plenty of choice for residents." Another professional told us, "[Name] doesn't like noisy places where there are lots of people, so he goes out to the country and horse riding where it is peaceful and quiet. He is taken on holiday every year and his likes and dislikes are taken into consideration when choosing a suitable place."

We observed the complaints procedure was displayed in the service and had been discussed at residents and staff meetings. The activities organiser told us about the forthcoming meeting with Future Choices. They said that this work was due to start in the autumn to look in closer detail about the things people wanted to change and to listen and support people. Future Choices is an organisation wide initiative Leonard Cheshire Disability developed to respond to the Department of Health initiative Working Together for Change on commissioning services. The Future Choices approach was about enabling people to look at options in their lives and any future plans they may have and to support people to realise those plans. This included the completion of person centred reviews and then participating in facilitated group sessions with staff to take account of their views.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2015 we identified issues with the quality of some records relating to people's care and support. Some of the charts used to monitor people's health were not completed in a consistent way, which meant that people could not be confident that they received safe and effective care that met their needs.

At this inspection we found remedial action had been taken to address the shortfalls that had been identified at the last inspection and while some of this work remained outstanding we could see progress had been made. However, further action was needed to ensure the quality monitoring systems were completed in a timely way, to ensure they were consistently effective in identifying shortfalls and driving improvements. For example, the timescale for the completion of full audits of personal plans in the provider's action plan, which had an original completion date of March 2016 was subsequently extended twice, to mid-June and then to the end of July 2016.

As part of our inspection we reviewed a Leonard Cheshire Disability audit report completed in July 2011. The registered manager informed us this was the last audit undertaken. We saw this identified the similar issues to those that we highlighted. For example, the report stated, "There is a lot of information in the daily record and it is difficult to chart progress without a lot of reading." When we visited we found that people's daily records were not being used by staff to assist them effectively to evaluate whether care plans remained appropriate. Following our visit the registered manager advised they had introduced the individual diaries to record people's daily activities within the past 12 months. However, when we visited we saw that staff recording in these was variable, with some entries left unsigned and gaps in recording. The auditing processes in place had not identified these issues. We found that the internal management audits that we saw lacked sufficient structure to ensure that all aspects of the service were monitored and to ensure that identified actions were completed in a timely way. We concluded that the provider did not have sufficiently effective systems in place to monitor the service that people received and assure themselves that it was consistently of a good standard.

We reviewed the minutes from a recent staff meeting. This was attended by a senior manager from the organisation and followed a complaint investigation undertaken by an independent consultant, which had impacted staff morale. The head of operations told us that the purpose of the meeting was held to reassure staff that any allegations were looked at seriously and to move forward positively with good team working.

Some staff said that staff practice was variable according to who was present in the home and the person responsible for managing the shift. Examples we were given included limited time spent with people; staff support and assistance given to people at mealtimes; staff smoking breaks, and the inappropriate use of mobile phones when assisting people. Managers' offices are located on the first floor in an area that is not accessible to people living in the home. This makes direct observation of staff practice difficult unless managers are working 'on the floor'.

Several staff reported the lack of senior management support when they had raised concerns previously. We

spoke with the registered manager about this but they reported events being spoken about were largely historical and not relevant. The registered manager agreed that there had been a difficult period, which had caused divisions within the staff team however they said this had not impacted on the quality of the care provided.

The area manager who attended the latest staff meeting had encouraged staff to work together positively to improve team work and support the registered manager. However, there were no plans in place that we could see to provide on-going staff support, motivate staff teams and monitor performance. This meant that there was the opportunity for further gaps and miscommunication between the different staff teams and staff members. We saw some evidence of this when we visited. For example, we saw a small voice recorder on the wall next to the menu board. Staff told us the use of this item had been discontinued because they said 'silly' messages had been recorded. A notice to this effect had been placed next to the equipment, which was not being used. This showed a lack of management oversight to address issues. The registered manager knew who it was but instead of addressing this with individuals or indeed every staff member a note had been left. This meant that people who would benefit from this communication aid did not have access to it and demonstrated a lack of commitment to resolve issues effectively.

This was a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. People who used the service, staff and visiting health care professionals all spoke positively about the registered manager. People who used the service and the staff we spoke with told us the registered manager was approachable. One person said, "I would highly recommend all the staff at Alne Hall and as a place to reside."

Before the inspection we asked the registered manager to confirm the progress of their action plan following the inspection in November 2015. We also asked to see a copy of the last audit undertaken by the Leonard Cheshire Disability Quality team to review in preparation for our follow up visit. The registered manager sent us a copy of a Leonard Cheshire Disability audit report completed in July 2011. When asked, the registered manager informed us this was the last audit undertaken. Following our inspection visit we met with the registered manager and the head of operations who provided us with further detail of the management systems, which were in place to assess the quality of the service to evaluate and improve practice. Examples included one to one meetings between head of operations and registered manager every six weeks. Management reporting systems were used to inform head office on complaints, safeguarding, accidents and incidents and these were reviewed by the quality improvement team to monitor trends and items notified to the head of operation.

Information regarding maintenance checks were held on the electronic system, to ensure that any actions were completed within set timescales. This included safety checks of legionella, asbestos, hoists and vehicle tail lifts. In addition to these checks a monthly health and safety audit was carried out in the service and a bi-annual audit was undertaken by the health and safety team

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective management systems were not in place to assess the quality of the service and to evaluate and take the necessary steps to improve the quality of the service. Regulation 17 (1)(2)