Regal Care Trading Ltd

Alpine Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection was carried out on 17 and 18 June 2015. It was an unannounced inspection.

The service provides personal care and accommodation for a maximum of 30 older people. There were 26 people living there at the time of our inspection, many of whom were living with dementia and additional needs such as mobility difficulties and sensory impairments. Some people were receiving end of life care. Some of the people living in the service were able to express themselves verbally, others used body language.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 the last inspection in August 2014 we found no concerns. During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking enforcement action to ensure the provider achieves compliance.

Summary of findings

People were not kept safe from abuse and harm as staff did not respond appropriately to incidents of abuse and did not have accurate contact details for reporting these. People were at risk of unsafe practices to help them move around the home as staff did not follow moving and handling best practice.

People were not protected from the risk of the spread of infection as the homes décor and furnishings made effective cleaning difficult.

The provider followed safe recruitment procedures to ensure staff working with people were suitable for their roles. However, staffing levels were not based on people's needs and did not promote their safety and wellbeing.

Medicines were not always stored safely and some necessary checks had not been made. Some records showed that topical medicines had not been given.

Staff did not have the necessary skills and knowledge to ensure they could meet people's diverse needs. Staff had not received the supervision and support they needed to enable them to carry out their roles effectively.

People were not protected from undue restriction as staff did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Meal times did not take account of individuals needs and some people's fluids were not effectively monitored.

People received medical assistance from healthcare professionals including district nurses, GPs, chiropodists and the local hospice. However, staff did not consistently follow guidance regarding people's health needs.

The premises did not meet the needs of people living with dementia and mobility difficulties.

Some staff were not kind or compassionate in their approach. Staff did not always listen to people or treat them with respect. Staff did not always respond or know how to respond, to people's distress.

People were not given information in a way they could understand.

People did not always receive a personalised service as some staff did not know people well enough to care for them in a way that met their needs and preferences. People's preferences and social needs were not always respected even when known. Activities did not meet the needs of people living with dementia and additional needs.

People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed and their involvement encouraged.

The service was not well led. The service had recently been taken over by a new provider having been in administration for the last three years and quality assurance systems had not been effective in recognising shortfalls in care and quality. We found a number of areas of poor practice during our inspection that had not been identified by the management.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of harm or abuse.

People were at risk of harm because staff did not consistently follow safe moving and handling practices.

People were not protected from the risk of the spread of infection in the service.

There were not sufficient staffing levels to safeguard the health, safety and wellbeing of people.

People were not consistently protected by safe systems for managing medicines.

Is the service effective?

Inadequate

The service was not effective.

People did not receive effective care from staff who had the necessary skills and knowledge to meet their needs. Staff did not receive the supervision and support required to carry out their roles.

People were not protected from undue restriction as staff did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Effective systems were not in place to ensure that everyone's fluids were monitored and that people received sufficient fluids. The timing of meals did not take into account personalised needs.

People were not consistently supported with their health needs.

The provider had not ensured the premises was suitable for people living with dementia and mobility difficulties.

Is the service caring?

Inadequate

The service was not caring

People were not consistently treated with compassion.

People were not consistently treated with dignity and respect.

People were not given information in a way they could understand.

Is the service responsive?

Inadequate

The service was not responsive.

Some staff did not know people well enough to provide person centred care and support.

People did not receive care that met their individual needs and preferences.

Summary of findings

People knew how to make a complaint and were given opportunities to give their views. Relatives told us they were kept informed by the home.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that there were systems and leadership in place to effectively monitor the culture, quality and safety of the services provided.

Alpine Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social care 2008 as part of our regulatory functions.

This comprehensive inspection was carried out in response to concerns that were shared with us and to check whether the provider was 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. The inspection was unannounced, carried out over two days by two inspectors on 17 and 18 June 2015 and included out of hours inspection.

We spoke with six people, nine relatives and four health professionals including District Nurses, a Physiotherapist and an Occupational Therapist. We also spoke with the registered manager, the director of operations, five care staff, two agency workers, the activities co-ordinator, the deputy manager, two members of the housekeeping staff and the maintenance worker. We examined records which included eight people's individual care records, five staff recruitment files, eight supervision records, staff rotas and staff training records. We sampled policies and procedures and the quality monitoring documents for the service. We looked around the premises and spent time observing the support provided to people within communal areas of the service. 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.

After the inspection we also spoke with the local authority safeguarding team, commissioners and clinical commissioning group.

Inadequate

Is the service safe?

Our findings

People told us, "I am safe enough I guess", and "It is safe because there are other people around." One person said, "I don't really feel safe- you never know what's going to happen next." A relative said, "I really hope the staff make sure residents are safe, it seems that they do." Another told us, "At the beginning it was ok but now there are not enough staff." We found the service was not safe.

We inspected the home in response to information of concern we had received and during the inspection we were made aware of additional concerns relating to people's safety in the service. We were shown a photograph of where a member of staff used unlawful restraint to ensure a person did not move freely. The service notified the appropriate authorities but did not do so until five days after the incident. Two senior members of staff were made aware of the photograph but did not report it to the local authorities. Although disciplinary procedures were implemented these did not take effect until four days after the incident which meant people may have been exposed to possible abuse. Staff told us they had received training and were aware of their responsibilities to safeguard people from harm but they had wanted to wait for the registered manager's view before taking action. One senior member of staff told us, "In hindsight I should have immediately raised a safeguarding (notification)." We spoke with the registered manager about their safeguarding responsibilities and they subsequently reported this and other safeguarding issues to the Local Authority. We looked at the service's safeguarding policy and found that it had incorrect contact details for reporting safeguarding concerns.

This meant people were not protected from the risk of harm or abuse because staff did not respond appropriately to incidents of abuse and did not have accurate contact details for reporting these. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Risk assessments were not consistently followed in practice. People's care plans included an assessment of mobility as well as a moving and handling review. However we observed and were told of moving and handling practices which placed people and staff at risk of injury. We observed that there was a sign on the wall where wheelchairs were stored that said foot plates must be used. In one person's care plan there was an accident and incident form dated March 2015 that said, "Staff are to ensure footplates are fixed and not flapping around." However we observed one person moved to the lounge in a wheelchair without footplates, which meant they were put at risk of harm and injury. We were told this was because the person did not bend their knees and had their legs outstretched. We observed two members of staff trying to assist this person to transfer them from their wheelchair to a standing hoist. As the person's legs were outstretched, staff were unable to position the person's feet on the hoist. Despite the person not having bent their knees, staff continued trying to connect the sling around the person's back, to the hoist. When the person voiced some distress, staff said, "Do you feel pain? You don't like this hoist do you?" The staff continued to move the person using another sling, however as the person was still unable to bend their knees this would also not connect to the hoist. The two staff were joined by a third carer who said, "This is hurting her, as it is a standing hoist." As a result, the hoist was removed and the person was left to remain in her wheelchair. When we spoke with the agency staff member involved, they said that they had not been given any guidelines as to how to safely and comfortably assist this person and were instead using their experience.

We spoke with visiting health professionals who told us that they thought people and staff were at risk of harm as equipment was inadequate. They told us, "The equipment is not appropriate; they have a standing hoist and a mobile hoist and nothing in-between." During our inspection we were made aware of another recent incident where staff moved a person in a wheelchair without footplates and another staff member witnessed the persons legs fold under the wheelchair.

During our inspection one staff member submitted a written report to the registered manager regarding concerns where a person with a broken hip was transferred from the lounge to their bedroom within a period of ten minutes. The staff member reported this as they felt that within such a short time frame, safe and comfortable moving and handling practice could not have taken place.

Staff did not consistently follow safe practices, putting both staff and people at risk of harm and injury. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Care plans included a dependency tool to determine the level of support people required. The registered manager told us that staffing levels were based on this analysis of need and that as the majority of people spent their day in the lounge, staffing levels were sufficient. However we found that this was not the case. People told us, “Staff have more to do and are rushed off their feet” and “The staffing has altered and you don’t really know who is coming on.” Relatives told us, “It is so short staffed at weekends” and, “Staffing levels could be a little better.” One relative told us, “We go in and we see things- there is never enough staff in the lounge; a month ago I found a man lying on the floor with no staff around and we had to go and find staff.”

Night staff told us, “Nights are busy; it should never be just two members of staff.” As a result of a recent incident, one additional member of staff had been deployed for providing one to one support to a person who was at high risk of falls. However, on the first day of inspection we observed and were told by staff, that two people had been up all night and had not been to bed and that this was usual for these two people. One night worker told us “We have wanderers to keep an eye on.” By 6am and before staff arrived for the day shift, five people were up and sitting in the communal area unsupervised. One person became distressed and was crying, “I can’t find anyone, I can’t find them.” This person’s care plan noted that they became, “Very anxious and emotional at times, often about being on their own,” and that the person, “ Is not orientated to her whereabouts and finds this distressful- staff need to reassure her at this time.” We observed another person who was disorientated and trying to find a toilet, at this point the inspector located a member of staff to assist.

During our inspection additional staff were brought in during the daytime, as well a manager from another home. On the second day of our inspection, there were five care workers and an activity co-ordinator in attendance. A member of care staff told us, “This is exceptional, usually there are only four of us and it is a struggle due to people’s complex needs.” Another member of staff told us, “The one to one has been put in for your benefit.” We looked at rotas planned for the days following our inspection and these indicated that planned staffing was to return to two staff at night and three care staff and a senior during the day time. The rota also showed that for the days following the inspection some night shifts were planned to be covered by agency staff alone, with no permanent members of staff. We also observed a member of care staff was cleaning the carpet after a person had been incontinent in the dining room. This task took half an hour, during which time they were taken away from care duties. The staff member told us, “I don’t mind doing this; it is all part of the job.” When we enquired about the whereabouts of domestic staff we were told they only worked in the mornings. This meant that while care workers were carrying out domestic tasks, less staff were available to respond to people’s needs.

This failure to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a very strong odour. On arrival we found that some areas of the building were not clean and toilets were soiled. We found a red sack full of used incontinence pads in a downstairs corridor and a laundry bin full of dirty clothing, in another corridor. One health professional told us, “There is a strong smell of urine but it has a lot of carpet and people are incontinent so it sometimes smells.” Another told us, “The smell is awful.” One relative said, “There is always a smell, sometimes it’s worse than others.” Staff told us that some people had recently had vomiting and diarrhoea and that the building had been deep cleaned. However they said, “It’s an impossible task, the place is falling apart, there is no way you can clean it properly.” And, “When you touch the paint, it flakes off.” We observed areas where the plaster work was crumbling and where paint had flaked on to the floor. We also saw that flooring that was designed to be sealed for effective cleaning, was damaged. We told the registered provider about this and during our inspection they took action to repair some damaged paintwork and plasterwork and to clean carpets.

The provider had not ensured the premises were clean and well maintained. There was an increased risk of infection to people. This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The senior care staff on each shift were responsible for giving medicines and we observed one member of staff as they gave people their medicines. Each person had a Medicine Administration Record sheet (MAR) with a photograph of the person to ensure staff gave the correct medicine to the right person. Staff and the registered

Inadequate

Is the service safe?

manager told us that storage of medicines was inadequate. We found that staff recorded the temperature of both the medicine room and the medicines fridge every day. However, we found that the medicine room was small, and so not all medicines could be stored there. We found that dressings were kept in a box positioned on the floor of the medicine room and this made access to the medicine room difficult. On the first day of our inspection we observed that boxes of food supplement drinks and topical medicines were not stored appropriately and were instead stacked outside a person's bedroom in a corridor. This meant people had access to prescribed medicines.

Staff told us they used two trolleys for medicines and these were kept in another cupboard where care plans were stored. During our inspection we found this cupboard unlocked and with two bags of medication on display on top of a trolley. One was marked for the fridge and therefore had not been stored appropriately. This meant that medicines were not always safely stored and people were at risk.

We also found that some people's medicine came under the Misuse of Drugs Act Regulations 2001 and required specific safe storage under the Misuse of Drugs (Safe Custody) Regulations 1973. Whilst these medicines were stored correctly we found that records were not up to date and accurate. One person's medicine had not been consistently checked and records showed that staff had checked them on two days since the 08 June 2015. We found that one person's medicine needed to be disposed of three months after opening. Records showed that it had been opened in November 2014 and whilst the person was no longer using it, this medicine had not been disposed of.

People were not consistently protected by safe systems for managing medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

Some risk assessments were in place and covered areas such as the use of bed rails, moving and handling, falls, skin integrity and loss of weight. They included measures to be taken by staff to minimise risks for people. For example, a person had been identified as being at risk of skin damage. The relevant risk assessment included instructions for staff to ensure they used pressure relieving equipment and changed their position regularly. This person used this equipment and staff checked their personal care needs several times during the day. Another person was unable to use their cord bells to summon help at night and staff checked on them hourly. Another person was at risk of choking and their risk assessment included guidance from a speech and language therapist about the provision of additional support at mealtimes. Staff followed this guidance and ensured they ate small portions of food slowly.

We looked at staff recruitment files and found they included a completed application with previous work history, qualifications and experience of the person applying for the job. References and criminal record checks were also included. This meant that the provider had taken action to ensure that permanent staff were as far as possible both suitable and safe to work with people living at Alpine.

Inadequate

Is the service effective?

Our findings

People told us staff, “Know what they are doing” and, “The staff know me well.” One relative told us, “The staff seem very well trained and efficient, they obviously have a lot of experience in the job.” However another relative told us, “Some of the staff are really good and some are not, staff are left to their own devices.” One health care professional told us, “Some of the staff lack the basic skills and knowledge needed to support people with complex needs.” Our observations indicated that the service was not always effective in meeting people’s needs.

Staff had received essential training that included first aid, fire awareness and moving and handling. Additional training was available, such as dementia care awareness, end of life, diabetes and catheter care. Where staff had completed these courses they were not always using skills or the learning from the training to deliver safe or effective care. Staff had undertaken training in mental capacity and safeguarding adults. However three care workers out of five we spoke with were not knowledgeable about Deprivation of Liberty Safeguards (DoLS), although they had received training. The Care Quality Commission (CQC) monitors the operation of (DoLS) which apply to care homes. We found that the registered manager understood when an application should be made and how to submit one. Appropriate applications had been made in respect of people being unable to come in and out of the premises as they pleased. However, an illegal restraint had been used by a member of staff which had restricted a person of their liberty. This restriction imposed on the person did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice.

Staff did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care worker was unable to demonstrate their knowledge of the appropriate authority to contact should they suspect abuse to take place. One member of staff told us, “The main trainer delivers the training but does not answer our questions and just talks over us, so it is sometimes difficult to relate what we learn to our daily work.” This meant that some training was not consistently effective in ensuring staff knowledge and practical skills.

One care worker told us, “We get supervision at least twice a year but we get informal supervision when we ask for support.” The home had a supervision policy that stated; “Every employee will be invited to a supervision session with their manager or supervisor at least 4-6 times each year and more often if a performance problem is under discussion.” The policy stated that the purpose of supervision was, “To promote standardised, safe and best practice working practices” and that each supervision would be recorded. However, staff had not received regular supervision that was recorded. One care worker had two individual supervision and one group supervision in the last two and a half years. Another care worker who started work eight months ago had received one supervision session and another staff member, suspended pending investigation, had received one supervision and one group supervision since starting ten months ago. This meant that staff were not supported with a system of regular supervision that enabled them to review their standards of work, discuss any concerns and to carry out their roles effectively.

Not all staff had received the appropriate support, training and supervision to ensure they could deliver care and treatment to service users safely and effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us, “The food is good” and staff, “Will get you a cup of tea if they have got the time to get in the kitchen to do it.” We observed lunch being prepared and served. The meal appeared hot and well- presented and was served in sufficient amounts. People were offered an alternative dish and were encouraged to have second helpings. Three members of staff helped people who were unable to eat independently. They provided encouragement and respected people’s pace.

One person’s care plan noted that they were able to eat independently but preferred to eat slowly and should be left to eat at their own pace. Although the care plan also stated they, “May require prompting.” However we observed that this person was helped to a chair for their lunch at 12.30. They waited half an hour for their meal to be served and remained sitting, eating slowly as their meal became cold over the course of four hours. As the person finished their lunch, staff served supper which meant this

person's meals were not timed to meet their needs. Their eating and drinking care plan gave no guidance as to how slowly this person preferred to eat and how best to support them in a way that met their needs.

Staff used hand held computer devices to record daily care and staff relied on these to alert them to delayed or missing care. The registered manager showed us their computerised system that recorded when care had been given. Where something was included in the plan of care this meant staff would be alerted should this not be done. However where there were no fluid targets this meant staff did not receive an alert when people had not drunk much. As a result we saw computerised notes that showed that some people had drunk very little as this had not been flagged up by the hand held devices. We spoke to the registered manager about this who acknowledged this was an issue and was planning to amend the information held on the devices.

We observed one person who got up at 5.30am and despite requesting a drink, waited one and half hours before being given one. This was then returned as had already gone cold before being served.

Food and drinks were not always offered or provided according to people's needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

One health professional told us that she was concerned that staff did not always follow guidance, "I have asked staff quite a few times to wash and cream her legs and I don't think this is always done, her legs are extremely dry and the cream would have helped." We checked this person's Topical Medicines Application Record which noted the cream should be applied morning and night. We found that on three out of the previous seven days there was no record that this topical medicine had been applied. The person's care plan said that they had a skin infection which meant their legs were at risk of swelling. As a preventive measure, the staff were instructed to ensure the person kept their legs elevated when sitting. We saw their legs were not elevated when they were sitting in the lounge. On the first day of our inspection we found that this person had not been to bed all night and was sat in a chair without their legs raised. At no point during our two day inspection did we observe this person have her legs elevated.

This meant people were not consistently supported with their health needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had many different changes in levels including slopes within the lounge and dining area. Changes in level were not marked or visible which meant people were at risk of tripping or falling. All corridors were decorated the same and although there was signage in place, we observed that some people found it difficult to find their way round the home. During the morning when staff were not present we were approached twice by people disorientated and unable to find the toilets.

The bathing and toilet facilities did not meet the needs of people who used mobility aids, required full hoisting or staff to support them with transferring. Bedrooms were positioned on the ground and first floor, none of which had en-suite facilities. There were two bathrooms and a wet room shared by everyone, as well as some additional individual toilets. However all bathrooms and toilets were small. Access was restricted as some doors opened onto radiator covers. This meant there was not the full door width available for entering. On the second day of our inspection we observed people having their hair washed in the hand basin of a ground floor toilet. The hairdresser stood bent under a wall mounted boiler whilst she supported people with washing their hair next to the toilet. When an inspector raised this with the hairdresser and manager, they were told this was because the bathrooms did not meet people's needs. One health professional told us, "The bathrooms are not conducive to people's needs and the toilets are too small- you couldn't get in there to attend to their personal needs," and "The bedrooms are too crowded, especially the rooms with two beds and especially when they try to put a hospital bed in."

Access to the first floor bedrooms was either by staircases or a lift. The lift had an inner door that was difficult to close and did not promote people's independence. Access to the garden patio was available through patio doors but these did not have a ramp that enabled easy access. Where people were living with dementia and had mobility difficulties the design did not aid their independence and navigation. The provider had not ensured the environment met the diverse needs of people living at the home.

Inadequate

Is the service effective?

This meant that service's layout and facilities were not suitable for the needs of people living there. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about people's preferences and dietary needs such as special diets were displayed in the kitchen. There was ample provision of fresh food in the fridges, freezers and larder. The service was awarded a food hygiene rating at level five which is the highest level, in January 2014. People told us they enjoyed the food in the service. They told us, "The food is lovely", "Very nice", "Always jolly good." A relative told us they were welcome to stay and eat with their family members if they wished. They said, "The food is always very nice and the staff are very welcoming." Some people had food and fluid charts and these were kept when people's appetite had declined and a referral made to a General Practitioner and a dietician appropriately. Fluid out-takes were monitored for people who needed catheter care.

People were referred to healthcare professionals appropriately and we saw records where people had accessed their GP, district nurses, dieticians, physiotherapists, and specialist consultants. Their guidance was included in people's care plans for staff to follow. For example, a community psychiatric nurse had provided guidance about how to manage a person's specific behaviour. This was followed in practice as staff used calming methods outlined in their care plan. One health professional told us, "Whenever I have raised issues, on the whole they (staff) have been good and they have done what I asked of them." A person's wound had healed satisfactorily when staff had followed instructions from a specialist nurse about how to dress and monitor the wound.

Is the service caring?

Our findings

People who were able to talk with us gave us mixed comments about the care they received. Some told us, "The staff are nice" and, "On the whole staff are very good." Others said, "You can have some night staff that are not so good but the lady this morning was nice." Some relatives told us, "The staff are really caring" and "I have never seen any of the staff act disrespectfully." Others told us, "I've seen good care and less good care; sometimes I watch people call out and staff tell them to sit down – Staff just palm them off." One member of staff told us, "I sometimes feel that agency staff are more forceful than I would like," and, "Some of these staff don't speak to the residents."

Some staff had developed relationships with people and were knowledgeable about people's individual needs. We observed that some staff treated people kindly. However, this approach was not consistently used by all the staff. We saw one person distressed and calling out to an agency staff member, "I am so frightened, please help me." The member of staff did not respond and walked away. One person looking on told us, "Staff don't do anything, she cries every day." We observed that the person became more distressed and the agency member of staff appeared unfamiliar with how to support them, instead repeatedly saying, "We need to change your pad." As the person became more distressed a permanent member of staff came to assist and was gentle and reassuring. We spoke to the agency staff member and they told us they had not been given guidelines as to how to support this person. One staff member said, "The handover lady was already late and so she was rushed in showing me around."

One agency staff member sat in the lounge and made no interaction or acknowledgement of people also sat in the lounge. We raised this with the deputy manager who spoke to the worker accordingly. We then observed this member of staff approach a person who had been eating to take away their plate and cutlery. The person held on to their fork and the member of staff attempted to take it out of her hand. When the person did not give the fork over, the member of staff expressed annoyance and frustration. The manner in which this staff member spoke to the person did not demonstrate care and compassion. We raised this with the registered manager who immediately spoke with the staff member and removed her from the home.

One staff member sat down next to a person who was sat at a dining table but not eating. The staff member began to eat and drink in front of them, offering no explanation or acknowledgement that they were there. Once the member of staff had eaten they left the table, again without speaking or smiling. This showed a lack of respect and courtesy.

One person was helped to a chair for their lunch at 12.30. The person remained in their chair for a further five hours. Over the course of five hours, the person was approached twice by a member of staff who enquired, "Are you all right love?" but left without seeking a response. Another member of staff told them, "This chair can't be comfortable, let's get you somewhere else shall we?" then left without following this up. When the inspector enquired, staff told them, "Oh she is fine she always take ages we just let her get on with it." A visiting manager from a sister home knelt by her side, maintained eye contact, smiled to her and gave appropriate encouragement for three minutes. While the person was eating, two members of staff came to eat their lunch. They each sat away at other tables without looking at the person who remained alone to eat and sang softly to herself for the whole afternoon. Activities were taking place in the lounge and the person was not given the opportunity to become involved in any activity. As the person finished their lunch, supper was served and they remained sitting in the same position. The staff did not enquire whether the person needed help with her personal hygiene needs. This showed that staff neglected to ensure people were comfortable and that their needs were consistently met.

Another person asked for a cup of tea. She was told, "Not yet, you must wait for the tea trolley it will come soon." A person told a member of staff, "I want to leave the table." The member of staff replied, "No, not yet, you must eat more." Although this reflected staff's concern about the person's appetite, the reply was spoken in a way that did not respect people's right of choice and dignity.

One person told us, "My family get annoyed because a lot of my clothes have gone missing." Relatives told us they understood how difficult things were as the laundry equipment kept breaking down. One relative told us, "The other week she had someone else's trousers on but we understand that happens in a care home." Another relative said, "Mum is sometimes wearing someone else's clothes," and another told us, "The majority of time she is in her own

Is the service caring?

clothes, it's not a problem to us." Although relatives understood the challenges, the service did not respect people's personal identity. There was no system in place to ensure that people wore their own clothes and that these were kept safe. Two housekeeping staff were deployed part-time and rotas showed that one member of laundry staff worked five hours a day. One relative told us, "The laundry lady is brilliant, she works over her hours as the dryer is always breaking down." People's clothing were washed, dried and returned to them the same day, however, staff told us that there was not enough time for people's clothes to be ironed regularly. The provider had not made sure they provided care and treatment in a way that ensured people's dignity and treated them with respect at all times The registered manager and operations director said they were exploring a new system for laundry.

During our inspection there was at times a strong odour throughout the home and on two separate occasions the dining area and ground floor corridor needed to be cleaned when a person was incontinent. We were approached by people who were unable to find a toilet themselves and we saw that bathrooms were small and people had commodes in their bedrooms. The deputy manager said that they struggled to support people with continence as there were often delays in the assessment undertaken by district nurses. We found incontinence pads stored in bathrooms and in one bathroom we found a list of people's names and the type of continence wear they required. This meant people's personal information was not respected or confidential. This list also included names of people who had not been assessed for continence and gave guidance as to what continence wear they should use. During our inspection we observed people sitting for long periods of time who were not supported to use a toilet. We found that continence plans were not always up to date or complete. For example, one person who was incontinent during our inspection, had a plan that made no reference to the aids they used. We spoke with a senior member of staff regarding people's continence and there was no suggestion of alternative ways for promoting people's continence. People were not consistently supported with their continence or supported to maintain their dignity and independence.

We asked the registered manager to show us records of when people had received a bath or shower. They explained that they did not include this in the plan of care held on hand held devices. This meant staff were not alerted when people had not been supported to bath or shower. We asked to look at the daily records of three people chosen at random. The registered manager was unable to find a record of them having bathed in the last week. This meant that there was no system in place to ensure that people's personal hygiene was respected as they wished and appropriate care given. The registered manager acknowledged this and told us they would ensure this was rectified.

People were not given information in a way they understood and that promoted informed decision making and independence. Relatives told us, "Some of the staff communicate well and some of them don't." We asked a member of staff how they communicated the choice of meals to people. They told us that they 'Wrote the choice on a piece of paper and showed it to them.' However we did not observe this in practice. We observed that people had a range of communication needs and that information was not always provided to people in a format that met their needs. For example, people were asked to take part in surveys but these were not accessible to many people living with dementia. There were pictorial signs at the entrance of communal areas to indicate their use however we observed that for some people these did not aid their way round the home. The daily menu and activities programme were handwritten on two notice boards. We asked four people whether they knew what they were about to eat and although they were able to communicate with us, none were able to identify what was on offer. There was a photograph of a meal pinned underneath the board, however it did not represent the meal of the day.

People were not consistently treated with dignity and respect and given information in a way that they could understand. People were not supported with their independence. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Is the service responsive?

Our findings

People's likes, dislikes and preferences were recorded in their care files. For example, where they preferred to sit while eating, what food they preferred, what type of clothing they liked to wear, what times they liked to get up and go to bed. Some people had completed parts of 'My Life", in which they recalled memories, their work, hobbies, family stories and things that were important to them. There were lists of people's favourite food and drink, films, actors, music, songs, and activities. One person had stated they liked the sound of cello music, cooking and works of a specific artist. Another person had stated they enjoyed Rock-N-Roll music, westerns films and football. However people's activity plans did not consistently take such interests and hobbies into consideration. People's individual interests recorded in their 'Life Story' were not reflected in the activities that were provided.

Permanent members of staff were aware of people's interests and preferences but agency staff were not. One told us, "No I don't know people's preferences or things like whether they take sugar." We saw that the dining area included pictures of people who had birthdays in June. We approached one agency member of staff and asked who was celebrating their birthday. They told us they did not know. The inspector pointed to people's photos and the member of staff said, "I don't know their names, just room numbers." Staff used hand held devices to record daily care and one agency member of staff told us, "Usually I would get introductions and be shown everything in the home but here I did not. I got this IPOD." We asked the member of staff how they would respond to a particular person's distress and were told, "That isn't in the IPOD. I don't know."

We looked at information available in the hand held devices which said that one person could get upset and in such instances staff were to reassure them. However, there was no guidance to explain to staff what this person would find reassuring. We looked at the person's care plan and this did not provide detailed guidance for staff. Staff did not have the information they required to meet people's needs

People's likes, dislikes and preferences were not consistently responded to. For example, a person's dislike of a particular dish was clearly outlined in their nutrition care plan and in their 'Life Story'. In the kitchen the cook referred to a list of preferred food and food to avoid for people. This person's specific dislike was not included in the list. This dish was included in the menu and served to the person who ate it. The person was not presented with an alternative although there were two dishes on the menu.

People were not engaged in meaningful activities. One person told us, "There is a lady that comes in, she gives us things to do- we have been making things to sell at the open day." One relative told us, "In any care home there can be a sense that in the afternoons there isn't anything to do and there has been an element of that here," and "I do think they can be left too long on their own at the dining tables."

An activities coordinator provided activities five days a week. During our inspection local school children visited to speak with people and their coordinator provided people with hand massage. We saw that the home had a Facebook page that showed photos of people outside, making cakes, listening to entertainers, tasting foods and celebrating events such as Chinese New Year. During our inspection we observed the coordinator propose to six people that they stepped outside in to the sunshine. Three people consented and were provided with sun hats and sun screen. They sat at a table outside and were smiling and conversing. The activities coordinator photographed them and they returned to the lounge a short while after.

One activity provided was bingo. Only four out of 17 people who sat in the lounge engaged in bingo. Not all people were invited to participate. A person told us, "We are bored, we just sit there and the lady just shouts numbers." Two people were watching television and an inspector positioned close to them was unable to hear the sound track as the activities coordinator was raising her voice to be heard by all. Other regular activities included jigsaws, memory games, skittles and quizzes. One relative told us, "He doesn't have any social needs now. He has a pressure cushion that he sits on and he is quite happy sitting there all day watching people coming and going." Another relative told us, "They don't have enough one to one, they are stuck in a corner just sitting there." One staff member told us, "We haven't the staff to cater for personalised needs." We found that where many people were living with dementia there was not sufficient personalised activity to

Is the service responsive?

stimulate and engage them. We spoke to the registered manager and operations director who said that they aimed to improve the care that people living with dementia received.

People did not receive personalised care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Care plans were reviewed monthly and updated when needs changed, for example when medicines were reviewed. However health professionals told us they felt the home was unable to meet some people's needs. One health professional told us "The manager and staff care about the residents but the care is not 100%," and "There are a lot of people with complex needs and dementia, who I really feel should have been moved on to homes and staff who have in-depth knowledge about dementia."

During the first day of our inspection we observed one person who although discharged from hospital had on-going health issues. We visited them in their bedroom that they shared and found them lying across the bottom of their bed with blankets rather than pillows positioned under their head. The person was not covered but had a sheet across their torso and appeared distressed saying, "It's been terrible." We asked the agency member of staff present what the person was saying and they replied, "I don't know." The member of staff ignored the person's distress before the inspector requested the person was made comfortable.

We spoke to four health professionals about this person who told us they were concerned about the homes ability to respond to this person's increased care needs. One health professional said, "Things changed quite dramatically and they (the service) didn't have the equipment to meet her needs." Another told us, "The bed is totally inappropriate, it's too low for safe moving and handling and it does not aid her pressure relief," and, "The sheet is not deep enough to be tucked in, and so it moves, creating pressure risk." We spoke to the registered manager who explained that they were awaiting the delivery of a hospital bed and that the person's family wanted them to be at Alpine. The registered manager told us that they sometimes struggled with making difficult decisions as to whether people could remain at Alpine or should be moved to nursing care. The provider told us that they were aware that some people needed to be reassessed and moved to a home that could meet their needs.

People did not receive responsive care that met their changing needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People's needs were assessed before they came into the service by the manager and their deputy. Care plans were developed to reflect people's needs including personal hygiene, communication, moving and handling, nutrition, continence, cognition, and social activities. For example, in a communication care plan, a person's need to be able to express their needs and wishes had been identified and staff were instructed to speak slowly and clearly, giving the person time to answer and be listened to. In a care plan about night-time care, a need for a person's skin to remain dry and intact was identified. Staff were instructed to check two hourly and reposition them in bed. Records indicated this was followed up in practice.

Relatives told us they felt welcome and involved. They told us, "They ring me if they have any concerns," and "For a member of the family, I get included." They told us they were kept informed. For example, when a person was unwell or when the home had been taken over by a new provider. One relative said "I get a lot of invitations and questionnaires through from them." We saw that residents meetings took place and looked at surveys that people and relatives had completed. We found that where relatives wanted to be involved they were enabled. For example, one person's care plan noted that they were sometimes assisted by their husband to eat.

The home's complaints procedure was included in the service user guide as well as the home's statement of purpose. There was a one page complaints procedure displayed that included timescales and contact details although the contact details for the local authority were out of date. One relative told us, "I've got a leaflet on the complaints procedure but I prefer face to face." Another told us, "I have never raised anything formally," and another said, "I have never seen the complaints book but three of us complained verbally." We looked at the complaints monitoring folder and found that two complaints had been logged during 2015 and on both occasions the registered manager had undertaken an investigation and recorded that they had taken action.

Is the service well-led?

Our findings

Most relatives felt they could approach the management team. One relative said, "The manager is great, I feel I could go to her, she is approachable, friendly and caring towards residents." Most members of staff we spoke with were satisfied with the manager's leadership style and support. They told us, "There is an open door policy we can just go into the office and talk to the managers", and "We are supported." One member of staff told us, "This place could be run better; the registered manager does not come out of her office often enough."

All the staff we spoke with were aware of the service's whistle blowing policy and of their responsibilities towards protecting people. They told us, "It is our duty to report anything we see that is not right", "I would not hesitate to speak up, even if there might be repercussions", and, "Whistleblowing is very important, just like safeguarding, it is about bringing attention to what is going on and make sure residents are treated safely." The home's whistle blowing policy that was displayed in the entrance had been reviewed and updated recently. However, we were made aware of concerns relating to people's safety and staff poor practice by two separate external professionals. Where a member of staff did recognise illegal restraint and poor practice, there was a delay in reporting this.

Some relatives described the home as homely, whilst others said "They make the best of what they have got" and, "It's a horrible building, it's not well kept." Staff told us that when the home had been in administration there had been challenges; "Before when we had the administrators, we were told we couldn't spend any money," and "Because it's a business every home has to be full." The registered manager told us "I want to continue and improve with a family home, a homely home." However we found that the environment, staff knowledge and some staff practices did not meet people's needs. The support and resources needed were not always available. The home had been taken over by a new provider in April 2015. We looked at the statement of purpose which had been updated with the new provider's details. The provider's vision and values were set out in the statement of purpose and included privacy, dignity, independence, choice, rights and fulfilment. However, during our inspection we observed practice that did not promote these values.

We asked the registered manager to supply us with quality assurance audits and they showed us the system operated prior to the new provider. This involved a system of monthly provider visits designed to capture evidence as to how the home met essential standards of safety and quality. However these visits had not taken place monthly. We found that the last two were undertaken in October 2012 and another in March 2015. Where issues were identified in the most recent visit, there was no action plan completed. We also found that both visits identified incomplete topical administration records and issues where medicines were out of date. During our inspection we found similar issues. This meant that where quality and safety issues had already been identified, necessary improvement had failed to take place.

A compliance and care management system was used to ensure policies were reviewed and updated continually. However, the safeguarding policy and complaints procedure both gave incorrect contacts details for the local authority. The staff handbook contained a code of practice for social care workers issued by a body that had ceased to exist in 2012.

We saw that a range of audits and spot checks were undertaken including infection control, care plans, personnel, medicines and dignity. However these had not identified the issues that were found during our two day inspection. The registered manager told us, "There is room for improvement but I think we are doing really well." We identified practices by both agency and permanent staff that did not promote people's safety or dignity. The manager had not identified these concerns and we saw that in a group supervision held in April 2015 they said, "Finally, I was very impressed with the quality of the first aid training and very proud of my staff. It proved how competent and experienced you are." The provider's governance systems failed to ensure that staff were supported with a system of regular supervision that enabled them to review their standards of work, discuss any concerns and to carry out their roles effectively

The registered manager understood their responsibilities for notifying the Care Quality Commission and referring concerns regarding people's safety to the appropriate authorities. However, a delay had occurred in referring recent incidents, which meant that people may have been exposed to possible abuse.

Is the service well-led?

One staff member told us, “As of yet we haven’t had much dealings with the new provider and up until recently we were in receivership and so were limited by what we could do.” The operations director had been in post less than two months and told us they were aware that improvement was needed as they had already “Identified gaps.” They told us that they were already exploring best practice in supporting people living with dementia and were aware of the need to improve the environment, activities and staff knowledge.

An action plan was being put together in response to recent safeguarding concerns and on the second day of our inspection there was a maintenance team working to rectify some of the maintenance issues.

The provider had not ensured that effective systems were in place 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

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not always supported by staff that knew them well. Staff did not know or respond to people's preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not protected from undue restriction as staff did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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 People were not protected from abuse as staff did not carry out their responsibilities to report incidents to the appropriate authorities in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not receive the support required to ensure their meals met their personalised needs. Some people did not have their fluids effectively monitored.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured that the home's layout and facilities were suitable for the needs of people.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider failed to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people. Staff were not provided with appropriate support and supervision.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect and given information in a way that they could understand. People were not supported with their independence.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 01 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not consistently follow safe practices, putting both staff and people at risk of harm and injury. The provider had not ensured the premises were clean and well maintained. There was an increased risk of infection to people. People were not consistently protected by safe systems for managing medicines and people were not consistently supported with their health needs.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 01 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that effective systems were in place to ensure the quality and safety of the service.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 01 September 2015.